Rules and Regulations for Critical Access Hospitals in Arkansas

Arkansas Department of Health

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TABLE OF CONTENTS

SECTION 3: DEFINITIONS.

For purposes of the regulations, the following definitions apply. ~~The word shall as used in these regulations means mandatory.~~

A. Administrator means the person responsible for the management of any facility requiring licensure under these regulations.

B. Alcohol/Drug Abuse Inpatient Treatment Center means a distinct unit within a hospital ~~facility, or distinct part of a facility,~~ in which services are provided for the diagnosis, treatment and rehabilitation of alcohol and drug abuse.~~;~~ ~~a facility which provides only counseling and room and board is not included in this definition.~~

~~1. For the purpose of these regulations an alcohol/drug abuse treatment center is a facility (either licensed as a hospital or an established diagnostic unit of an acute psychiatric or rehabilitation hospital) or a free-standing unit in which services are provided over a continuous period, exceeding 24 hours for two or more persons not related to the proprietor for the diagnosis, treatment and rehabilitation of alcohol and drug abuse.~~

~~2. Alcohol and drug abuse inpatient center regulations are to be applied in conjunction with the Rules and Regulations for Hospitals and Related Institutions in Arkansas where applicable. (See Section 45, Alcohol/Drug Abuse Inpatient Treatment Centers.)~~

~~3. The requirements established for alcohol/drug abuse inpatient treatment centers shall not be construed as changes in the requirements already established for licensing of any health care facility as delineated in these regulations.~~

C. Basic hospital services means the services that all licensed hospitals must provide. Basic services consist of:

1. Governing Body;

2. Medical Staff;

3. General Administration;

4. Patient Care;

5. Health Information;

6. Pharmacy;

7. Food and Nutrition;

8. Infection Control;

9. Laboratory;

10. Radiology;

11. Respiratory Therapy;

12. Emergency; and

13. Physical facility maintenance

D. Critical Access Hospital (CAH) means a hospital located in a rural area that is:

1. Located more than a 35 mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15 mile drive) from a hospital, or;

2. Provides 24 hour emergency care services as determined necessary for ensuring access to emergency care in each area served by a Critical Access Hospital;

3. Provides staffing according to Rules and Regulations for Hospitals and Related Institutions in Arkansas;

4. Meets Centers of Medicare and Medicaid Services (CMS) Conditions of Participation for Critical Access Hospitals; or

5. Was operating as a licensed Critical Access Hospital in Arkansas as of April 2007.

E. Department means the Arkansas Department of Health.

~~C~~F. Emergency Services Facility means a facility originally operated as a licensed hospital that ~~is licensed only for emergency services. The Department is empowered to license hospitals which~~ has~~ve~~ discontinued inpatient services but is licensed to continue to provide emergency services. ~~if there is no other hospital emergency service in the community Ark. Code Ann. § 20-9-218.~~

G. General Hospital means any facility used for the purpose of providing short-term inpatient diagnostic care and treatment, including general medical care, surgical care, obstetrical care, and specialized services or specialized treatment.

H. Infirmary means any facility used for the purpose of offering temporary medical care and/or treatment exclusively for persons residing on a designated premise, e.g., schools, reformatories, prisons, etc. and where the persons are kept for 24 hours or more.

I. Institution means, for the purpose of these regulations, a facility which requires a license. Institution does not include an establishment:

a. Operated by the federal government or by any of its agencies; or
b. Licensed or certified by the Office of Alcohol and Drug Abuse Prevention of the Division of Behavioral Health of the Department of Human Services as an alcohol and drug abuse inpatient treatment center.

J. Licensee means the person to whom a license is issued for the purpose of operating the institution described in the application for licensure, who shall be responsible for maintaining approved standards for the institution of any state, county, or local government unit and any division, board, or agency thereof.

~~L. Maternity and General Medical Care Hospital means any facility limited to providing short-term inpatient obstetrical and general medical diagnostic care and treatment.~~

~~M. Maternity Hospital means any facility limited to providing short-term inpatient obstetrical diagnostic care and treatment.~~

K Observation is a designated patient status as opposed to a designated area. Patients in observation status are those patients requiring periodic monitoring and assessment necessary to evaluate the patient's condition or to determine the need for possible admissions to the hospital in an inpatient status. Usually observation status shall be for 48 hours or less.

L. Off-campus Emergency Department means an emergency services department of an Arkansas licensed hospital located off-site from the main hospital campus but functions as a fully integrated department of the parent hospital.

M. Outpatient Psychiatric Center means a facility in which psychiatric services are offered for a period of ~~4~~8 to 16 hours a day, and where, in the opinion of the attending psychiatrist, hospitalization as defined in the present licensure law is not necessary. This definition shall not include Community Mental Health Clinics and Centers, as they now exist. ~~The requirements established for outpatient psychiatric centers shall not be construed as changes in the requirements already established for the licensing of any health care facility, as delineated in these Regulations.~~

N. (1) Outpatient Surgery Center (Ambulatory Surgery Center) means a~~ny~~ facility in which surgical services~~, other than minor dental surgery,~~ are offered that~~which~~ require the use of general or intravenous anesthetics ~~and/or render the patient incapable of taking actions for self-preservation under emergency conditions without assistance from others~~, and where, in the opinion of the attending physician, hospitalization is not necessary.

(2) "Outpatient surgery Center" does not include:

(a) a medical office owned and operated by a physician or more than one

(1) physician licensed by the Arkansas State Medical Board, if the medical office does not bill facility fees to a third party payor; or

(b) a dental office that has a Facility Permit for Moderate Sedation or a Facility Permit for General/Deep Sedation issued by the Arkansas State Board of Dental Examiners.

O. Psychiatric Hospital means any facility, or a distinct part of a facility, used for the purpose of providing inpatient diagnostic care and treatment for persons having mental disorders.

P. Recuperation Center means any facility or distinct part of a facility, which includes inpatient beds with an organized Medical Staff, and with medical services that include physician services and continuous nursing services to provide treatment for patients who are not in an acute phase of illness but who currently require primarily convalescent or restorative services (usually post-acute hospital care of relatively short duration). A facility that furnishes primarily domiciliary care is not within this definition.

Q. Rehabilitation Hospital or Facility means, for the purpose of these regulations, an inpatient care facility, or a distinct part of a facility, which provides rehabilitation services for two or more disabled persons not related to the proprietor, for more than 24 hours through an integrated program of medical and other restorative services. A disabled person shall be considered to be an individual who has a physical or mental condition which, if not treated, will probably result in limiting the performance or activity of the person to the extent of constituting a substantial physical, mental, or vocational handicap.

R. Shall means mandatory.

~~D~~S. State Health Officer means the Secretary of the State Board of Health.

~~The following categories of facilities (E-Q), as defined herein, established for the purpose of providing inpatient diagnostic care and treatment for more than 24 hours for two or more persons not related to the proprietor, may not be conducted or maintained in this state without being licensed.~~

~~Q~~T. Surgery and General Medical Care Hospital means any facility limited to providing short-term inpatient surgical and general medical diagnostic care and treatment.

~~The following categories (R-S) of outpatient facilities may not be conducted or maintained in this state without being licensed.~~

SECTION 4: LICENSURE AND CODES.

A. ~~Necessity for~~ License required. No general hospital or distinct part, critical access hospital or distinct part, recuperation center or distinct part, infirmary, rehabilitation facility or distinct part, outpatient surgery center, or alcohol/drug abuse inpatient treatment center ~~or distinct part~~, psychiatric hospital or distinct part, outpatient psychiatric center or emergency services facility~~, as defined in Section 3, Definitions~~ may be established, conducted, or maintained in the State without first obtaining a license.~~, with the exception of the following:~~

~~l~~B. Exceptions to license requirement. The following facilities do not require a license from the Department:

1. A facility operated by the Federal Government; and

2. A First Aid Station.

C. Basic services required. Every licensed hospital must provide basic services.

~~B~~D. Application for License.

l. An applicant shall file applications under oath with the Department upon forms provided by Health Facility Services and shall pay annual license fee as indicated by Act 574 of 1997.

2. These fees shall be paid into the State Treasury or refunded to the applicant if a license is denied. The application shall be signed by the owner, if an individual or partnership, or in the case of a corporation, by two of its officers, or in the case of a governmental unit, by the head of the governmental department having jurisdiction over it. The application shall set forth the full name and address of the institution for which license is sought and such additional information as the Department may require, including affirmative evidence of ability to comply with such reasonable standards, rules, and regulations as may be lawfully prescribed hereunder. The application for annual license renewal shall be postmarked no later than January 2 of the year for which the license is issued. The license applicant for an existing institution postmarked after the date shall be subject to a penalty of one dollar per day for each day and every day after January 2.

3. A license issued hereunder shall be effective on a calendar year basis and shall expire on December 31 of each calendar year. A license shall be issued only for the premises and persons in the application, and shall not be transferable. If the facility changes ownership the license shall expire. The license shall be posted in a conspicuous place on the licensed premises. A license issued under previous regulations shall be effective

through the period for which it was issued. The adequacy of cooperative agreements between hospitals in terms of service provided by each hospital and the type of licenses issued to each hospital shall be determined by the Arkansas Department of Health.

~~C~~E. Facility Change of Ownership.

l. It shall be the responsibility of the licensed entity to notify Health Facility Services in writing at least 30 days prior to the effective date of change of ownership.

2. The following information shall be submitted to Health Facility Services for review and approval:

a. License application;

b. Request for Medicare Certification (where applicable);

c. Legal documents, ownership agreements, the license previously issued to the facility, and other information to support relicensure requirements; and

d. Licensure fee as indicated by Act 574 of 1997.

3. For the purpose of these regulations the licensed entity is the party ultimately responsible for operating the facility. The same entity also bears the final responsibility in decisions made in the capacity of a Governing Body, and for the consequences of these decisions.

~~D~~F. Facility Name Change and/or Address.

1. The facility shall notify Health Facility Services of any name and/or address change;

2. The previously issued license shall be returned to Health Facility Services; and

3. A fee, as indicated in Act 574 of 1997, shall be submitted to Health Facility Services for issuance of a new license.

~~E~~G. Management Contract.

l. It shall be the responsibility of the licensed entity to notify Health Facility Services in writing at least 30 days prior to entering into a management contract or agreement with an organization or firm. A copy of the contract or agreement shall also be submitted to Health Facility Services for review

to assure the arrangement does not materially affect the license status.

2. An organization or firm who contracts with the licensed entity to manage the health care facility, subject to Governing Body approval of operational decisions, is generally considered an agent rather than an owner. In such instances a licensure change is not required.

~~F~~H. Separate License. An individual license shall be required for an institution maintained on separate premises even though it is operated under the same management, except in cases where the hospital management of a general hospital operates a detached building which can be utilized in a limited way for general medical care. Separate licenses are not required for separate buildings on the same grounds.

~~G~~I. Temporary Licenses. This license shall be for less than one year and for a time specified on the temporary license by the Department.

~~H~~J. Revocation of License. The Department is empowered to deny, suspend, or revoke a license on any of the following grounds:

1. Violation of any of the provisions of Act 414 of 1961, as amended by Act 258 of 1971, or Act 190 of 1975, Act 536 of 1977, or Act 273 of 1983, Act 980 of 1985, or Act 516 of 1987; Act 143 of 1987, Act 399 of 1987, or Act 348 of 1987, or the Rules and Regulations lawfully promulgated hereunder; or

2. Permitting, aiding, or abetting the commission of any unlawful act in connection with the operation of the institution. (Section 22, Act 414 of 1961, as amended).

3. The right of appeal of any revocation shall be as specified in the appeal procedure of the Arkansas Department of Health.

NOTE: If services are to be temporarily suspended, a functional program, with plans and specifications as applicable, shall be submitted to Health Facility Services for approval prior to such suspension.

~~I~~K. Inspection. Any authorized representative of the Department shall have the right to enter the premises of any institution at any time in order to make whatever inspection necessary in accordance with the minimum standards and regulations prescribed herein.

~~J~~L. Penalties.

1. Any person, partnership, association, or corporation which establishes, conducts, manages, or operates any institution within the meaning of Act

414 of 1961, as amended by Act 258 of 1971, Act 190 of 1975, Act 536 of 1977, Act 273 of 1983, Act 980 of 1985, And Act 516 of 1987; and Act 143 of 1987, Act 348 of 1987, and Act 399 of 1987, without first obtaining a license therefore as herein provided, or who violates any portion of this act or regulations lawfully promulgated hereunder, shall be guilty of a misdemeanor, and upon conviction thereof shall be liable to a fine of not less than $25.00 nor more than $100.00 for the first offense and not less than One Hundred Dollars 100.00), nor more than $500.00 for each subsequent offense, and each day such institution operates after a first conviction shall be considered a subsequent offense. (~~Section 27, Act 414 of 1961, as amended~~ Ark. Code Ann. §20-9-202.)

2. Any institution licensed by the authority of these regulations that has received damage due to fire, tornado, earthquake, man-made or natural disaster shall notify the Department by telephone immediately and follow with a preliminary report within 48 hours, and a complete report when the incident has been thoroughly investigated. The submitted report shall include, but not be limited to, damage to the building, damage estimates, injuries to patients, staff and the public, etc. If the Department is not notified, the institution shall be assessed a fine in the amount of $50.00 for each day, or portion thereof, the incident is not reported or $500.00 maximum.

~~K~~M. Codes. See Section 43, Physical Facilities, List of Referenced Publications.

SECTION 6: MEDICAL STAFF.

All persons admitted and discharged to any institution governed by these standards shall be under the care of a person duly licensed to practice medicine in Arkansas (hereafter called physician or surgeon). In institutions where two or more physicians are allowed to practice there shall be an organized Medical Staff. Members of the staff shall be qualified legally and professionally for the positions to which they are appointed. Individuals who are not hospital employees, who work in the hospital shall be credentialed through the Medical Staff with approval from the Governing Body. (Refer to Section 36, Specialized Services: Emergency Services.)

Note: See Ark. Code Ann. § 17-95-107 regarding requirements for health care organizations that credential physicians/authorized staff to use the Arkansas State Medical Board's Centralized Credentials Verification Service (CCVS).

A. Credential Files of the Medical Staff and Other Authorized Staff. An individual file shall be maintained for each physician/other authorized staff practicing in the hospital and shall include at least the following:

1. Verification of age, year, and school of graduation and statement of postgraduate or special training and experience;

2. Specific delineation of privileges requested and granted;

3. A detailed application signed by the applicant, the Chairman of the Credentials Committee and an officer of the Governing Body;

4. Documentation of the applicant's agreement to abide by the Medical Staff Bylaws and hospital requirements;

5. Verification of current Arkansas license;

6. Verification of each applicable physician's Drug Enforcement Agency (DEA) registration;

7. Verification of at least three references;

8. Documentation of all actions taken by the Medical Staff and Governing Board indicating the type of privileges granted, approval of appointment/reappointment and other related data;

9. Evaluation of members' professional activities at the time of reappointment; and

10. Non-employee practitioners may be screened through the Human Resources Department or another hospital designee. The requested privileges and credentialing shall be approved by the Medical Staff.

NOTE: Hospitals shall report to the ~~Arkansas State Medical B~~appropriate professional licensing board the names of ~~physicians~~ individuals whose hospital privileges have been terminated or revoked for cause.

B. Medical Staff Bylaws. The Medical Staff Bylaws shall include at least the following information:

1. A provision stating the Medical Staff shall be responsible to the Governing Body of the facility for the quality of medical care provided for patients in the hospital and for the ethical and professional practices of members;

2. A provision stating the requirements for medical and other authorized staff membership, including allied health professionals;

3. A provision stating the division of the Medical Staff and clinical departments;

4. A provision stating the election of officers, responsibilities and terms;

5. A provision establishing Medical Staff committees, functions, frequency of meetings and composition (quorum);

6. A provision establishing frequency of general Medical Staff meetings, specifying attendance requirements;

7. A provision establishing written minutes be maintained of all Medical Staff meetings and the minutes shall be signed by the physician chairman;

8. A provision for an appeals process which delineates the procedures for a physician or other authorized staff to follow in challenging staff, that if ratified by the Governing Body, adversely affects his/her appointment or reappointment to the Medical Staff;

9. A provision establishing the designation of a specific physician who shall direct each clinical/diagnostic service;

10. A provision delineating requirements for maintaining accurate and complete medical records. (See Health Information Services, Section 14.);

11. A provision for selection and approval of nationally recognized protocols for use in the Emergency Department;

12. A provision for approval of the bylaws and amendments by the Medical Staff and the Governing Body; and

13. Documentation of appointments, reappointments and approval of requested privileges to the medical and other authorized staff as specified in the bylaws, but at least every two years.

C. Medical Staff Minutes. Medical Staff minutes shall include at least the following:

1. Documentation of review of committee reports including quarterly Quality Assurance/Performance Improvement (QA/PI);

2. Review, approval and revision of the Medical Staff Bylaws and Rules and Regulations;

3. Election of officers as specified by the Bylaws; and

4. Documentation of physicians designated as chairmen of the committees to direct the services defined in the Medical Staff bylaws.

D. Quality Assurance/Performance Improvement (QA/PI).

1. The organization shall develop, implement and maintain an ongoing program to assess and improve the quality of care and services provided. A multidisciplinary committee shall meet at least quarterly to provide oversight and direction for the program; the hospital shall maintain minutes of the meetings. A Quality Assurance/Performance Improvement Plan shall be developed and maintained to describe the manner in which QA/PI activities shall be conducted in the hospital. The QA/PI plan shall be reviewed and approved by the Chief Executive Officer, Medical Staff and Governing Body annually.

   a. All hospital and Medical Staff programs, services, departments and functions, including contracted services related to patient care, shall participate in ongoing quality assurance/performance improvement activities.

   b. The hospital shall collect and assess data on the functional activities identified as priorities in the QA/PI plan.

   c. Data collected shall be benchmarked against past performance and/or national or local standards.

   d. Improvement strategies shall be developed for programs, services, departments and functions identified with opportunities for improvement.

   e. The effectiveness of improvement strategies and actions taken shall be monitored and evaluated, with documentation of conclusions regarding effectiveness.

   f. Identify and reduce medical errors and adverse patient events.

   g. Approved organizational abbreviation list.

2. Scope of QA/PI Program. The QA/PI program shall include, but not be limited to, ongoing assessment and improvement activities regarding the following:

   a. Access to care, processes of care, outcomes of care and hospital-specific clinical data, including applicable Peer Review Organization (PRO)/Quality Assurance/Performance Improvement Organization (QA/PIO) data;

   b. Customer satisfaction (patients and families, physicians and employees);

   c. Staff performance as it relates to the staff as a whole when reviewing aspects of care;

   d. Complaint resolution;

e. Utilization and discharge planning data; and

f. Organizational performance.

3. Program Responsibilities. The Governing Body shall assume overall responsibility and accountability for the organization-wide QA/PI program. The Governing Body, Chief Executive Officer and Medical Staff shall ensure QA/PI activities, address identified priorities and be responsible for the development, implementation, monitoring and documentation of improvement activities.

4. Reporting. QA/PI activities shall be reported to the Governing Body on at least a quarterly basis and shall be documented in the Governing Body meeting minutes.

5. Policies and Procedures. Policies and procedures pertaining to the QA/PI program which are not contained within the QA/PI plan shall be maintained in a manual, reviewed and approved annually.

6. Program Evaluation. An evaluation of the QA/PI program shall be conducted by the hospital and reported to the Governing Body annually. The evaluation shall be based upon objective data and shall include programs, services, departments and functions targeted by the hospital for improvement, as well as those conducting ongoing QA/PI activities. Changes in the QA/PI program and QA/PI plan shall be made in response to the evaluation.

E. Discharge Planning. There shall be a discharge plan for each patient.

1. Discharge plans shall incorporate ~~n ongoing plan, consistent with~~ available community and hospital resources, such as ~~, to provide or make available~~ social, ~~work,~~ psychological, nutritional, and educational services, to meet the medically-related needs of the patients and to facilitate the provision of follow-up care.

2. There shall be ~~a~~ policies~~y~~ and procedures developed for discharge planning which include~~.~~:

~~1~~. a. ~~Discharge planning shall be~~ initiation of discharge planning~~ed~~ at the time of the patient's admission~~.~~;

~~2~~. b. reassessment of patient's condition and needs prior to the patient's discharge;

c. patient and family education regarding the discharge plan which includes:

1. follow-up care and treatment;

2. available community and hospital resources; and

d. transfers and referral processes ~~The patients, along with necessary medical information, shall be transferred or referred~~ to appropriate facilities, agencies or outpatient services as needed~~,~~ for follow-up or ancillary care, including ~~.~~ necessary medical information.

~~3.~~

F. Organ and Tissue Donation. The Governing Body of each Acute Care Hospital shall cause to be developed appropriate policies, procedures, and protocols for identifying and referring potential organ and tissue donors. The written policies and procedures shall include but not be limited to the following subjects:

1. Determination and declaration of brain death;

2. Organ procurement procedures:

   a. Identifying potential donors;

   b. Referring potential donors; and

   c. Obtaining consent.

3. Role of attending physician;

4. Role of the procurement coordinator (employee of procurement agencies);

5. Reimbursement for cost of donation;

6. Liabilities associated with donation;

7. Agreement with organ procurement agency designated by Center for Medicare and Medicaid Services (CMS);

8. A consent procedure which encourages reasonable discretion and sensitivity to the family circumstances in all decisions regarding organ and tissue donations;

9. Determination by the organ procurement agency personnel of the suitability of the organs and/or tissues for transplantation; and

10. Requirements for documentation in the patient's medical record that the family of a potential organ donor has been advised of their right to donate or decline to donate.

SECTION 7: GENERAL ADMINISTRATION.

A. Each institution shall have an Administrator responsible for the management of the institution. In the absence of the Administrator, an alternate with authority to act shall be designated. The responsibilities of the Administrator shall include:

1. Keeping the Governing Body fully informed of the conduct of the hospital by submitting periodic written reports or by attending meetings of the Governing Body;

2. Conducting interdepartmental meetings at regular intervals and maintaining minutes of the meetings;

3. Preparing an annual operating budget of anticipated income and expected expenditures; and

4. Preparing a capital expenditure plan for at least a three year period.

B. Policies and procedures shall be provided for the general administration of the institution and for each department, section or service in the facility. All policies and procedures for departments or services shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date signature of the department supervisor and/or person(s) conducting the review.

C. An accurate daily patient census sheet as of midnight shall be available to the Department at all times.

D. The facility shall have visitation policies determined by the Medical Staff, Governing Body and Administration which shall include:

1. Limitation when patient care is hindered or disrupted; and

2. Development by the Governing Body with advice from the Medical Staff and Infection Prevention and Control Committee regarding persons under the age of 12 who visit critical care areas of the hospital.

E. Provisions shall be made for safe storage of patients' valuables.

F. Animals such as cats, dogs, birds and fish and aquatic animals shall not be permitted in health care facilities. Exceptions shall be made for service animals, animals that participate in pet therapy, fish and aquatic animals in approved aquariums. (See Section 25, Pet Therapy Program.) All exceptions shall be approved by Health Facility Services.

1. Service animals shall be permitted only under the following guidelines:

a. Only animals specifically trained as service animals shall be allowed into the facility.

b. Service animals shall not be allowed into the facility if they are unhealthy, feverish, or suffer from gastroenteritis, fleas or skin lesions.

c. Healthy, well-groomed animals shall be allowed to enter the facility into areas that are generally accessible to the public (i.e., lobbies, cafeteria, and nurses stations on unrestricted units). The owner of the animal shall be directed to inquire about the possibility of a visit before entering a patient's room. Authorization to visit shall be given by a unit supervisor.

d. Service animals shall be walked before entering the facility or shall be diapered in a manner to prevent contamination of the facility environment with excreta. Service animals shall not be fed within the facility.

e. Petting or playing with service animals by hospital personnel or patients shall be prohibited.

f. Owners of service animals shall be instructed to wash their hands before having patient contact.

g. Visiting with service animals shall be restricted in the following circumstances:

1) The patient is in isolation for respiratory, enteric or infectious diseases or is in protective isolation;

2) The patient, although not in protective isolation, is immunocompromised or has a roommate that is;

3) The patient is in an intensive care unit, burn unit or restricted access unit of the hospital;

4) The patient or roommate is allergic to animals or has a severe phobia; and

5) The patient or roommate is psychotic, hallucinating or confused or has an altered perception of reality and is not amenable to rational explanation.

h. Animals which become loud, aggressive or agitated shall be removed from the facility immediately.

2. Fish and aquatic animals shall not be permitted in health care facilities without prior written approval by Health Facility Services. Aquariums shall be approved by the Medical Staff and Infection Prevention and Control Committee. (Turtles will not be considered for approval.)

a. Aquariums shall meet the following requirements:

1) Aquariums shall be self-contained, shock proof, break proof and quiet in operation.

2) Aquariums shall be constructed or positioned in such a manner as to be leak-proof, spill proof and to preclude patients or staff from having direct contact with the animals or water in the aquarium.

3) Aquariums and associated equipment shall be cleaned frequently by

appropriately trained personnel who do not have direct contact with patients or patient care items.

4) Aquariums shall be placed only in areas which are accessed by the general public. Aquariums shall not be placed in critical care areas (i.e., nursing stations, surgery, patient rooms, ICU, etc.)

5) Aquariums shall be kept in a state of good repair at all times.

b. There shall be written procedures for cleaning and caring for the aquarium.

c. There shall be written procedures for dealing with clean up in the event there is a major accident concerning the aquarium.

d. Fish or aquatic animals shall be of varieties that do not bite, sting and are considered non-toxic or non-poisonous.

G. Each facility shall develop and maintain a risk-assessed all hazards written disaster plan. The plan shall:

1. be tailored to meet specific disaster risks present in the area, such as earthquakes, tornados, floods, nuclear reactor failures, etc;

2. include widespread disasters as well as ~~for a~~ disasters occurring within the local community and hospital facility;

3. ~~The plan shall include~~ provide~~sions~~ for complete evacuation of the facility;

4. provide for ~~and~~ care of mass casualties and increased patient volume;

5. provide for transfer of patients, including those with hospital equipment, to an alternate site;

6. contain two rehearsal~~sed at least twice~~ a year, preferably as part of a coordinated drill in which other community emergency agencies participate;~~.~~ and

a. ~~O~~one drill shall simulate a disaster of internal nature and the other external;

b. one drill shall be planned and one shall be "no notice;" and~~.~~

c. w~~W~~ritten reports and evaluation of all drills shall be maintained;~~.~~

7. contain specific provisions to supply food, water, generator fuel and other essential items for 72 hours (applies to inpatient facilities only);

8. develop, maintain and exercise redundant communication systems; and

9. facilities with AWIN (Arkansas Wireless Information Network) issued equipment shall include regular maintenance and personnel training for its use.

H. There shall be a posted list of names, telephone numbers and addresses available for emergency use. The list shall include the key hospital personnel and staff, the local police department, the fire department, ambulance service, Red Cross and other available emergency units. The list shall be reviewed and updated at least every six months.

I. There shall be rules and regulations governing the routine methods of handling and storing flammable and explosive agents, particularly in operating rooms, delivery rooms, laundries and in areas where oxygen therapy is administered.

J. All refrigerated areas, including freezers, shall be provided with thermometers and records maintained to document the temperatures checked on a daily or weekly basis, as required.

K. The facility shall provide access to appropriate educational references to meet the professional and technical needs of hospital personnel.

L. A safety committee shall develop written procedures for the reporting and prevention of safety hazards. The committee shall meet at least quarterly or more frequently if necessary to fulfill safety objectives. Minutes of the meeting shall be maintained.

M. All Departments and/or Services shall receive annual education on safety, fire safety, back safety, infection control, universal/standard precautions, disaster preparedness and confidential information.

N. Any hospital or related institution that closes shall meet the requirements for new construction in order to be eligible for relicensure. Once a facility closes, it is no longer licensed. The license shall be immediately returned to Health Facility Services. To be eligible for licensure all the latest life safety and health regulations shall be met. Refer to Section 4, Licensure and Codes, item B., Application for License and item H., Revocation of Licenses.

O. The facility Administrator shall assure the development of policies and procedures in accordance with Ark. Code Ann. § 20-9-307 that, upon request of the patient, an itemized statement of all services shall be provided within 30 days after discharge or 30 days after request, whichever is later. The policy shall include a statement advising the patient in writing of his/her right to receive the itemized statement of all services.

P. The facility shall establish a process for prompt resolution of patient grievances to include the following:

1. The facility shall inform each patient whom to contact to file a grievance.

2. The Governing Body shall approve and be responsible for the effective operation of the grievance process unless delegated in writing to another responsible individual.

3. The facility shall establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the facility.

Q. A physician shall pronounce the patient dead and document the date, time and cause of death.

R. Patient care providers not employed by the hospital, who are involved in direct patient care, shall follow hospital policies and procedures.

SECTION 9: ADMINISTRATION REPORTS.

A. All communicable diseases shall be immediately reported to the Arkansas Department of Health. The institution shall furnish pertinent required information related to the disease to the ~~local health unit or~~ Arkansas Department of Health.

B. Occurrences which threaten the welfare, safety or health of the public such as epidemic outbreaks, poisoning, etc., shall be reported either by phone or facsimile to the local or State Health Officer. The institution shall furnish other pertinent required information related to the occurrence to the ~~local health unit or~~ Arkansas Department of Health.

C. Immediate capacity for disaster admissions shall be reported daily to the Disaster Preparedness Section of the Arkansas Department of Health.

SECTION 11: PATIENT CARE SERVICE.

A. Organization. Nursing Services shall be directed by a nurse executive who is a Registered Nurse qualified by advanced education and management experience. The nurse executive's education and experience shall be directly related to the facility's stated mission and to the nursing care needs of the patient population.

1. The nurse executive shall have overall authority for the development of organization-wide nursing standards and policies and procedures that describe how patient care needs are assessed, evaluated and met.

2. Development and implementation of the organization's plans for providing nursing care to the patient shall be approved by the nurse executive.

3. Policies, procedures and standards shall be defined, documented and accessible to the nursing staff in a written or electronic format. Each element shall be approved by the nurse executive or designee prior to implementation.

4. The nurse executive and nursing staff shall collaborate with appropriate Governing Body, Medical Staff, management and other clinical leaders in developing, implementing, revising and monitoring patient care improvement activities.

5. The nurse executive or designee shall be responsible for orienting and maintaining adequate numbers of qualified staff for patient care.

6. Staff meetings shall be conducted at least monthly for the purpose of reviewing the quality of nursing care provided. Meeting minutes and attendance shall be maintained.

7. If the organization provides clinical facilities for nursing students, there shall be a written agreement that defines:

   a. The facility's responsibilities; and

   b. Responsibilities of the educational institution, including supervision of students and responsibilities of the instructor.

8. Clinically relevant in-service educational programs shall be conducted at regularly scheduled intervals ~~with~~ not less than 12 times per year. There shall be evidence of ~~documentation which includes~~ program dates, ~~content, presenter, date and time presented and signatures of~~ attendees, and subject matter.

9. There shall be a continuous QI program that is specific to the patient care

administered. The program shall reflect nursing staff participation including reports to appropriate hospital committees.

B. Qualifications.

1. A current, valid license to practice nursing in Arkansas shall be held by all nurses hired in the facility as well as private duty and contract/pool nurses. There shall be a procedure to assure all licenses are current.

2. Licensed nursing personnel shall practice under the Nurse Practice Act of the State of Arkansas and current Arkansas State Board of Nursing Rules and Regulations.

3. The qualifications required for each category of nursing staff shall be in written policy. Job descriptions shall be available for review.

4. There shall be documented evidence of appropriate training for all nonlicensed staff who are assigned patient care duties.

5. The nurse executive or designee(s) participates with administration in decisions relative to the selection and promotion of nursing personnel based on qualifications and capabilities and recommends the termination of employment when necessary.

6. All licensed nursing personnel shall be competent in life support measures.

C. Staffing.

There shall be an adequate number of Registered Nurses on duty at all times and available for bedside care of any patient when needed on a 24 hour basis. In addition, there shall be sufficient Registered Nurses to staff all patient care units. A Registered Nurse shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of the nursing staff. There shall be written criteria to substantiate the assignments.

D. Evaluation and Review of Patient Care Services.

1. There shall be established working relationships with other services of the hospital, both administrative and professional. The factors explaining the standard are as follows:

a. Registered Nurses confer with the physicians relative to patient care;

b. Interdepartmental policies affecting patient care are made jointly with the nurse executive or designee(s); and

c. Procedures are established for scheduling laboratory and X-ray examinations, for ordering, securing, and maintaining supplies and equipment needed for patient care and for ordering diets, etc.

2. There shall be on-going review and evaluation of nursing care provided for patients.

a. A Registered Nurse plans, supervises, and evaluates the nursing care for each patient in all settings where nursing care is provided.

b. Each patient shall have a plan for provision of care. Each patient plan of care shall be current. Plans indicate patient care required, how it is to be accomplished, and the methods, approaches, goals, and modifications necessary to ensure best results for the patient. The patient's plan of care shall be initiated upon admission.

c. There shall be documentation of the nursing care provided. The following information shall be documented:

1) The initial patient assessment;

2) Date and time of treatments and/or dressing changes;

3) Medication Administration Record (MAR) including the date, time, dosage and manner of administration and the initials of the nurse administering the medication. When personnel other than nursing administer medication and the MAR is not utilized, a record of that ancillary department shall comply with this requirement and be included in the medical record;

4) Date, time, dosage and manner of administration of all PRN medications to include reason for administration and results;

5) Bedtime and between meal snacks or feedings and the percentage of diets consumed;

6) Change in patient's appearance and/or condition;

7) Patient complaints; and

8) Mode of discharge and to whom the patient was

discharged. If a patient expires, the time the physician was called, time arrived, the time the patient was pronounced dead and the fact that relatives were present shall be recorded. (If relatives were not present, a note shall be made regarding their notification and disposition of the patient's belongings).

d. A Registered Nurse shall observe each patient at least once per shift and the observations shall be documented in the patient's medical record.

NOTE: Block charting and co signatures are not acceptable.

E. Patient Care Facilities and Equipment.

l. There shall be no more beds maintained in the building than the number of beds for which the hospital is licensed except in the case of a public disaster or national emergency and then only as a temporary measure.

2. No beds shall be in the hallway or on the floor except in case of emergency.

3. Children under the age of 16 years shall not be cared for in a room with an unrelated adult patient.

4. Provisions shall be made for safe storage of patients' valuables.

5. All facilities for cleaning and storage of patient care supplies and equipment shall be used only for the purpose for which they are designed.

6. Thermometers shall not come in contact with more than one patient without disinfection or proper covers.

7. All single-use equipment used by a patient shall either be sent home with the patient at the time of discharge or destroyed.

8. Only currently dated equipment and supplies shall be available for patient care. All equipment shall be kept clean and in good condition.

9. Observation is a designated patient status as opposed to a designated area. Patients in observation status are those patients requiring periodic monitoring and assessment necessary to evaluate the patient's condition or to determine the need for possible admission to the hospital in an inpatient status. Usually observation status shall be for 48 hours or less.

Patients in observation status may be accommodated within the facility:

a. In private, semi-private or multi-patient rooms. Furniture shall be arranged to provide adequate room for patient care procedures and to prevent the transmission of infection;

b. Cubicle curtains, privacy screens, or an approved equivalent shall be provided for patient privacy in all multi-patient rooms. The utilization of such curtains or screens shall be such that each patient shall have complete privacy;

c. Each room or cubicle shall be provided with oxygen, vacuum and a nurse call button;

d. Hand hygiene facilities shall be available within the area;

e. Hospital grade furniture shall be provided. Bed rails shall be provided on beds;

f. For each area in which a patient bed is utilized, a reading light shall be provided for each bed. The location and design shall be such that the light is not annoying to other patients;

g. Patient toilets shall be provided and accessible to all patients; and

h. Adequate space shall be provided for medical supplies.

Patients that remain in observation status for a period of 24 hours or more shall have provided to them accommodations equivalent to the accommodations they would have if they were admitted as an inpatient.

SECTION 13: RESTRAINTS.

A. Restraint use should be implemented in the least restrictive manner possible, applied in accordance with safe and appropriate techniques and ended at the earliest possible time.

B. Each ~~physician's~~ order for the application of restraints shall be time limited and shall include the type of restraint to be used. Restraints orders shall not be written as a standing order or on an as needed basis (PRN).

C. Restraints either physical or chemical shall be applied only after less restrictive measures have failed. Restraints shall not be used as a matter of convenience for the staff or as a tool for disciplining the patient. When the use of a restraint is clinically indicated, it shall be used only in accordance with the order of a physician or non-physician licensed medical professional who has been appropriately credentialed by the medical staff with approval by the governing body.

D. Documentation of a comprehensive assessment and modification to the plan of care shall include the less restrictive measures attempted, justification for the continued need of restraint and that the patient and/or significant other has been informed of the reason for restraint use.

E. Documentation in the patient's record regarding any type of restraint shall include the times the restraint was applied, released, and discontinued, as well as evidence of continual assessment, monitoring and re-evaluation of the patient's condition during the restraint incident.

F. When restraint use is ordered by other than the attending physician, the attending physician shall be informed as soon as possible.

G. Patients in leather or locked restraints shall be under constant observation.

H. All staff that have direct patient contact shall have ongoing education and training in the proper and safe use of restraints.

SECTION 14: HEALTH INFORMATION SERVICES.

A. General Requirements.

1. A medical record shall be maintained for each patient admitted for care in the hospital.

2. The original or a copy of the original (when the original is not available) of all reports shall be filed in the medical record.

3. The record shall be permanent and shall be either typewritten or legibly written in blue or black ink.

4. All typewritten reports shall include the date of dictation and the date of transcription.

5. All dictated records shall be transcribed within 48 hours.

6. Errors shall be corrected by drawing a single line through the incorrect data, labeling it as "Error," initialing, and dating the entry.

7. Additional patient records room requirements are provided in Section 61, Physical Facilities, and Health Information Unit.

8. Disease, operation, and physicians indices shall be maintained (manual, abstract, or computer). Records shall be indexed within one month following discharge. Indices maintained on computer shall be retrievable at any time for research or quality assurance/performance improvement monitoring.

9. Records of discharged patients shall be coded in accordance to accepted coding practices. Records shall be coded within one month of the patient's dictated discharge summary.

10. Relevant educational programs shall be conducted at regularly scheduled intervals with no less than 12 per year. There shall be written documentation with employee signatures, program title/subject, presenter, date, and outlines or narrative of presented program.

11. A Master Patient Index shall be maintained by the Health Information Services. Index information shall include at least the full name, address, birth date, and the medical record number of the patient. The index may be maintained manually or on computer and shall contain the dates of all patient visits to the facility. If the Index is maintained on computer, there shall be a policy and procedure on permanent maintenance.

12. Birth certificates shall be completed according to the current rules and regulations of Vital Records, Arkansas Department of Health.

13. A unit record system shall be maintained. A unit record is defined as all inpatient and outpatient visits for each patient being filed together in one unit.

14. A policy and procedure manual for the Health Information Management Department shall be developed. The manual shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

15. A qualified individual shall be employed to direct the hospital's Health Information Department. If a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT) is not employed as Director on a full-time basis by the ~~facility~~ hospital, a consultant shall make periodic visits to evaluate functions of the Department and train personnel.

16. All patient records, whether stored within the Health Information Management Department or other areas, either within the facility or away from the facility, shall be protected from destruction by fire, water, vermin, dust, etc.

17. Medical records shall be considered confidential. Only authorized personnel shall have access to the medical records. All medical records (including those filed outside the department) shall be secured at all times. If authorized personnel are not available, the department shall be locked. Records shall be available to authorized personnel from the Arkansas Department of Health.

18. Release of medical information shall be restricted by the facility's policies and procedures.

19. All medical records shall be retained in either the original, microfilm or other acceptable methods for 10 years after the last discharge. After 10 years a medical record may be destroyed provided the facility permanently maintains the information contained in the Master Patient Index. Complete medical records of minors shall be retained for a period of two years after the age of majority.

20. Procedures shall be developed for the retention and accessibility of the patients' medical records if the hospital or other facility closes. The medical records shall be stored for the required retention period and shall be accessible for patient use.

21. All entries into the medical record shall be legible. There shall be no erasures or obliterations of the original information contained in a medical record.

22. Medical records shall be complete and contain all required signed documentation (including physician reports) no later than 30 days following the patient's discharge date.

23. Patient records shall be destroyed by burning or shredding. Patient records shall not be disposed of in landfills or other refuse collection sites.

24. A QA/PI program shall be continuous and specific to the services.

25. In the event of a physician's death or permanent incapacitation, incomplete medical records shall be reviewed in a manner approved by the Medical Staff. Approval to file incomplete medical records shall be obtained in a manner approved by the Medical Staff and a statement explaining the circumstances be placed in each record.

B. Authentication of Medical Record Entries.

1. Each entry into the medical record shall be authenticated by the individual who is the source of the information. Entries shall include all documents, observations, notes, and any other information included in the record.

2. Signatures shall be at least, the first initial, last name and title. Computerized signatures may be either by code, number, initials, or the method developed by the facility.

3. The hospital's Medical Staff and Governing Body shall adopt a policy regarding dictation that permits authentication by electronic or computer generated signature. The policy shall identify those categories of the staff within the hospital that are authorized to authenticate patient records using electronic or computer generated signatures.

4. At a minimum, the policy shall include adequate safeguards to ensure confidentiality.

   a. Each user shall be assigned a unique identifier which is generated through a confidential code.

   b. The policy shall include penalties for inappropriate use of the identifier.

   c. The user shall certify, in writing, that he or she is the only person

authorized to use the signature code.

d. The hospital shall periodically monitor the use of identifiers; the process by which the monitoring shall be conducted shall be described in the policy.

5. The system shall make an opportunity available to the user to verify that the document is accurate and the signature has been properly recorded.

6. Each report generated by a user shall be separately authenticated.

7. A user may terminate authorization for use of electronic or computer generated signature upon written notice to the Director of Health Information Services.

8. Rubber stamp signatures shall be acceptable if a letter from the physician is on file explaining that the physician shall be the only person using the stamp and the stamp shall remain in his/her possession at all times. The signature stamp shall be the full legal name of the physician with his/her professional title.

9. Transcribed reports dictated by other than the attending physician shall be signed by the credentialed individual dictating the report and the attending physician. Dictation of reports by other than the attending physician is limited to history, physical, discharge summary, operative reports and progress notes. Reports dictated by resident physicians for training purposes require only the signature of the attending physician.

C. Electronic Health Information

1. Policies and procedures governing electronic health information within the organization and with external entities shall be adopted by the Governing Body.

2. The policies and procedures shall provide for the use, exchange, security and privacy of electronic health information. The policies and procedures shall provide for standardized and authorized availability of electronic health information for patient care, administrative purposes and research. The policies and procedures will be in compliance with current guidelines and standards as established in federal and state status.

D. Record Content.

1. Identification data shall include at least the following:

a. Patient's full name - maiden name if applicable;

b. Patient's address, telephone number, and occupation;

c. Date of birth;

d. Age;

e. Sex;

f. Marital status (M.S.D.W.);

g. Dates and times of admission and discharge;

h. Full name of physician;

I. Name and address of nearest relative or person or agency responsible for patient and occupation of responsible party;

j. Name, address, and telephone number of person(s) to notify in case of emergency;

k. Medical record number; and

2l. A general consent for medical treatment and care. This shall be signed by the patient or guardian. Written or verbal consent shall not release the hospital or its personnel from upholding the rights of its patients including but not limited to the right to privacy, dignity, security, confidentiality, and freedom from abuse or neglect.

32. Clinical reports shall include the following and shall comply with listed requirements:

a. A History and Physical Examination (HPE) shall be in the patient's medical record within 48 hours of the patient's admission to the facility. The HPE must be authenticated by the attending or treating physician shall be documented by the attending physician and shall contain the following:

l) Family (medical) history and review of systems - if noncontributory, the record shall reflect such;

2) Past medical history;

3) Chief complaint(s) - a brief statement of nature and duration of the symptoms that caused the patient to seek medical attention as stated in the patient's own words;

4) Present illness with dates or approximate dates of onset;

5) Physical examination;

6) Provisional or admitting diagnosis (es); and

7) History and physical examinations may be completed up to 30 days prior to admission if ~~the physician updates~~ the examination is updated at the time of admission. The updated HPE must be authenticated by the attending or treating physician.

b. Progress notes shall be recorded, dated and signed. The frequency of the physician's progress notes shall be determined by the patient's condition. Dictated progress notes are acceptable and shall be placed in the patient's medical record within 48 hours.

c. Orders shall be authenticated with a legible and dated signature in a timely manner as defined by Medical Staff By-Laws. Telephone/verbal orders shall be recorded by appropriate personnel and cosigned by the originator within 96 hours.

d. A discharge summary shall recapitulate the significant findings and events of the patient's hospitalization and his/her condition on discharge. ~~This shall be documented by the attending~~ The discharge summary must be authenticated by the attending or treating physician within 30 days of the patient's discharge. The final diagnosis shall be stated in the discharge summary.

e. Autopsy findings shall be documented in complete protocol within 60 days and the provisional anatomical diagnosis shall be recorded within 72 hours. A signed authorization for autopsy shall be obtained from the next of kin and documented in the medical record before an autopsy is performed.

f. Original, signed diagnostic reports (laboratory, X-rays, CATs, SCANs, EKGs, fetal monitoring, EEGs) shall be filed in the patient's medical record. Physicians' orders shall accompany all treatment procedures. Fetal monitor and EEG tracings may be filed separately from the medical record if accessible when needed.

g. Reports of ancillary services (Dietary, Physical Therapy, Respiratory Care, Social Services, etc.) shall be included in the patient's medical record.

h. Reports of Medical Consultation, if ordered by the attending physician, shall be included in the patient's medical record within

time frames established by the Medical Staff.

E. Records of Complementary Departments. In addition to the general record content requirements stated above, parts F., G. and H. are required, as applicable.

F. Surgery Records.

1. A specific consent for surgery shall be documented prior to the surgery/procedure to be performed, except in cases of emergency, and shall include the date, time and signatures of the patient and witness. Consent shall be obtained by the surgeon and documented in the patient's medical record. (Abbreviations are not acceptable.)

2. A History and Physical Examination (HPE) on admission containing medical history and physical findings shall be documented by the attending physician on in the patient's medical record prior to surgery. In cases of emergency surgery, an abbreviated physical examination, and a brief description of why the surgery is necessary shall be included in the HPE written by the physician. (See Section 14, Health Information Services, Record Content.) The HPE must be authenticated by the attending or treating physician or surgeon.

3. An anesthesia report, including preoperative evaluation and postoperative assessment, shall be documented by the Anesthesiologist and/or Certified Registered Nurse Anesthetist (CRNA). The pre-evaluation and post assessment shall be dated and timed.

   a. Preoperative anesthesia evaluation shall be completed prior to the patient's surgery.

   b. Report of Anesthesia. A CRNA who has not been granted authority by a facility, as a DEA registrant, to order the administration of controlled substances shall give all orders as verbal orders from the supervising physician, dentist, or other person lawfully entitled to order an anesthetic.

   c. Post anesthesia assessment shall be documented in the medical record prior to the patient's discharge, not to exceed 48 hours after the patient's surgery. If the patient is in need of continued observation, the anesthetist shall be readily available. Discharge criteria shall be established and approved by the Medical Staff and Governing Body. If the patient meets the discharge criteria within a three hour period postoperatively, a post anesthesia assessment is not required.

4. An individualized operative report shall be written or dictated by the

physician or surgeon immediately following surgery and shall be signed within 72 hours. The report shall describe (in detail) techniques, findings, pre and postoperative diagnosis, and tissues removed.

5. A signed pathological report shall be maintained in the medical record of all tissue surgically removed. A specific list of tissues exempt from pathological examination shall be developed by the Medical Staff.

G. Obstetrical Records.

1. A pertinent prenatal record shall be updated upon admission, or history and physical examination signed by the physician shall be available upon the patient's admission and be maintained in the patient's medical record.

2. A record of labor and delivery, authenticated by the physician, shall be maintained for every Obstetrical patient.

3. Documentation of the patient's recovery from delivery shall be maintained.

4. Nurses' postpartum record, graphics and nurses' notes shall be maintained.

H. Newborn Records.

1. A newborn history and physical examination shall be completed by the physician within 24 hours of birth. The following additional data shall be required:

   a. History of the newborn delivery (sex, date of birth, type of delivery, and anesthesia given the mother during labor and delivery); and

   b. Physical examination (weight, date, time of birth, and condition of infant after birth).

2. There shall be a consent for circumcision (if applicable).

3. A procedure note for circumcision shall be documented by the physician.

4. A discharge note or summary ~~shall be documented by the physician~~ describing the condition of the newborn at discharge and follow-up instructions given to the mother must be prepared and included in the medical record. The discharge note or summary must be authenticated by the attending or treating physician.

5. Hospitals shall comply with State Law and Health Department

requirements for newborn testing. ~~(~~See ~~Table 10, Appendix.)~~ *Rules and Regulations Pertaining to Testing of Newborn Infants* and Ark. Code Ann. § 20-15-301 et seq.

6. Birth certificates shall be completed on all infants born in the hospital, or admitted as a result of birth in accordance with the requirements of Vital Records, Arkansas Department of Health.

SECTION 17: FOOD AND NUTRITION SERVICES.

A. Administration.

1. The Food and Nutrition Services shall be under the daily, including weekends, onsite supervision of a qualified individual. The individual shall be at a minimum a certified dietary manager and:

   a. Be responsible for the daily management of clinical and administrative dietetic aspects of the service by formulating, reviewing and revising policies and procedures for all Food and Nutrition Services practices;

   b. Ensure that all personnel in the service are oriented in their respective duties;

   c. Implement a maintenance program to ensure food service facilities, equipment and utensils are maintained in a safe, clean, sanitary manner and are replaced at specific intervals or as needed;

   d. Participate on hospital-wide departmental committees as required;

   e. Ensure that trained staff are maintained for daily administrative and clinical nutrition practices. A minimum of a two week current work schedule shall be posted and reflect all positions, including the department director; and

   f. Develop, implement and maintain a system for record keeping relating to all department functions dependent on the department's scope of services, e.g., patient assessments, counseling, diet instructions, temperatures, educational programs, etc.

   g. A hospital within a hospital may contract with the host hospital for food and nutrition services. Contracted services shall:
      i. be under a current agreement; and
      ii. shall meet all requirements of this section.

2. Policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

3. Policies and procedures shall include:

   a. Job descriptions and performance evaluations;

   b. Orientation;

   c. Preventive maintenance;

   d. Infection prevention and control measures;

   e. Safety practices; and

f. Cleaning of equipment and applicable areas.

4. Clinically relevant educational programs shall be conducted at regularly scheduled intervals with not less than 12 per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented~~ program dates, attendance, and subject matter.

5. Nutrition Services shall have an ongoing QA/PI Program that addresses both clinical and administrative issues. A mechanism for reporting results of audits shall be provided, to include: indicators monitored, thresholds/standards established, results, corrective plan/corrective action taken and follow-up.

6. Time and duty schedules for all hourly employees shall be maintained.

7. Diet Manual shall be authorized by the Medical Staff, reviewed and revised, as needed, to reflect current recognized dietary practices. A cover page shall be affixed with the date of review and appropriate signatures and a copy of the manual shall be located on each patient unit. Use of electronic diet manuals is acceptable.

8. Menus shall:

a. Be planned/approved by the registered dietitian and meet the nutrition needs of the patients in accordance with the current recommended dietary guidelines of the Food and Nutrition Board, National Research Council and the currently approved facility diet manual in accordance with the written diet order.

b. Be dated at least one week in advance. The current week's menus shall be posted and available in the kitchen. The meals prepared and served shall correspond with the posted menu, or written diet orders.

c. Not be restrictive in nature (e.g., seasoning, fat, sodium, sugar content) unless required by a modified/therapeutic diet order.

d. Be of equivalent nutrition value when substitutions/changes are made. Menus/production schedules, showing all changes, shall be retained for at least 30 days.

9. Diets shall be in writing and signed by a physician or a mid-level practitioner if privileged by the Medical Staff and Governing Body. Notification according to facility policy shall be made to the Nutrition Services Department on a timely basis, kept current and include current date, the patient's name, room number and diet order.

B. Food Services.

1. At least three meal equivalents shall be served daily at regular intervals, approximately five hours apart. No more than 15 hours shall elapse between the serving of the evening meal and the morning meal. The meals shall be served at approximately the same hour each day.

2. Food shall be prepared in accordance with approved menus and standardized recipes and in a manner to conserve nutritive value, flavor and appearance.

3. Food shall meet patient needs and shall be attractive, palatable and served at proper temperatures.

4. An identification system shall be implemented for patient trays to ensure that each patient receives the appropriate diet as ordered.

5. Nourishing bedtime snacks, appropriate to the patient's needs, shall be made available

6. Only foods prepared and stored under the direction of Nutrition Services, in accordance with the *Rules and Regulations Pertaining to Retail Food Service Establishments ~~of the Arkansas Department of Health~~* shall be served ~~in a hospital~~ to patients.

7. All individuals who assist patients in the preparation, heating, reheating, consumption of food, sanitation of food ware and kitchen equipment, etc., while in the facility or on the facility grounds, shall be under the direction of Nutrition Services and in compliance with the *Rules and Regulations Pertaining to Retail Food Service Establishments ~~of the Arkansas Department of Health~~*. Documentation of educational programs on food preparation, safety and sanitation shall be performed for all applicable personnel (e.g., Occupational Therapy, Nursing) by Nutrition Services at least annually.

8. Food shall not be consumed in the kitchen.

9. Food shall be transported in a manner that maintains safe food temperatures and prevents contamination. Food carts shall not block corridors/exits, emergency equipment or patient doorways.

10. All storage containers/foodstuffs shall be stored a minimum of ~~12~~6 inches above the floor on non-porous, easily cleaned racks, dollies or shelving, in a manner that protects the food (or food contact surfaces) from splash and other contamination and permits easy cleaning of the storage area.

11. Plastic milk crates shall not be permitted for storing of food or equipment, except for the intended use for milk storage.

12. Temperature documentation of all food refrigerators/freezers in the kitchen and cafeteria shall be performed a minimum of three times per day at opening, mid-operation and closing of the department.

13. Temperature documentation of all nourishment refrigerators/freezers in patient care areas shall be performed at least daily

14. Proper temperatures of vending machines containing potentially hazardous foods shall be ensured daily by the facility. Vending machines shall be equipped with a thermometer, easily visible to food service personnel for the purposes of monitoring the temperature of the internal environment. These machines shall have the capacity to render themselves inoperable if temperatures in excess of 40 degrees Fahrenheit are maintained for more than two hours. Documentation of such downtime shall be maintained to include remedial action taken.

15. If, for any reason, the refrigeration equipment does not maintain the appropriate

temperature, action shall be taken and a record of remedial action and downtime shall be recorded and maintained by the facility.

16. Temperature documentation of the dish machine shall be recorded with each meal and these records shall be maintained by the facility. If the temperatures (and, if applicable, dwell times) are not maintained properly, action shall be taken and a record of remedial action, back-up procedures used and downtime shall be maintained by the facility.

17. If the facility uses a chemical method for sanitizing food preparation and serving ware, a record of the water temperature, the chemical used and appropriate parts per million (ppm) shall be maintained by the facility at each use.

18. The temperature of the hot and cold potentially hazardous foods shall be recorded at least at the beginning and end of meal service that continues for more than 15 minutes. If meal service lasts for 15 minutes or less, food temperature documentation is required only at the beginning of food service.

19. Documentation of the testing/calibration of food/refrigeration/freezer thermometers shall be performed according to manufacturer's recommendations.

20. Food thermometers shall be sanitized after each use and stored in a manner that prevents contamination.

21. Only dietary and authorized personnel shall be allowed in the kitchen.

22. Sanitation shall be in accordance with the *Rules and Regulations Pertaining to Retail Food Service Establishments~~ of the Arkansas Department of Health~~*.

C. Food Safety/Sanitation.

1. Whole eggs and raw meat shall be stored separately and in a way that prevents contamination of other food items in refrigerated units.

2. Reheated food shall attain a temperature above 165º Fahrenheit prior to placement in steam tables, warmers, or other hot food storage units. Steam tables, warmers or other food storage units shall not be used for the rapid heating of potentially hazardous food.

3. Disposable gloves shall be worn to eliminate direct handling of food. Gloves shall be properly discarded after being used, torn or contaminated.

4. Ground beef or ground beef products shall be cooked to an internal temperature of 160º Fahrenheit or higher.

5. Potentially hazardous food shall be tempered or thawed only:

   a. In designated tempering units at a temperature not to exceed 45º Fahrenheit;

   b. In general refrigeration units at a temperature not to exceed 40º Fahrenheit;

   c. As part of the conventional cooking process; or

d. In a microwave, provided the food is immediately transferred to conventional cooking process.

6. Potentially hazardous food that is left over shall be labeled as such with the date and time it was removed from service.

7. Potentially hazardous food shall be chilled to a temperature below 40° Fahrenheit and retained for no longer than 48 hours.

8. Food contact surfaces, i.e., cutting boards, of all equipment and utensils, shall be sanitized by immersion for at least one-half minute in clean, hot water at a temperature of at least 180º Fahrenheit or by any other method approved by Health Facility Services. Counter tops and other huge industrial equipment shall be washed down with concentrated solutions.

9. Clean linens, mopheads and cloths shall be stored in a manner to prevent contamination prior to use.

10. Soiled linens, etc., shall be stored covered, separately from clean linen, food storage, preparation and serving areas. Containers for holding such items shall be made of non-absorbent materials. Soiled linens shall be removed from the department daily.

11. Food inventory shall be handled on a first-in, first-out basis. A system for labeling and dating canned, dry and potentially hazardous foods shall be implemented.

12. Potentially hazardous frozen foods removed from freezer storage to be thawed shall be labeled with the date of pull from the freezer for thawing.

13. Supplies and perishable foods for a 24 hour period and nonperishable foods for a three day period shall be on the premises to meet the requirements of the planned menus.

NOTE: These regulations are referenced to the Arkansas Board of Health *Rules and Regulations Pertaining to Retail Food Service Establishments~~, of the Arkansas Department of Health.~~*

D. Clinical Services.

1. Clinical Dietitian/Nutritionist.

Shall be a registered dietitian, or registry eligible, and evaluate and oversee the delivery of effective nutrition care based on current, recognized nutrition practices. If not full-time, make regularly scheduled visits to accomplish the following:

a. Review, revise and approve a current diet manual for facility use;

b. Review, revise, approve and implement nutrition care policy and procedures, standards of nutrition care, nutrition care protocols and the Nutrition Services QA/PI Program;

c. Coordinate nutrition care through communication with other patient care services;

d. Provide for the initiation of nutrition screening of all patients upon admission and periodic screening of patients during their hospital stay;

e. Provide for the nutrition evaluation assessment of patients at nutrition risk, as defined by the Medical Staff, and collaborate with the physician on the findings of the evaluation;

f. Ensure competency of all nutrition services personnel who perform assessments, counseling, develop care plans and participate in discharge planning;

g. Provide to the facility evidence of continuing education hours;

h. Perform orientation, preceptorship and ongoing training/educational programs for staff;

i. Review and revise nutrition counseling/diet education practices that are individualized to patient needs;

j. Monitor the enforcement of all policies and procedures and practices relating to food safety and sanitation;

k. Develop, implement and maintain a system for recording data related to patient care;

l. Collaborate with Nursing and Pharmacy to provide food/drug interaction counseling; and

m. If the dietitian is a consultant, submit reports to the facility Administrator reflecting services performed at each regularly scheduled visit.

2. Nutrition Screening and Documentation.

a. Nutrition Screening shall be completed within 24 hours of admission on all patients to determine nutrition risk and notify the physician and dietitian of any patients that are at nutrition risk.

b. Psychiatric, Alcohol and Drug and Rehabilitation patients shall be rescreened seven days from the initial screen and at least every 14 days thereafter.

3. Nutrition Evaluations and Care PlansCare Process.

a. A nutrition evaluation assessment of patients at nutrition risk, as reflected in the medical record, shall include as appropriate:

1) Anthropometric measurements including height, weight, BMI, and goal weightThe patient's percentage of goal body weight range;

2) Abnormal pertinent laboratory values;

3) The patient's caloric and protein needs;

4) ~~The percentage of food intake since admission~~nutrient intake compared to estimated needs;

5) Determination of abnormal intake or recent weight loss/gain prior to admission;

6) An objective evaluation of the patient's compliance with a physician ordered diet prior to admission;

7) Pertinent food/drug interactions;

8) An evaluation of the patient's special feeding/nutrient/fluid needs;

9) Patient's food preferences, dislikes, allergies or intolerances; and~~.~~

10) Nutrition summary including identification of nutrition problems

b. The patient care plan on all patients found to be at nutrition risk shall include the following nutrition components, as appropriate:

1) ~~The need for~~ individualized nutrition counseling;

2) ~~Need for~~ discharge planning;

3) ~~Need for~~ comprehensive nutrition assessments to include further clinical, laboratory, social or nutrition data to assist with the ongoing evaluation;

4) ~~Need for~~ follow-up care to evaluate the effectiveness of the nutrition regimen; and

5) Any requests ~~to the physician~~ for alterations or modifications to the ordered diet's nutrient content, consistency, administration route/method or meal pattern as served in the hospital in order to meet the nutrition needs and/or special feeding needs of the patient.

4. Nutrition Counseling. Documentation of nutrition counseling shall include:

a. Description of the individualized nutrition counseling;

b. Objective evaluation of the patient's and/or ~~significant other~~caregiver's understanding and ability to carry out the diet order; and

c. Plans for continued counseling and/or recommendations ~~to the physician~~ for post-discharge counseling and evaluation of patient diet compliance.

5. ~~Follow up~~ Nutrition ~~Care.~~ Monitoring and Evaluation.

a. Shall be performed at a minimum of every 72 hours with documentation in the patient's medical record when the patient is at nutrition risk. If the patient's nutrition status is stable, follow-up shall be at least every seven days.

b. Shall be documented in the patient's medical record ~~by a qualified designated Nutrition Services representative~~ on all patients at nutrition risk.

c. Shall be documented to include an evaluation of the effectiveness of the prescribed nutrition regimen, changing nutrition status/needs, nutrition counseling and/or recommendations to improve patient nutrition care.

SECTION 18: INFECTION PREVENTION AND CONTROL.

A. General.

1. The facility shall develop and use a coordinated process that effectively reduces the risk of endemic and epidemic ~~nosocomial~~ healthcare associated infections (HAI) in patients, health care workers and visitors.

2. There shall be a comprehensive list of communicable diseases for which patients shall be isolated and for which there are visitation restrictions. The list, and other policies and procedures for isolation, shall conform to the latest edition of the Centers for Disease Control and Prevention, Atlanta, Georgia (CDC) Guidelines.

3. It shall be the duty of the Administrator or his/her designee to report all infectious or communicable diseases in the facility to the Arkansas Department of Health, Epidemiology, as required by the Rules and Regulations Pertaining to Communicable Disease in Arkansas (Ark. Code Ann. §§ 20-7-109, 110) and CMS mandatory reporting requirements for Medicare certified facilities.

4. The Administrator shall designate a qualified individual who shall:

   a. Coordinate the activities of the Infection Prevention and Control Committee;

   b. Direct surveillance activities;

   c. Ensure policies established by the Committee are carried out; and

   d. Gather and report data regarding the hospital's ~~nosocomial infections~~HAI.

5. There shall be policies and procedures establishing and defining the Infection Prevention and Control program to include:

   a. Definitions of ~~nosocomial infections~~ HAI and communicable diseases based on the current CDC or National Healthcare Safety Network (NHSN) surveillance definitions;

   b. Perform an annual facility-based risk assessment to determine the infections that are most likely to occur in the facility. Infections to be addressed include (but are not limited to) the following: ~~Measures for identifying, investigating and reporting nosocomial infections and communicable diseases and a system of evaluating and maintaining records of infection among both patients and~~

~~health care workers which specify the type of infection from the following site categories~~:

1) Ventilator associated event (VAE)~~Respiratory~~;

2) Clostridium difficile infection (CDI)~~Gastrointestinal~~;

3) Central line associated blood stream infection (CLABS)~~Surgical wounds~~; and

4) Catheter associated urinary tract infection (CAUTI)~~Skin;~~.

~~5) Urinary tract;~~

~~6) Septicemias; and~~

7) Use of intravascular catheters.

NOTE: The facility's system for surveillance, calculation and evaluation of the incidence of ~~nosocomial infections~~ HAI within the facility shall conform to CDC's National ~~Nosocomial Infections Surveillance System (NNIS)~~ NHSN ~~and~~ or CDC publications as applicable.

c. ~~Method(s) for c~~Calculat~~e~~ing HAI ~~nosocomial infection attack~~ rates;

d. Measures for assessing and identifying patients and health care workers at risk for HAI ~~nosocomial infections~~ and communicable diseases;

e. Methods for obtaining reports of infections and communicable diseases in patients and health care workers in a manner and time sufficient to limit the spread of infection;

f. A plan for monitoring and evaluating at least the following areas or departments to ensure policies and procedures are followed:

1) Inpatient and outpatient surgery;

2) Delivery;

3) Nursery;

4) Central sterilization and supply;

5) Housekeeping;

6) Laundry;

7) Food and Nutrition;

8) Laboratory;

9) Nursing;

10) Maintenance;

11) Invasive specialty laboratories (special procedures);

12) Radiology; ~~-~~and

13) Hemodialysis units.

g. Measures for prevention of infections~~, at least those associated with the following~~ including but not limited to:

1) Intravenous (IV) devices;~~Intravascular therapy;~~

2) Indwelling urinary catheters;

3) Ventilator care~~Tracheostomy~~;

~~4) Respiratory care;~~

4~~5~~) Burns; and

5~~6~~) Immune suppressed patients.~~; and~~

~~7) Other factors which compromise a patient's resistance to infection.~~

h. Measures for prevention of communicable disease outbreaks, especially Mycobacterium tuberculosis (TB). All plans for the prevention of transmission of TB shall conform to the most current CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities;

i. Isolation procedures and requirements for infected, immune suppressed patients and patients colonized or infected with resistant organisms. Procedures shall conform to the most current CDC Guidelines.

j. Provisions for education of patients and their families concerning infections and communicable diseases to include hand hygiene and any isolation precautions;

k. A plan for monitoring and evaluating all aseptic, isolation and sanitation techniques employed in the facility to ensure that approved infection prevention and control procedures are followed;

l. Techniques for:

1) Hand hygiene including policies and procedures that reflect facility-selected national guidelines for soap and water as well as alcohol based hand rub if used;

2) Respiratory protection including policies and procedures that reflect facility-selected national guidelines;

3) Asepsis/sterile technique;

4) Sterilization;

5) Sanitary food preparation;

6) Disinfection;

7) Housekeeping;

8) Linen care;

9) Liquid and solid waste disposal of both infectious and regular waste. Disposal of infectious waste shall conform to the latest edition of the Rules and Regulations Pertaining to the Management of Medical Waste from Generators and Health Care Related Facilities;

10) Sharps safety~~Needle disposal~~;

11) Separation of clean from dirty process; and

12) Other means of limiting the spread of contagion.

m. Authority and indications for obtaining microbiological cultures from patients;

~~n~~. ~~A requirement that disinfectants, antiseptics and germicides be used in accordance with the manufacturer's directions;~~

~~o~~n. Employee health; and

~~p~~o. Visitation rules, especially for patients in isolation, critical care, pediatrics and other special care units, including postpartum care.

6. There shall be an orientation program for all new health care workers concerning the importance of infection prevention and control and each health care worker's responsibility in the hospital's infection prevention and control program.

7. There shall be a plan for each employee to receive annual educational programs as indicated based on assessments of the Infection Prevention and Control process.

8. ~~The infection control officer shall m~~Maintain a log of ~~infectious and communicable~~ documentation of reportable diseases.

9. No items shall be used past the expiration date.

B. Infection Prevention and Control Committee.

1. There shall be a multidisciplinary committee appointed by ~~the~~ Administrati~~o~~n~~r~~ to develop, implement and monitor direction for the Infection Prevention and Control program based on services impacting the i~~I~~nfection prevention and c~~C~~ontrol process.

2. The Medical Staff shall appoint a physician to serve as chairperson of the Infection Prevention and Control Committee. Additional physician members may be appointed.

3. The Infection Prevention and Control Committee shall meet at least ~~every two months~~quarterly. Minutes of the meetings shall reflect the C~~c~~ommittee's actions in monitoring and directing the hospital's Infection Prevention and Control program.

4. The Infection Prevention and Control Committee shall fulfill the following responsibilities:

a. Assist in the development and approval of all infection prevention and control policies and procedures within the facility;

~~b. Annually review and approve all infection control policies and procedures within the facility;~~

~~c~~. ~~Direct all departments relative to the purchase of equipment and/or supplies used for disinfection, decontamination, sanitation and/or sterilization;~~

~~d. Annually review and approve all products used throughout the facility relative to disinfection, decontamination, sanitation and/or sterilization and approve all interim changes;~~

~~e. Annually review and approve the list of communicable diseases for which patients shall be isolated;~~

~~f. At each meeting review the results of the biological spore tests on all the facility's sterilizers;~~

bg. Ensure that an antibiogram is prepared at least annually and compared to the previous one to identify trends;

ch. Monitor any contractual services relative to infection prevention and control (e.g. waste management and laundry) to ensure compliance with all applicable regulations; and

di. Review any special infection prevention and control studies conducted within the facility~~.~~; and

e. Provide oversight for disinfectants and sterilants.

C. Employee Health.

1. There shall be policies and procedures for screening health care workers for infectious/communicable diseases and monitoring for health care workers exposed to patients with any communicable diseases. The policies and procedures shall reflect facility-selected national guidelines.

2. There shall be employee health policies and procedures regarding preventing the transmission of infectious diseases. The policies and procedures shall reflect facility-selected national guidelines~~ in the following categories:~~

~~a. Health care workers affected with any disease in the communicable stage;~~

~~b. A carrier of any communicable disease; and~~

~~c. Health care workers affected with boils, jaundice, infected wounds, diarrhea or acute respiratory infections.~~

3. There shall be policies which clearly state when health care workers shall not render direct patient care.

4. There shall be a plan for ensuring that:

   a. each health care worker is free from TB; and

   b. The facility follwos the latest ~~has an annual TB skin test or is evaluated~~ tuberculosis screening and tuberculosis prevention ~~in accordance with~~ guidelines approved by the Arkansas Department of Health (Rules and Regulations Pertaining to: the Control of Communicable Diseases-Tuberculosis)~~; Section 1, Section 13 - Arkansas Department of Health Tuberculosis Program Amendment 22394 Adopted in February, 1994)~~.

5. There shall be a plan for ensuring that all health care workers who are exposed to blood and other potentially infectious body fluids are offered immunizations for Hepatitis B.

SECTION 20: RADIOLOGICAL SERVICES.

A. Radiology.

1. Each hospital shall have shock-proof diagnostic X-ray facilities.

2. Radiological Services shall be under the direction of a physician, who is a member of the Medical Staff.

   a. The physician director shall be certified (or eligible for examination) by the American Board of Radiology.

   b. At a minimum, a board certified radiologist shall be available on a consultative basis. Documentation of the radiologist's visits shall be required.

3. Radiological Services shall be supervised by a technologist who is qualified by experience or education and has at least two years technical experience.

4. A radiologic technologist with at least two years training shall be on duty 24 hours or on call at all times.

5. Radiologic staff who use the radiologic equipment and administer procedures shall have written verification of training and shall have approval in writing by the physician director.

6. Radiologic technologists shall not independently perform fluoroscopic procedures.

7. Radiologic staff who administer agents for diagnostic purposes shall have written verification of training. . A current list of radiology employees who administer agents for diagnostic purposes shall be approved by the physician director and maintained by the facility.

8. Radiology personnel who participate in direct patient care shall maintain competency in life support measures or the equivalent.

9. Clinically relevant educational programs shall be conducted at regularly scheduled intervals with not less than 12 per year. There shall be evidence of ~~written documentation with employee signatures, program title/subject, presenter, date and outline or narrative of presented~~ programdates, attendance, and subject matter..

10. Policies and procedures for the department shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department and/or person(s) conducting the review. Policies and procedures shall include:

    a. Job descriptions for every type employee;

    b. A written list of all tests/procedures performed by the Radiology Department and the list shall be available to the Medical Staff;

c. Infection prevention and control measures;

d. The holding of patients;

e. Orientation practices for new employees;

f. Operation of equipment;

g. Management of an adverse reaction;

h. Cleaning and disinfecting procedures; and

i. Posting of signs.

11. Radiology personnel shall receive yearly instruction in:

a. Safety precautions; and

b. Managing emergency radiation hazards and accidents.

12. A documented preventive maintenance and quality control program shall include:

a. Radiology personnel ~~shall wear a whole body monitoring device if they are likely to receive a radiation dose greater than 10 percent of the annual total effective dose equivalent limit of five rem. Monitoring of radiology personnel for exposure to radiation with integration over a period not to exceed one month;~~ shall follow the dosimetry requirements identified in the *Rules and Regulations for Control of Sources of Ionizing Radiation.*

b. Preventive maintenance for all diagnostic and therapeutic radiologic equipment to assure a safe working condition. Safety and calibration checks shall be made according to manufacturer's directions, not exceeding one year intervals;

c. Annual inspection of all leaded gloves, aprons and similar protective devices at least once a year with documentation to include: the name of the examiner, identification of the protective device examined and the results plus corrective action taken;

d. Documentation of safety, calibration, and inspection checks maintained for the life of the equipment; and

e. Remedial and corrective action recorded in response to equipment "down time," with documentation to include: the piece of equipment involved, time/date malfunction occurred, action taken, time/date when the equipment became operational.

13. X-ray films shall not be stored in radiologic examination rooms.

14. X-ray films shall be filed according to a recognized filing system.

15. X-ray prescription/work requests shall be authorized by a written and signed physician's order and shall include the following:

    a. Identification of the patient;

    b. Date the test was ordered;

    c. Physician's name;

    d. Concise statement as to the reason why the X-ray/test was ordered; and

    e. Originator's signature.

16. The radiologic report shall be signed by a physician and shall be placed in the medical record.

17. The Radiological Services shall have an ongoing QA/PI program that addresses patient care issues. A mechanism for reporting results of audits shall be provided, to include: indicators monitored, thresholds/standards, results, corrective plan/corrective action taken and follow-up.

18. This section establishes requirements for radiology that are in addition to, not in substitution of the *Rules and Regulations for Control of Sources of Ionizing Radiation*.

19. Actual X-ray film shall be retained for five years.

20. X-ray films and reports shall be stored in a room that is equipped with a smoke detection system. An extinguishing system shall be made available.

21. Locked security shall be ensured for the written reports maintained in the X-ray file when the storage area is not under the direct supervision of radiology personnel.

22. Dual image viewing shall be available in the OR, ER & Radiology areas.

23. Facilities shall maintain the capacity to view x-ray films.

B. Nuclear Medicine Services.

1. Nuclear Medicine procedures shall be under the direction of a physician, qualified in Nuclear Medicine, who is a member of the Medical Staff.

2. Nuclear Medicine services shall be supervised by a nuclear medicine technologist who has completed certification requirements and has at least two years technical experience.

3. Nuclear Medicine staff who use the equipment and administer procedures shall have written verification of training and shall have approval in writing by the physician director and Medical Staff.

4. All radioactive materials shall be purchased, stored, administered and disposed of in a manner consistent with the requirements of the *Rules and Regulations for Control of*

Sources of Ionizing Radiation or with the specific condition of a Radioactive Material License issued pursuant to these regulations.

5. The policy and procedure manual shall be reviewed annually and revised as necessary. Included in the manual shall be a cover page with signatures of those reviewing the manual and a month/day/year of review. The policies and procedures shall include:

   a. Job description for each employee;

   b. A list of tests/procedures performed by Nuclear Medicine;

   c. Safety practices;

   d. Management of an adverse reaction;

   e. Orientation for new employees;

   f. Operation of equipment;

   g. Cleaning and disinfecting procedures;

   h. Posting of signs;

   i. Quality control;

   j. Quality Assurance/Performance Improvement;

   k. Clean up of spills;

   l. Receipt/disposal of radioactive materials; and

   m. Radiation safety plan.

6. All nuclear medicine personnel who participate in direct patient care shall maintain competency in life support measures.

7. There shall be a documented preventive maintenance and quality control program:

   a. Monitoring of nuclear medicine personnel for exposure to radiation shall be integrated over a period not to exceed one month;

   b. Nuclear medicine personnel ~~shall wear a whole body monitoring device if they are likely to receive a radiation dose greater than 10 percent of the annual total effective dose equivalent limit of five rem. They shall also wear an extremity monitoring device if they are likely to receive a radiation dose to the extremity or skin greater than 10 percent of the skin or extremity dose limit of 50 rem;~~ shall follow the dosimetry requirements identified in the *Rules and Regulations for Control of Sources of Ionizing Radiation.;*

c. All nuclear medicine equipment shall be maintained in safe working condition. Preventive maintenance, safety and calibration checks shall be made according to manufacturer's directions, not to exceed one year interval;

d. Documentation of all safety, calibration and inspection checks shall be maintained for the life of the equipment; and

e. Remedial and corrective action shall be recorded in response to equipment "down time." Documentation shall include: the piece of equipment involved, time/date malfunction occurred, action taken, and time/date when equipment became operational again.

8. The nuclear medicine "hot lab" shall be kept locked when not under the direct supervision of authorized personnel.

9. There shall be an emergency eye wash available in the nuclear medicine "hot lab".

10. All nuclear medicine staff who administer agents for diagnostic purposes shall have written verification of training and approval by the physician director and individual(s) supervising the training.

11. Clinically relevant educational programs shall be conducted on regularly scheduled intervals at not less than 12 per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented~~ program dates, attendance, and subject matter.

12. All nuclear medicine requests shall be authorized by a written and signed physician's order and shall include the following:

a. Identification of the patient;

b. Date;

c. Physician's name;

d. Originator's signature; and

e. Reason/justification for the test.

13. The nuclear medicine report shall be signed by a physician. The original shall be placed in the medical record.

14. Films shall not be stored in radiologic or nuclear medicine examination rooms.

15. The storage of nuclear medicine films shall comply with the guidelines under Section 20, Radiological Services.

C. Guidelines for Mobile Services. The Governing Body and Medical Staff shall approve the provisions for establishing services in accordance with the following criteria:

1. General Considerations.

a. The installation is governed by the following Arkansas Department of Health publications:

1) *Rules and Regulations for Hospitals and Related Institutions in Arkansas*, Section 20, Radiological Services; and

2) *Rules and Regulations for Control of Source of Ionizing Radiation*.

b. Approvals shall be granted by the Arkansas Department of Health:

1) Health Facility Services; and

2) Radiation Control and Emergency Management.

c. The mobile service provider shall maintain fire, theft, general and professional liability insurance.

2. Operating Policies.

a. All examinations shall be authorized by a written and signed physician's order;

b. Examinations shall be performed under the direction of and interpreted by a qualified physician, with documented training or experience, who is a member of the hospital's Medical Staff;

c. Examinations shall be performed by a licensed radiologic technologist ;

d. The Radiology Department shall maintain current policies and procedures for use of the mobile units to include infection prevention and control and safety;

e. All personnel who administer agents for diagnostic purposes shall have written verification of training and approval by the physician director and individual(s) supervising the training;

f. Hospital personnel shall transport patients to and from the mobile unit according to hospital safety policies;

g. Oxygen and emergency medical supplies shall be maintained and readily available;

h. The hospital Pharmacy may provide necessary medical supplies including contrast media, but proper handling and control of dated items shall be ensured;

i. A log of all patients shall be maintained;

j. Films shall be maintained in the same manner as X-ray films;

k. Personnel who participate in direct patient care shall be competent in life support measures; and

l. Contracted services shall be under current agreement and the contractor shall fulfill all requirements of this section.

3. Refer to Section 52, Physical Facilities, Imaging Suite

SECTION 21: PHYSICAL THERAPY.

Licensed physical therapist means any person licensed to practice physical therapy by the Arkansas State Board of Physical Therapy.

The practice of licensed physical therapy assistants shall be performed under the supervision of the licensed physical therapist. The supervising therapist shall be readily available for consultations, evaluations and establishment of each program prior to delegation of any treatments and determination of patient discharge.

If physical therapy services are rendered by an individual who does not meet at least the assistant-level qualifications (aide/technician), a qualified physical therapist shall be on the premises and immediately available to provide assistance and direction throughout the time the services are rendered.

A. Physical therapy services shall be provided under the direction of a physician member of the Medical Staff.

B. Physical therapy services shall be supervised by a physical therapist licensed by the Arkansas State Board of Physical Therapy. Physical therapy assistants and aides shall comply with all state licensure requirements.

C. A policy and procedure manual for Physical Therapy shall be developed. The manual shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

D. There shall be written policies and procedures which shall include:

1. Job descriptions for each type of employee;

2. Infection prevention and control measures;

3. Standards of care;

4. Criteria for assuring continuous communication of the patient's therapy and progress to the physician;

5. Assembly and operation of equipment;

6. Physical therapy services provided and a list of services made available to the Medical Staff;

7. Documentation specifying who may perform special procedures and give patient instruction; this shall be verified by the physician director;

8. Safety practices;

9. Orientation practices for new employees; and

10. Cleaning, disinfecting and sterilizing procedures.

E. There shall be an adequate supply of reference material for the physical therapist which shall include current literature.

F. All physical therapy prescriptions/work requests shall be authorized by a written and signed physician's order.

G. Equipment shall be adequate for the services offered and maintained in good repair.

1. Equipment shall be serviced, calibrated and operated according to the manufacturer's directions.

2. All physical therapy equipment shall be under the control of the physical therapy supervisor.

3. A preventive maintenance program shall be implemented with periodic inspection of all equipment and appropriate records maintained for the life of each piece of equipment.

4. All temperature-dependent patient use equipment shall have the temperature checked and recorded before each patient use or at least daily, if used, to ensure patient safety.

H. Physical therapy records for each patient shall include:

1. Current written plan of care;

2. Statement of treatment objectives;

3. Statement of patient's short-term and long-term rehabilitation potential;

4. Functional limitations;

5. Justification of continued rehabilitative care; and

6. Documentation of daily treatments.

I. Clinically relevant educational programs shall be conducted on a regularly scheduled interval not less than 12 times per year. There shall be evidence of written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented program dates, attendance and subject matter.

J. All physical therapy personnel who participate in direct patient care shall be competent in life support measures.

K. There shall be an ongoing QA/PI program.

L. Hospitals which have swimming pools shall comply with applicable sections of Rules and Regulations Pertaining to Swimming Pools and Other Related Facilities.

M. Contracted physical therapy services shall be under current agreement and the contractor shall fulfill all requirements of this Section.

SECTION 22: OCCUPATIONAL THERAPY.

In facilities with an organized Occupational Therapy Department, the following shall apply:

A. Occupational Therapy Services shall be under the direction of a physician member of the Medical Staff.

B. Occupational Therapy Services shall be supervised by a currently licensed therapist in the field of rehabilitation services.

C. There shall be sufficient occupational therapy supportive technical staff to provide authorized Occupational Therapy Services.

D. The policy and procedure manual shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

E. There shall be written policies and procedures which shall include:

1. Job descriptions for every type of employee;

2. Documentation specifying who may perform special procedures and give patient instructions. This shall be verified by the physician director;

3. Orientation practices for new employees;

4. Occupational therapy services provided and a list of services provided to the Medical Staff; and

5. Safety practices.

F. Current reference material shall be available for the occupational therapist.

G. All occupational therapy prescriptions/work requests shall be authorized by a written and signed physician's order.

H. Equipment shall be adequate for the services offered and maintained in good repair.

1. Equipment shall be serviced, calibrated and operated according to the manufacturer's directions.

2. All occupational therapy equipment shall be under the control of the occupational therapy supervisor.

3. A preventive maintenance program shall be implemented with periodic inspection of all equipment and appropriate records maintained for the life of each piece of equipment.

4. All temperature-dependent patient use equipment shall have the temperature checked and recorded before each patient use.

When appropriate elements are planned and arranged for shared use by physical therapy patients and staff, one or both services shall be responsible for the preventive maintenance program and the retention of records.

I. Occupational therapy records for each patient shall include:

1. Current written plan of care;

2. Statement of treatment objectives;

3. Statement of patient's short-term and long-term rehabilitation potential;

4. Justification of any continued rehabilitation care; and

5. Documentation of the patient's condition and response to treatments.

J. Clinically relevant educational programs shall be conducted on a regularly scheduled basis at not less than 12 per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented~~ program dates, attendance, and subject matter.

K. All occupational therapy personnel shall maintain competency in life support measures.

L. There shall be an ongoing QA/PI program.

M. Contracted occupational therapy services shall be under current agreement and the contractor shall fulfill all requirements of this Section.

SECTION 23: SPEECH PATHOLOGY/AUDIOLOGY SERVICES.

In facilities with an organized Speech Language Pathology/Audiology Services Department, the following shall apply:

A. Speech Pathology/Audiology Services shall be under the direction of a physician member of the Medical Staff.

B. Speech Pathology/Audiology Services shall be supervised by a therapist who is currently licensed.

C. There shall be sufficient supportive personnel to provide authorized speech pathology/audiology services.

D. There shall be documentation, verified by the physician director, of who may perform special procedures and give patient instructions.

E. Policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

F. There shall be written policies and procedures which shall include:

1. Job descriptions for every type of employee;

2. Orientation procedures for new employees;

3. Infection prevention and control measures;

4. A listing of services/treatments available to the Medical Staff; and

5. Safety practices.

G. Equipment shall be in good repair and under the control of the therapist supervisor. Documentation of preventive maintenance shall be maintained for the life of each piece of equipment.

H. Current reference material shall be available for the department.

I. Clinically relevant educational programs shall be conducted on a regularly scheduled basis at not less than 12 per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented~~ program dates, attendance, and subject matter.

J. All speech pathology/audiology prescriptions/work requests shall be authorized by a written and signed physician's order.

K. Speech Pathology/Audiology Services records for each patient shall include:

1. Current written plan of care;

2. Statement of treatment objectives;

3. Statement of patient's short-term and long-term rehabilitation potential;

4. Justification of any continued rehabilitation care; and

5. Documentation of progress notes following treatment given to patients.

L. All Speech Pathology/Audiology personnel shall maintain competency in life support measures.

M. There shall be an ongoing QA/PI program.

N. Contracted Speech Pathology/Audiology Services shall be under current agreement and the contractor shall fulfill all requirements of this Section.

SECTION 24: RECREATIONAL THERAPY.

In facilities with organized Recreational Therapy Services, the following shall apply:

A. Recreational Therapy Services shall be under the direction of a physician member of the Medical Staff;

B. Recreational Therapy Services shall be supervised by a therapist with current certification;

C. There shall be sufficient Recreational Therapy supportive staff to provide authorized Recreational Therapy Services;

D. There shall be documentation, verified by the physician director, of who may perform special procedures and give patient instructions;

E. The policy and procedure manual shall have evidence of ongoing review and/or revision. The first page of the manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review;

F. There shall be written policies and procedures which shall include:

1. Job descriptions;

2. Infection prevention and control measures;

3. Recreational Therapy Services provided and a list of services shall be made available to the Medical Staff;

4. Orientation practices for new employees and volunteer personnel;

5. Assembly, operation and maintenance of all equipment;

6. Safety practices;

7. Security of supplies and tools; and

8. Activities off-campus.

G. All equipment, tools and machines shall be in good repair and under the control of the therapist supervisor. Documentation of preventive maintenance shall be maintained for the life of each piece of equipment;

H. Current reference material shall be available for the department;

I. Clinically relevant educational programs shall be conducted on a regularly scheduled basis at not less than 12 per year. There shall be evidence of written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented program dates, attendance, and subject matter.;

J. All recreational therapy prescriptions/work requests shall be authorized by a written and signed

physician's order and shall include:

1. Identification of the patient;

2. Date;

3. Physician's name;

4. Type, frequency and duration of treatment; and

5. Originating signature.

K. Recreational Therapy Service records for each patient shall include:

1. Current written plan of care;

2. Documentation of attendance by the therapist in team meetings and the contribution by the therapist to the treatment plan;

3. Statement of treatment objectives;

4. Statement of patient's short-term and long-term rehabilitation potential;

5. Record of daily activity participation;

6. Justification of any continued rehabilitation care; and

7. Progress notes.

L. All Recreational Therapy personnel shall maintain competency in life support measures;

M. There shall be an ongoing QA/PI program;

N. If food and/or nutritional service functions are offered, infection prevention and control, storage and supervision shall be coordinated with the Dietary Department of the facility; and

O. Contracted Recreational Therapy Services shall be under current agreement and the contractor shall fulfill all requirements of this Section.

SECTION 25: PET THERAPY PROGRAM

Definitions.

"Program" means Pet Therapy Program.

"Pet" means an animal that has been specifically screened, trained, and authorized by the hospital to participate in the Program.

"Handler" means an individual who has been specifically credentialed and authorized by the hospital to participate in, and to accompany and control pets participating in, the Program.

A. The Program shall be approved by the Governing Body, Medical Staff, and the Infection Prevention and Control Committee.

B. The Infection Prevention and Control Committee shall, in conjunction with a licensed Veterinarian, establish the Medical Criteria that each pet shall meet in order to participate in the Program.

C. The hospital shall establish the Behavioral Criteria that each pet shall meet before participating in the Program.

D. A licensed Veterinarian shall certify that a participating pet:

1. Meets the hospital's medical criteria; and

2. Is free of communicable disease causing organisms.

E. A licensed Veterinarian, a local protection society or a pet therapy association or society shall certify that a participating pet meets the Hospital's Behavioral Criteria.

F. Pets found to have a communicable disease shall be excluded from the Pet Therapy Program until the pet is treated and has one negative culture, if culturing of the causative agent is feasible. Pets expressing behavioral problems will be excluded from the program until the behavioral problem is remedied.

G. Pets shall be bathed and groomed before each hospital visit. Pets shall be free of fleas while visiting the hospital.

H. The hospital shall establish an orientation program for the Handlers. Handlers shall attend this program before participating in the Program. The orientation program shall include, at least, patient confidentiality, appropriate infection prevention and control measures, safety, and appropriate emergency protocols. Records of the orientation program shall be kept.

I. The hospital shall keep records of each visit the Pet makes. The records shall include, at least, the date, the identity of the Pet, the identity of the Handler, all the patients visited; the area in which the patient visits were made, and any infectious condition the patient had or any type isolation the patient was in at the time of the visit.

J. The pet and handler shall be escorted at all times by a staff member appropriate to the area visited. Patient safety and confidentiality shall be maintained at all times.

K. The Pet shall be under the direct supervision of the handler at all times and shall be on a leash or in a crate at all times while in the hospital. Other patients, visitors, and employees shall be discouraged from petting the pet.

L. The Hospital shall provide an area to walk the pet. There shall be procedures for immediate clean up of all accidents.

M There shall be procedures for patient hand washing, visit area clean up and cleaning of the patients room. If a pet visits a patient in bed, the bed linens will be changed immediately after the visit. A barrier shall be placed over the bed if the pet is placed directly on the patient's bed.

N. The attending physician in conjunction with the Infection Control Officer, will determine the appropriateness of the pet visits. The attending physician shall approve and order each Pet visit. The orders shall be documented in the medical record.

SECTION 26: SPECIALIZED SERVICES: SURGICAL SERVICES.

A. Organization and Supervision.

1. An organizational plan shall be developed.

2. Surgical Services shall be under the medical direction of a qualified physician or a physician committee.

3. A Surgical Services Registered Nurse supervisor shall be accountable and responsible for patient care.

4. Surgical Services shall have written policies and procedures that include:

   a. Operative and special consents;

   b. Fire and disaster plans;

   c. Environmental control;

   d. Visitor and traffic control to include allowance for no one other than staff or professionals without the expressed consent of the physician and operating room supervisor;

   e. Safety practices;

   f. Infection prevention and control measures;

   g. Care and disposition of surgical specimens, cultures and foreign bodies;

   h. Care of special equipment including preventive maintenance contracts and records;

   i. Emergency management;

   j. Orientation of all personnel; and

   k. Medication accountability. (Refer to Section 11, Patient Care Service and Section 16, Pharmacy.)

5. Clinically relevant educational programs shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented~~ program dates, attendance, and subject matter.

6. A surgery schedule shall be maintained in the surgery suite.

7. There shall be a continuous QA/PI program that is specific to the patient care administered.

8. A current roster of physicians and dentists with a delineation of each physician's and dentists surgical privileges shall be accessible and available in the confidential files of the Surgical Services Registered Nurse and in the files of the hospital administrator.

9. The following information shall be maintained in the surgery services log:

   a. Patient's full name;

   b. Hospital number;

   c. Surgeon;

   d. Assistant surgeon;

   e. Type of anesthetic and person administering;

   f. Pre and postoperative diagnoses;

   g. Circulating nurse;

   h. Scrub nurse(s);

   i. Procedures;

   j. Complications;

   k. Sponge, needle, and instrument count;

   l. Time of beginning and ending of case; and

   m. Other persons present.

B. Environment, Equipment and Supplies.

1. A safe operating room environment shall be established, controlled and consistently monitored.

2. At a minimum, the following general equipment and supplies shall be in the surgical suite:

   a. Call-in system;

   b. Crash cart;

   c. Cardiac monitor

   d. Defibrillator;

   e. Resuscitating equipment;

f. Suction equipment; and

g. Thoracotomy set.

3. Equipment and supplies necessary to meet the requirements of the services provided:

a. Stretcher;

b. Anesthetic equipment and supplies;

c. Adjustable operating table with waterproof pad;

d. Side tables;

e. Approved surgical light;

f. Medical gases;

g. 24 hour supply of sterile linen;

h. Wall clock; and

i. Equipment and supplies for timed scrubbing technique.

C. Staffing.

1. Surgical personnel including a Registered Nurse shall be available to provide emergency surgical services on a 24 hour basis.

2. A Registered Nurse shall be present in the operating room for the duration of the surgical procedure. Additional auxiliary personnel shall be available as necessary.

3. Only qualified Registered Nurses may perform circulating duties in the operating room.

4. There shall be documentation of training and/or experience for all operating room personnel assigned to surgical procedures.

SECTION 27: SPECIALIZED SERVICES: POSTANESTHESIA CARE UNIT.

A. Postanesthesia Care Unit (PACU) Services shall be provided in a well organized manner under the direction of a qualified physician and under the supervision of a Registered Nurse.

B. Policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review. Policies and procedures shall include:

1. Lines of authority and nursing supervision;

2. Transfer of patients from the Operating Room to Postanesthesia Care Unit;

3. Criteria for discharge of patients from the Postanesthesia Care Unit; and

4. The care of patients in the event the Postanesthesia Care Unit closes (including provisions of adequate nursing staff).

C. There shall be adequate nursing staff in attendance with every patient during anesthesia recovery.

D. A physician shall order the discharge of the patient from the Postanesthesia Care Unit.

E. Equipment shall be available in accordance with services provided.

F. The Registered Nurse shall assess and document assessment of each PACU patient.

G. Clinically relevant educational programs shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be evidence of ~~documentation which includes~~ program dates, attendance, and subject matter.~~content, presenter, date and signatures of attendees~~.

H. There shall be an ongoing QA/PI program that is specific to the patient care administered.

SECTION 29: SPECIALIZED SERVICES: ANESTHESIA SERVICES.

A. Organization and Staffing. Anesthesia Services shall be provided in a well organized manner under the direction of a qualified physician. The service is responsible for all anesthesia administered.

B. Those administering anesthesia shall be credentialed by Medical Staff and approved by the Governing Body. A current roster, with delineation of privileges for those administering anesthesia, shall be maintained and readily available.

C. Anesthesia shall be administered by the following:

1. Anesthesiologist;

2. Physician qualified to administer anesthesia; or

3. Certified Registered Nurse Anesthetist (CRNA) under the supervision of a physician.

D. Written policies and procedures specific to Anesthesia Services shall have evidence of ongoing review and/or revision. The first page of the manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

E. Policies and procedures shall include:

1. Preanesthesia evaluation;

2. Approved anesthesia agents;

3. Methods of delivery of anesthesia;

4. Intraoperative anesthesia record;

5. Post anesthesia follow-up report;

6. Mechanism for routine checking and maintenance of anesthesia machines and equipment for safe use;

7. Medication accountability. See Section 16, Pharmacy, Section 11, Patient Care Service, and Section 12, Medications;

8. Responsibilities in the discharge of patients from the Post anesthesia Care Unit. See Section 27, Post anesthesia Care Unit; and

9. Infection prevention and control measures.

F. All medications and anesthetic agents administered to the patient shall be ordered by the prescriber and/or anesthesia provider. This includes preoperative as well as intraoperative and postoperative medications.

G. There shall be an ongoing QA/PI program that is specific to the patient care administered.

SECTION 30: SPECIALIZED SERVICES: LABOR, DELIVERY, LABOR DELIVERY RECOVERY (LDR), LABOR DELIVERY RECOVERY POST PARTUM (LDRP), POST PARTUM AND MATERNAL-CHILD EDUCATION.

A. Labor Room and/or LDR, LDRP Room.

1. Provisions shall be made for patients in labor in either a designated labor room and/or birthing room. Rooms used only for labor shall be in close proximity to the delivery room. Furniture, washable wallpaper, pictures, radio, television, and other items may be used as long as the needs of the mother and baby are not compromised. Items selected shall be made of durable materials, with a smooth, impervious surface which can be easily cleaned and disinfected.

2. All beds used for labor shall be equipped with side rails.

3. There shall be equipment and supplies available for the examination and preparation of patients in labor, which shall consist of the following:

   a. Precipitous delivery tray;

   b. Stethoscope;

   c. Suction equipment;

   d. Sterile gloves;

   e. Emergency medications as approved by the Pharmacy and Therapeutics Committee and supplies to include laryngoscopes, airways, endotracheal tubes and infant ambu bags; and

   f. Fetal monitoring device.

4. A physician shall be immediately available when Oxytocin is administered. "Immediately available" shall be determined by the hospital's administrative staff, Medical Staff and Governing Body.

5. Father or support persons may be allowed with the patient during labor unless medically contraindicated.

B. Delivery Areas.

1. Hospitals offering delivery and maternity services shall comply with the requirements of this section. (See Section 14, Health Information Services and Section 11, Patient Care Service.)

2. General operating rooms may not be used for deliveries, except for major surgical deliveries. Delivery rooms shall be separate from operating rooms and shall not be used for any other purpose, with the exception of a tubal ligation immediately following a delivery. Delivery rooms may be used for Caesarean sections provided the usual operating room equipment is used, and surgical policies and procedures related to the delivery are made a part of the labor and delivery manual.

3. The following equipment and supplies shall be provided:

   a. Supply of medications as approved by the Pharmacy and Therapeutics Committee;

   b. Infant identification and supplies. Identification shall be done in the delivery room at the time of birth and shall remain in place during the entire period of hospitalization. Identification information shall be sufficient to identify the infant(s) with one mother. Identification bands shall be waterproof plastic with tag inserts written in waterproof ink;

   c. Heated bassinet, crib, or incubator;

   d. Supply of prophylaxis medication for the prevention of infant blindness. The medication shall be administered within one and one-half hours of the time of birth per written order of the physician;

   e. Commercially manufactured delivery table/birthing bed with a waterproof non-conductive table pad;

   f. Side tables for instruments and other necessary equipment;

   g. Approved surgical light;

   h. Wall clock;

   i. Equipment and supplies for timed scrub technique and an approved disinfectant soap;

   j. Apgar score chart;

   k. Suction equipment (infant and adult);

   l. Sphygmomanometer; and

   m. Fetal monitoring device.

C. Organization.

1. Delivery services shall be under the direction of a qualified physician and under the supervision of a Registered Nurse. A Registered Nurse shall be present during labor, delivery and post delivery of each patient. The birth shall be attended by a physician or a certified nurse midwife with hospital privileges.

2. Patients shall be provided with direct care by a Registered Nurse during labor, delivery, recovery and postpartum.

   a. All patients in active labor shall be attended and/or monitored.

   b. Qualified nurses, in adequate numbers shall be provided to meet the needs of each patient.

3. An on-call schedule shall be provided to ensure that a physician with obstetrical privileges is readily available to perform obstetrical services at all times. "Readily available" shall be determined by the hospital's Administrative Staff, Medical Staff and Governing Body.

4. Qualified Registered Nurses shall always be available in-house for labor and delivery patients. When there are no patients, on-call staff may be utilized if approved by the Medical Staff and Governing Body.

5. Procedures for obtaining the mother's Rh factor shall be provided by the facility or documented by the mother's attending physician upon admission.

6. When a patient presents to the hospital for evaluation, the physician shall be notified.

7. Policies and procedures shall include:

   a. Immediate delivery;

   b. Obstetrical emergencies;

   c. Setting up and cleaning the delivery room, LDR or LDRP room, and C-section room;

   d. Equipment requirements;

   e. Visitation;

   f. Climate control (physical);

g. Infection prevention and control measures;

h. Aseptic techniques;

i. Intermittent rooming in;

j. Anesthesia;

k. Deliveries occurring outside the delivery area;

l. Infectious patients; and

m. Infant security.

8. A permanent record of all deliveries shall be maintained. There shall be a reasonable attempt to collect current information to include the following:

a. Mother's name, date of birth, maiden name, father's name if available, hospital number, gravida-para, ABO type, Rh factor, and length of gestational period;

b. Baby's sex, race, date of birth, time of birth, weight, apgar score, and baby identification band number;

D. Anesthesia.

1. Only a physician, anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) shall be permitted to initiate and reinject continual epidural or caudal anesthesia and to initiate or continue general or regional anesthesia.

2. A physician shall be immediately available if CRNAs are administering anesthesia. “Immediately available” shall be determined by the hospital’s Administrative Staff, Medical Staff and Governing Body.

3. The permanent record shall contain the names of the physician, anesthesiologist, anesthetist or CRNA.

E. Postpartum Care.

1. Policies and procedures shall be developed specific to the care of maternity patients.

2. Maternity patients shall not be routinely cared for in rooms with patients admitted for diagnosis other than maternity.

3. After an observation period, the infant may stay in the room with the mother for the duration of the hospital stay.

4. Mothers with infection, fever or other condition that could adversely affect the safety and welfare of others shall be immediately segregated and isolated in a separate room.

F. Maternal-Child Education. The hospital shall develop an educational program for the care of the obstetrical patient and infant. Policies and procedures shall include:

1. Personal hygiene;

2. Dietary instruction;

3. Care of episiotomy and perineum;

4. Care of incision;

5. Breast care;

6. Exercise program;

7. Car seat safety (Ark~~ansas State Law~~ Code Ann. § 27-34-101 et seq.);

8. Preventive health;

9. Referral services; ~~and~~

10. Infant care~~.~~; and

11. Distributing educational materials for shaken baby syndrome (Ark. Code Ann. § 20-9-1401 et seq.).

SECTION 31: NURSERY SERVICES.

The newborn nursery shall be under the direct supervision of a Registered Nurse with clinical skills in newborn nursing. The newborn nursery shall be located within or adjacent to the postpartum unit. The following requirements shall apply to all nurseries:

A. Nurseries shall not be used for any other purpose and shall never be left unattended when occupied.

B. Infants born outside the hospital or with proven or potential infections shall be isolated from other infants in the Nursery. Infants with infections, skin rash, or diarrhea shall be immediately separated and isolated.

C. Isolettes shall not serve as a sole means of isolation. Provisions for isolation shall be provided.

D. The following equipment shall be provided in nurseries:

1. Individual approved type hospital bassinets. Wicker or woven type bassinets shall not be used;

2. Metal or approved plastic diaper and waste containers. The lids on these containers shall be operated by a foot control or equivalent device;

3. Infant scales;

4. Blankets and linen;

5. Suction equipment; and

6. Incubators suitable for the care of premature infants provided in the ratio of at least one incubator to 20 bassinets.

E. Infant emergency supplies:

1. Emergency medications approved by the Pharmacy and Therapeutics Committee;

2. Infant laryngoscope;

3. Suction catheters;

4. Endotracheal tubes;

5. Stylets; and

6. Infant airways and IV supplies.

F. Strict hand hygiene techniques shall be maintained by all personnel. A clean barrier shall be used by anyone handling the infant.

G. Infant clothing shall be furnished by the hospital; however, if the mother wishes to provide clothing for the infant, hospital personnel shall examine the clothing to make sure it meets hospital requirements. Diapers shall be available in necessary quantities.

H. Formula Feedings.

1. Any individually packaged, presterilized formula delivered by an outside source shall be approved by the facility.

2. There shall be an adequate supply of sterile disposable ready-to-use formula bottles available.

3. Formulas shall be stored in enclosed cabinets.

4. The expiration date shall be checked on each bottle prior to infant feeding.

5. Policies and procedures shall be developed in conjunction with the Infection Prevention and Control Committee regarding the handling, labeling and storing (separately) of breast milk.

6. Individual nipple shields and breast pumps used in infant feeding shall be cleaned according to hospital infection prevention and control policies and procedures.

7. If the facility has a breast milk bank the policies and procedures shall be submitted to and approved by the Arkansas Department of Health and hospital Infection Prevention and Control Committee.

I. Rooming-In Service. Hospitals providing a newborn nursery may provide rooming in for infants on an intermittent or 24 hour basis based on the mother's request.

SECTION 34: SPECIALIZED SERVICES: CENTRAL STERILIZATION AND SUPPLY.

A. Each hospital shall provide central medical and surgical supply services with facilities that are responsible for processing, sterilizing, storing, distributing supplies and equipment to all units of the hospital. (Refer to Section 66, Physical Facilities, Central Medical and Surgical Supply Department, for space and equipment requirements.)

B. The central sterilization and supply service shall be under the direct supervision of a Registered Nurse or other qualified person who is trained in management, aseptic procedures, supply processing and control methods which are applicable to central sterilization and supply service.

C. Policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department and/or person(s) conducting the review.

D. Policies and procedures shall include:

1. Job descriptions;

2. Infection prevention and control measures;

3. Assembly and operation of equipment;

4. Safety practices;

5. Orientation for new employees;

6. Care and cleaning of equipment;

7. Evaluation of:

   a. Cleaning effectiveness; and

   b. Sterilizing effectiveness.

8. Receiving, decontaminating, cleaning, preparing, disinfecting and sterilizing reusable items;

9. Assembling and wrapping of packs (to include the double-wrapped techniques);

10. Storage and distribution of sterile equipment/medical supplies;

11. Use of chemical indicators and biological spore tests for sterilizers;

12. Recalling and disposing/reprocessing of outdated sterile supplies;

13. Cleaning and disinfecting of surfaces, utensils, and equipment;

14. Specifications for cold-liquid sterilization and gas sterilization (if used); and

15. Collection and disposal of supplies recalled by the manufacturer.

E. There shall be an ongoing QA/PI program specific to the area.

F. Precautions shall be exercised to prevent the mixing of sterile and unsterile supplies and equipment. The precautions shall be set forth in written policies.

G. Procedures shall be developed for unloading and transporting flash sterilized items. The procedures shall be developed with the assistance of the Infection Control Committee and shall provide for the aseptic transfer within the physical constraints of the facility.

H. Relevant educational programs shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented program.

I. A liaison with the Infection Prevention and Control Committee shall be maintained.

J. Records shall be maintained of all autoclave loads, both routine and immediate use or"flash," which shall include the date, time, lot number (on routine loads), the time at temperature (where a recorder is not available), item(s) sterilized and shall identify the person performing the task.

1. Autoclaves shall meet the following requirements:

2. The efficacy of autoclaves, both for routine and immediate use or "flash" use, shall be determined weekly through the use of biological spore monitors:

3. The results of all biological spore monitoring shall be reported to the Infection Prevention and Control Committee; and

4. Failures of the biological spore test shall be brought to the attention of the Infection Prevention and Control Officer or designee immediately so the appropriate surveillance measures can be initiated.

NOTE: All materials sterilized from the date of the biological spore monitor failure to the last successful biological spore monitor shall be re-sterilized before use.

K. All autoclaves within the facility shall be maintained in accordance with the manufacturer's written directions. Records shall be maintained of all maintenance and repairs for the life of the equipment.

L. Chemical indicators for sterility shall be used with each cycle

M. The facility shall validate compliance and efficacy of the sterilization policy through the quality review process. The sterilization policy shall describe the mechanism used to determine the shelf life of sterilized packages. The policy shall:

1. Be consistent with published industry standards (AAMI and APIC).

2. Stress that sterility is related to integrity of pack regardless of whether expiration dating or event-related expiration is utilized.

ON. Event-related/Indefinite dating of sterile packs is acceptable.

	ALLOWABLE SHELF LIFE
Double-wrapped Muslin, Paper or Polypropylene	Use for rapid turn-around items only in well controlled environment, < 30 days
Double-wrapped Muslin, Paper or Polypropylene Placed in a Plastic Dust Cover Then Heat Sealed or Bonded	Indefinite Event related
Paper or Polypropylene Peel Pack (Paper, Plastic or Tyvek/Mylar)	Event related and/or per manufacturer's instructions Indefinite
Rigid Containers, Caskets, Etc.	Per Manufacturer's Instructions

NOTE: 1. Stock rotation shall be based on the "first in-first out" principle.

21. Sterile storage areas shall maintain a temperature of no more than 75°EF and a relative humidity of no more than 70%. Ventilation shall be 10 air changes per hour and shall follow clean to dirty flow.

32. The interior of the dust cover shall not be considered sterile.

43. Indefinitely dated items shall be labeled with the date of sterilization and state "contents sterile unless package is damaged." Packages that are wet, dropped on the floor, compressed or torn shall be rejected.

54. The lot number or control number and expiration statement shall be visible through the package or another tag shall be placed on the outside.

65. Containers for sterilization systems shall be scientifically proven suitable for the specific sterilization cycle used; the container system shall be verified as the correct one for the cycle. (Manufacturer's instructions shall be followed.)

76. Double-wrapped shall mean the end results of the wrapping technique will yield an envelope within an envelope a two-ply covering.

87. The date of sterilization and load control number shall be placed on each sterilized pack.

~~P~~O. Immediate use or "f~~F~~lash" (autoclaving) shall be restricted to unplanned or emergency situations. Flash sterilization shall never be used as a convenience to compensate for inadequate inventories of instruments or implantables. Flash sterilization of implantables shall be restricted to the direst circumstances.

~~Q~~P. Items which are to be immediate use flash sterilized shall be cleaned and decontaminated before the sterilization process.

~~R~~Q. Traffic areas in which immediate use or flash sterilization is carried out shall be restricted to authorized personnel wearing surgical attire consisting of surgical scrubs, shoe covers, masks and hair covers. The sterilizer shall not be located adjacent to any potential sources of contamination such as scrub sinks, clinical sinks or hoppers, wash sinks, linen or trash disposal areas.

~~S~~R. For immediate use or flash sterilization, minimal time at effective temperature shall conform to the following:

AUTOCLAVE	LOAD	MINIMAL TIME AT TEMPERATURE
Gravity	Nonporous (Simple Metal Instruments)	3 minutes at 132EC (270EF)
Gravity	Porous (Towels, Rubber, Plastic) Nonporous Mix	10 minutes at 132EC (270EF)
Gravity	Nonporous with Lumens, Deep Grooves, Sliding Parts	10 minutes at 132EC (270EF)
Gravity/Prevacuum	Complex Devices, Air-powered Drills	Per Manufacturer=s Instructions
Prevacuum	Nonporous	3 minutes at 132EC (270EF)
Prevacuum	Porous/Nonporous	4 minutes at 132EC (270EF)

~~T~~S. Items that previously have been packaged, sterilized, and issued, but not used may be returned to the sterile storage area if the integrity of the packaging has not been compromised and there is no evidence of contamination; such items may be dispensed when needed.

Items that previously have been packaged, sterilized and issued to the patient care units or other areas where the environment is not controlled shall be discarded if they are

single use items, or unwrapped and reprocessed through decontamination if they are reusable.

~~U~~T. Sterile materials shall be stored eight to ten inches from the floor and at least 18 inches from the ceiling and at least two inches from outside walls. Items shall be positioned so that packages are not crushed, bent, compressed, or punctured and sterility is not compromised.

~~V~~U. All sterilization techniques other than steam (plasma, ethylene oxide, chemical, etc.) shall follow the manufacturer's directions and meet all state and federal regulations.

SECTION 35: SPECIALIZED SERVICES: RESPIRATORY CARE.

A. Respiratory Care Services shall be under the direction of a physician member of the Medical Staff.

B. Respiratory Care Services, including equipment, shall be supervised by a qualified and trained respiratory therapist.

C. There shall be sufficient personnel qualified and trained in respiratory care to provide respiratory care services.

1. Services may be performed by an assistant only when a qualified and trained respiratory therapist is readily available for consultation; and

2. Personnel qualified and trained in respiratory care shall be on the premises whenever continuous ventilatory support is provided to patients.

D. All respiratory care personnel shall maintain competency in:

1. Life support measures;

2. Isolation techniques; and

3. Safety techniques for oxygen and oxygen equipment.

E. The policy and procedure manual shall have evidence of ongoing review and/or revision. The first page of the manual shall have the annual review date and signature of the department supervisor and/or person(s) conducting the review.

F. Policies and procedures shall include:

1. Job descriptions;

2. Documentation, verified by the physician director, of who may perform special procedures and give patient instructions;

3. Safety practices;

4. Handling, storage and dispensing of therapeutic gases;

5. Infection prevention and control measures;

6. Assembly and operation of equipment;

7. ~~Posting of "no smoking," "oxygen in use," or "oxygen precautions" signs;~~

~~8~~. Respiratory care services provided and a list of services shall be available to the Medical Staff;

8~~9~~. Steps to take in the event of an adverse reaction;

9~~10~~. Cleaning, disinfecting and sterilizing procedures; and

10~~1~~. Orientation policies for new employees.

G. Clinically relevant educational programs shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented~~ program dates, attendance, and subject matter.

H. If arterial blood gases are performed the Respiratory Care department shall subscribe to a nationally recognized proficiency testing program for blood gases and meet the quality control requirements for clinical laboratories.

I. The Respiratory Care Service shall have sufficient equipment and adequate facilities appropriate for safety and effective provision of care.

1. Equipment shall be serviced calibrated, and operated according to manufacturers' directions.

2. An approved safety system shall be used with therapeutic gases.

3. Resuscitation, ventilatory and oxygenation support equipment shall be available for patients of all sizes.

4. Ventilators for continuous assistance or controlled breathing shall be equipped with alarm systems.

5. A preventive maintenance program shall be implemented and records maintained for the life of the equipment.

J. All Respiratory Care prescription/work requests shall specify the type, frequency and duration of each treatment, and, as required, the type and dose of medication and the type of diluent and oxygen or medical air.

K. Respiratory Care reports of blood gas results shall be prepared in duplicate and signed by the therapist responsible for the procedure/test. The original shall be placed in the patient's medical record and the copy retained in the department file.

L. Accurate records shall be maintained regarding the type and duration of each treatment given. These records shall be correlated with the patient's medical record.

M. Respiratory Care documentation for each patient shall include:

1. Current written plan of care to include goals and objectives;

2. Instructions to patient or patient's family; and

3. Type and duration of the treatment given.

N. When oxygen is being administered to a patient:

~~1. "No Smoking," "oxygen in use," or "oxygen precautions," signs shall be posted;~~

1~~2~~. Patients, visitors and personnel shall be apprised of the fire hazard; and

2~~3~~. If the patient is in a tent, alcohol or rub-on lotion shall not be used.

O. Oxygen shall be humidified in accordance with physician's orders.

P. If reusable reservoirs are used to humidify the oxygen, the reservoirs shall be cleaned and disinfected to a high-level of disinfection. (A high-level disinfection can be expected to kill all microorganisms with the exception of high numbers of bacterial endospores. Only sterile solutions and diluents shall be used in humidification and nebulizing equipment. Nebulizers (in-line and hand-held), between treatments on the same patient, shall be disinfected to a high level and rinsed in sterile water or, if a small volume medication nebulizer, air dried. All other semicritical equipment shall be cleaned and disinfected in accordance with the Center for Disease Control and Prevention's Guidelines.

Q. After use, all equipment shall be returned to a central location for thorough cleaning, servicing and disinfecting before use on another patient.

R. There shall be an ongoing QA/PI program.

S. Contracted Respiratory Care Services shall be under current agreement and the contractor shall fulfill all requirements of this section.

NOTE: The National Fire Protection Association Vol. 99, Health Care Facilities, is a mandatory reference for developing safety regulations for Respiratory Care Services.

SECTION 36: SPECIALIZED SERVICE: EMERGENCY SERVICES.

NOTE: Federal EMTALA requirements apply

A. Every licensed hospital shall have a dedicated emergency department. The following hospitals are excepted:

1. Psychiatric hospitals;

2. Rehabilitation hospitals; ~~and~~

3. Long term acute care hospitals~~.~~; and

4. Prison hospitals.

B. The hospital's emergency department shall have organized services, ~~and~~ procedures, and nationally recognized protocols for ~~any~~ emergenc~~y~~ies.

C. Diagnostic and treatment equipment, medications, supplies and space shall be adequate in terms of the size and scope of services provided. Recussitation and life support equipment shall include but not be limited to:~~-~~.

1. Airway control and ventilation equipment including laryngoscope and endotracheal tubes, valve-mask resuscitator, sources of oxygen, pulse oximeter, CO_2 monitoring;

2. Suction devices;

3. Standard IV fluids and administration devices, including IV catheters;

4. Intravenous fluid and blood warmers;

5. Sterile surgical sets for standard ED procedures;

6. Gastric lavage equipment; and

7. Blood pressure monitoring equipment.~~:~~

D. Each emergency department shall have diagnostic imaging and diagnostic laboratory capabilities available twenty-four (24) hours per day, seven (7) days per week. Such laboratory services shall include:

1. Standard analyses of blood, urine, and other body fluids;

2. Blood typing and cross-matching;

3. Coagulation studies;

4. Comprehensive blood bank or access to a community central blood band and adequate hospital storage facilities; and

5. Blood gases and pH determination.

~~D~~E. An inventory list of all supplies and equipment including all items on the crash cart, shall be checked each shift and after each use.

~~E~~F. The location and telephone number of the nearest poison control center and a list of poison antidotes shall be posted in the emergency department.

G. Screening examination~~taffing.~~

Each patient presenting to the emergency department ("ED") shall have a medical screening examination by a qualified medical personnel. The examination shall be completely documented.

H. Treatment and Disposition

1. If a patient is screened as having an emergency medical condition, ~~the qualified medical personnel shall contact the~~ a physician ~~requested by the patient or the physician on call~~ shall be contacted to discuss the assessment findings and patient's condition. A physician shall determine disposition of the patient.

2. If a patient is screened as having a non-emergency medical condition, a hospital may allow treatment and disposition of the patient by a physician or non-physician licensed medical professional. This individual must be appropriately credentialed by the medical staff with approval by the governing body to provide non-emergent medical care in the Emergency Department.

I. Physician availability

1. Arrangements shall be provided, such as a duty or on-call roster, to ensure a physician is available for all emergency patients as determined by the screening examination.

2. Arrangements shall be made for obtaining specialized medical services.

J~~3~~. Staffing.

1. The Emergency Service shall be under the supervision of a Registered Nurse.

2. All patient care personnel assigned to the emergency department shall receive orientation and be competent in life support measures.

3. An Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) (as appropriate) trained person shall be in-house and immediately available.

~~1.~~

4. The Registered Nurse shall assume the responsibility for the nursing functions of the Emergency Services. This includes:

a. Supervision;

b. Evaluation of the patient's emergency nursing care needs;

c. The assignment of nursing care for each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of the nursing staff;

d. Supplies and equipment;

e. The emergency department record (See Section 7, General Administration and Sections 15, Medical Record Requirements for Outpatient Services, Emergency Room and Observation Services.); and

f. Maintenance of an emergency department log.

5. Emergency Medical Technician (EMT). Pursuant to the Arkansas Emergency Medical Service Act Ark. Code Ann. §§20-13-201 et.seq., if a hospital allows an Arkansas Certified Emergency Medical Technician to perform specified procedures within the Emergency Room or be a member of a hospital code team the following action shall be taken:

a. The Medical Staff shall approve the privileges granted to the individual EMT with concurrence of the hospital's Governing Body. Specific policies governing the supervision and the procedures to be performed by an EMT shall be developed by the Medical Staff and approved by the hospital's Governing Body. In no event shall an EMT perform a procedure that he/she is not certified to do by the Office of Emergency Services of the Arkansas Department of Health;

b. Approved EMT's shall function in accordance with physician's orders and under the direct supervision of either the physician or Registered Nurse responsible for Emergency Services;

c. Students in EMT training programs approved by the Office of Emergency Medical Services of the Arkansas Department of Health shall be trained by qualified instructors within the hospital under guidelines established by the Medical Staff and approved by the Governing Body; and

d. A roster with the delineation of privileges shall be maintained and readily available.

~~G~~K. Medications. (See Section 16, Pharmacy and Section 12, Medications.)

~~H~~L. Off-Campus Emergency Departments (off-campus EDs). Off-campus EDs may be owned and operated by an Arkansas licensed hospital. Off-campus EDs shall meet all requirements for hospital EDs. Off-campus EDs shall:

1. Function as a department of the parent hospital.

2. Be fully integrated into the parent hospital's systems and operations.

   a. Medical staff must be part of the parent hospital's single organized medical staff.

   b. Nursing personnel must be part of the hospital's single organized nursing service.

   c. Emergency laboratory and imaging services must be available 24 hours/day, 7 days/week.

   d. Quality assessment/performance improvement (QAPI) program must be integrated into the parent hospital's QAPI program.

   e. Records must be maintained as part of the hospital's single medical record system.

   f. Infection control practices must meet the requirements of the parent hospitals infection control policies and practices.

   g. Emergency services must meet accepted standards of practice for hospital emergency department.

   h. Patients who require further care must have access to all services of the main hospital.

3. Be open 24 hours per day, 7 days per week.

M. Emergency Services Facility. The Arkansas Department of Health may license under Ark. Code Ann. § 20-9-218, hospitals which have discontinued inpatient services to continue to provide emergency services if there is no other hospital Emergency Service in the community.

1. The Emergency Services Facility shall be subject to inspection and to all other provisions of Ark. Code Ann. §§ 20-9-201 et. seq. and 20-13-201 et. seq., as amended.

2. The Emergency Services Facility shall have agreements with licensed hospitals to accept patients who are in need of inpatient hospital services.

3. An emergency facility shall not have licensed inpatient beds, however, at least one holding/observation bed shall be provided for patient use not to exceed 24 hours.

4. Emergency Service Facilities shall provide, or contract to provide emergency ambulance services licensed by the Arkansas Department of Health, that include radio communication and patient telemetry. It is further required that contractual agreements be made for patient air transport services.

5. Policies and procedures shall be developed and approved by Health Facility Services of the Arkansas Department of Health, prior to issuance of a license, and the facility may not provide services without a license.

6. Clinically relevant educational program shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be evidence of ~~documentation which includes~~ program ~~content, presenter,~~ dates, ~~presented and signatures of~~ attendance~~ees.~~, and subject matter.

7. There shall be an ongoing QA/PI program that is specific to the patient care administered.

SECTION 37: SPECIALIZED SERVICE: PSYCHIATRIC SERVICES.

A. Psychiatric care units in general hospitals shall meet the construction requirements of Section 48, Psychiatric Nursing Unit, and shall in all respects comply with the requirements of Section 42, Physical Facilities, Patient Accommodations (Adult Medical, Surgical, Communicable or Pulmonary Disease) except furniture, equipment and supplies may be modified by the attending physician on an individual patient basis as verified by signed orders.

B. General Requirements.

1. Each psychiatric care unit shall have a written plan describing the organization of services or the arrangement for the provision of such services to meet patient needs.

2. The services shall include, but not be limited to, diagnostic evaluation, individual or group therapy, consultation and rehabilitation.

3. The unit shall be under the direction and management of a psychiatrist who is qualified by training and experience for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry and licensed in the State of Arkansas.

4. The Program Director of the unit shall be an individual with at least two years administrative experience.

5. The unit shall furnish, through the use of qualified personnel, psychological services, social work services, occupational therapy, recreational therapy and psychiatric nursing.

6. The unit shall have a qualified Director of Nursing with a Master's Degree or be qualified by education and experience in the care of the mentally ill. If the director does not meet the qualifications, there shall be regular documented consultation by a qualified Registered Nurse.

7. Staffing for the unit shall ensure the presence in the unit of a Registered Nurse at all times. There shall be adequate numbers of Registered Nurses, Licensed Practical Nurses, and mental health workers to provide the care necessary under each patient's active treatment program.

8. The unit shall provide or have available, psychological services to meet the needs of the patients.

9. There shall be a social service staff to provide services in accordance with accepted standards of practice and established policies and procedures.

10. The unit shall provide a therapeutic activities program. The program shall be appropriate to the needs and interests of the patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

11. There shall be a procedure for referrals for needed services.

12. There shall be adequate space, equipment and supplies for services to be provided effectively and efficiently in functional surroundings that are readily accessible to the patients. All space, equipment and facilities, both within the psychiatric facility and those utilized outside the facility, shall be well maintained and shall meet applicable federal, state and local requirements for safety, fire, health and sanitation.

13. Policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department director and/or person(s) conducting the review.

14. Clinically relevant educational program shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of the presented~~ program dates, attendance, and subject matter.

15. Staff meetings shall be held at least monthly. Dated minutes of each meeting shall be kept in writing.

16. There shall be an ongoing program for orientation of staff.

17. All psychiatric services personnel shall maintain competency in life support measures.

18. There shall be an ongoing QA/PI program.

C. Medical records shall include at least:

1. Identification data including patient's legal status;

2. Admitting psychiatric diagnosis as well as diagnoses of medical problems;

3. Reason for the patient's admission;

4. Social service records including reports of interviews with patients, family members and others and a social history and assessment;

5. Psychiatric evaluation (See Section 15, Medical Record Requirements for Outpatient Services, Emergency Room, Observation Services and Psychiatric Records); and

6. Treatment plan (See Section 15, Medical Record Requirements for Outpatient Services, Emergency Room, Observation Services and Psychiatric Records).

D. Medications. (See Section 16, Pharmacy.)

E. Food and Nutritional Services. (See Section 17, Food and Nutrition Services.)

F. Organization of psychiatric nursing units and services in general hospitals:

1. Medical direction shall be provided by a qualified psychiatrist and under the supervision of a Registered Nurse, qualified by training and experience in psychiatric nursing.

2. In addition to the requirements set forth for Nursing Services in Section 11, Patient Care Service, policies and procedures shall be developed specific to the care of the psychiatric patient.

G. Supplies and equipment shall be commensurate with the type of services offered.

H. Medical Records (See Section 15, Medical Record Requirements for Outpatient Services, Emergency Room, Observation Services and Psychiatric Records).

SECTION 39: OUTPATIENT PSYCHIATRIC CENTERS.

Any facility in which psychiatric services are offered for a period of ~~4~~8 to 16 hours a day, and where, in the opinion of the attending psychiatrist, hospitalization, as defined in the present licensure law, is not necessary, is considered an Outpatient Psychiatric Facility. This definition does not include Community Mental Health Clinics and Centers as they now exist. Such facilities shall conform with applicable sections if those services are provided within the facility. Such facilities shall conform with applicable sections of Section 75, Physical Facilities, Outpatient Care Facilities.

A. General Requirements.

1. Each psychiatric facility shall have a written plan describing the organization of outpatient services or the arrangement for the provision of such services to meet patient needs.

2. The outpatient services shall include, but not be limited to, diagnostic evaluation, individual or group therapy, consultation and rehabilitation.

3. The center shall be under the direction and management of a psychiatrist who is qualified by training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry and licensed in the State of Arkansas.

4. The Program Director of the Outpatient Center shall be an individual with at least two years of administrative experience.

5. The center shall furnish, through the use of qualified personnel, psychological services, social work services, occupational therapy, recreational therapy and psychiatric nursing.

6. The center shall have a qualified Director of Nursing with a Master's Degree or be qualified by education and experience in the care of the mentally ill. If the director does not meet the qualifications, there shall be regular documented consultation by a qualified Registered Nurse.

7. Staffing for the center shall insure the presence in the center of a Registered Nurse during the hours the unit is open. There shall be adequate numbers of Registered Nurses, Licensed Practical Nurses and mental health workers to provide the care necessary under each patient's active treatment program.

8. The center shall provide or have available, psychological services to meet the needs of the patients.

9. There shall be a social service staff to provide services in accordance with accepted standards of practice and established policies and procedures.

10. The center shall provide a therapeutic activities program. The program shall be appropriate to the needs and interests of the patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

11. There shall be a procedure for referrals for needed services that are not provided directly by the facility.

12. There shall be adequate space, equipment and supplies for outpatient services to be provided effectively and efficiently in functional surroundings that are readily accessible and acceptable to the patients and community services. All space, equipment and facilities, both within the psychiatric facility and those utilized outside the facility, shall be well maintained and shall meet applicable federal, state and local requirements for safety, fire, health and sanitation.

13. Policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

14. Clinically relevant educational program shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be evidence of program ~~written documentation with employee signature, program title/subject, presenter,~~ dates, attendance, and subject matter. ~~and outline or narrative of the presented program.~~

15. Regular staff meetings shall be held at least monthly. Dated minutes of each meeting shall be kept in writing.

16. There shall be an ongoing program for orientation of staff.

17. There shall be an ongoing QA/PI program.

B. Medical records shall include at least:

1. Identification data including patient's legal status;

2. Admitting psychiatric diagnosis as well as diagnoses of medical problems;

3. The reasons for the patient's admission to this level of care;

4. Social service records including reports of interviews with patients, family members and others and a social history and assessment;

5. Psychiatric evaluation (See Section 37, Specialized Services: Psychiatric Services.);

6. Treatment plan (See Section 37, Specialized Services: Psychiatric Services.); and

C. Medications. Outpatient Services utilizing medications in therapeutic programs shall fulfill the requirements in Section 16, Pharmacy.

D. Food and Nutritional Services. (See Section 17, Food and Nutrition Services.)

E. Physical Facilities. The Outpatient Psychiatric Centers shall comply with Section 75, Physical Facilities, Outpatient Care Facilities.

SECTION 40: REHABILITATION HOSPITALS AND UNITS.

A. General Requirements.

1. Rehabilitation Hospital means a hospital or a distinct part of a hospital as designated in Section 3, Definitions, of these regulations which is used for the primary purpose of providing rehabilitative services as so defined and shall comply with Sections 1, Authority, through Section 38, Specialized Services: Care of Patients with Pulmonary Disease in General Hospitals. Each hospital or unit shall have the capability of providing or arranging for emergency services 24 hours per day, seven days per week.

2. Any comprehensive physical rehabilitative program shall provide through the use of qualified professional personnel, at a minimum, the following clinical services:

   a. Physical therapy;

   b. Occupational therapy;

   c. Speech therapy; and

   d. Social services or psychological services.

   NOTE: May be provided under contract or arrangement on an as needed basis.

3. A physician qualified by training, experience and knowledge of rehabilitative medicine shall be appointed as the Medical Director.

4. Nursing Services shall be under the direct supervision of a Registered Nurse who has a Master's Degree or be qualified by education and experience in Rehabilitative Nursing. If the Registered Nurse does not have the required credentials, a Master's prepared Registered Nurse shall be available as a consultant. The number of Registered Nurses, Licensed Practical Nurses and other nursing personnel shall be adequate to formulate and carry out the nursing components of the individual treatment plan for each patient. There shall be a Registered Nurse on duty 24 hours per day, seven days per week, to plan, assign, supervise and evaluate nursing care and to provide for the delivery of nursing care to patients.

5. A physician licensed in the State of Arkansas shall be responsible for each patient's general medical condition as needed. Medical services shall be available 24 hours per day, seven days per week as needed. Upon admission there shall be written orders for the immediate care of the

patient.

6. Policies and procedures shall be developed. The manual shall have evidence of ongoing review and/or revision. The first page of the manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

7. Clinically relevant educational programs shall be conducted on a regularly scheduled basis not less than 12 per year. There shall be evidence of written documentation with employee signature, program title/subject, presenter, date and outline or narrative of the presented program dates, attendance, and subject matter.

8. Regular staff meetings shall be held at least monthly. Dated minutes of each meeting shall be kept in writing.

9. There shall be an ongoing QA/PI program.

B. Special Medical Record Requirements. (Refer also to Section 14, Health Information Services.) The medical record shall include:

1. Reason for referral to physical rehabilitation services or admission to the comprehensive physical rehabilitation program;

2. History and physical examination including patient's clinical condition, functional strengths and limitations, indications and contra-indications for specific physical rehabilitative services and prognosis;

3. Goals of treatment and the treatment plan, including any problem that may affect the outcome of physical rehabilitation services, and criteria for the discontinuation of services;

4. Interdisciplinary treatment plans to include measurable goals of treatment and criteria for discharge. The plan shall include ongoing assessments as required by the patient's medical condition. Documentation of patient and family in the development of the treatment plan and resolution of problems and rehabilitation potential;

5. A discharge summary that includes recommendations for further care;

6. Patient evaluation procedures, including treatment plan for each patient based on the functional assessment and evaluation. The initial treatment plan shall be developed within 24 hours, and a comprehensive individualized plan developed no later than one week after admission and updated at least monthly. The plan shall state the rehabilitative problem, goals and required therapeutic services, as well as prognosis, anticipated

length of stay and discharge disposition;

C. Physical Environment. The Rehabilitation Facility shall comply with Section 42, Physical Environment.

D. Physical Facilities. The Rehabilitation Facility shall comply with Section 76, Physical Facilities, and Rehabilitation Facilities.

SECTION 41: RECUPERATION CENTERS.

Any facility which includes inpatient beds with an organized Medical Staff, and with medical services including physician services and continuous nursing services to provide treatment for patients who are not in an acute phase of illness but who currently require primarily convalescent or restorative services, shall be considered a recuperation center and shall comply with applicable Sections 1, Authority, through 72, Physical Facilities, Electrical Standards.

A. Quality Assurance/Performance Improvement, Infection Prevention and Control, Pharmacy and Therapeutics, and Utilization Review.

1. The Recuperation Center shall maintain a Quality Assurance/Performance Improvement Committee consisting of the Nurse Manager, Medical Director, and at least three other members of the center's staff, which shall meet at least quarterly to provide oversight and direction for the center's quality assurance/performance improvement activities. Minutes of the Quality Assurance/Performance Improvement Committee shall be maintained.

2. QA/PI activities shall include ongoing monitoring, with identification of opportunities for improvement, actions taken, and evaluation of the results of actions. QA/PI activities shall be reported at least quarterly to the Medical Staff and Governing Body through the hospital-wide QA/PI program.

3. Reporting of all infection prevention and control, medication and utilization review issues specific to the center shall be evident in the minutes of the hospital-wide Infection Control, Pharmacy and Therapeutics and Utilization Review Committees. Frequency of reporting shall be defined in policies and procedures consistent with State laws.

B. Patient identification. Patient armbands shall not be routinely used. Reasonable measures shall be used to identify patients.

C. Restraints. See Section 13, Restraints.

D. Documentation Requirements.

1. An assessment of the patient's needs shall be completed by a Registered Nurse on admission.

2. Each assessment shall be coordinated with all health professionals.

3. The interdisciplinary team shall develop a comprehensive care plan based on the patient's identified needs, measurable goals of treatment, methods

of intervention, and documentation of resolution or continuance. There shall be documentation of the patient and family's participation in the development of the care plan.

4. Verbal/telephone orders shall be reduced to writing and countersigned by the physician.

E. Physical Environment. The requirements in Section 44, Physical Facilities, Patient Accommodations (Adult Medical, Surgical, Communicable or Pulmonary Disease) shall apply to recuperation centers with the following exceptions:

1. The patient dining, recreation, and day room(s) may be in separate or adjoining rooms and shall have a total of 35 square feet per patient bed.

2. Patient corridors shall have handrails on both sides of the corridors. A clear distance of one and one-half inches shall be provided between the handrail and the wall. The top of the gripping surface of handrails shall be 32 inches minimum and 36 inches maximum above the finish floor. Ends of handrails and grab bars shall be constructed to prevent snagging the clothes of patients. Exception, special care areas such as those serving children.

F. Health Information Services. Applicable parts of item D. of Section 14, Health Information Services and Section 15, Medical Record Requirements for Outpatient Services, Emergency Room, Observation Services and Psychiatric Records.

G. Nursing Services. A Registered Nurse shall observe each patient at least once per shift and the observations shall be documented in the patient's medical record.

SECTION 42: PHYSICAL ENVIRONMENT.

A. Building and Grounds.

1. The building and equipment shall be maintained in a state of good repair at all times.

2. Facilities and their premises shall be kept clean, neat and free of litter, rubbish.

3. Rooms for gas fired equipment shall not be used for storage except for noncombustible materials.

4. Portable equipment shall be supervised by the department having control of such equipment and shall be stored in areas which are not accessible to patients, visitors, or untrained personnel.

5. Exit Access Corridors shall be maintained clear and unobstructed of stationary and non-patient related portable equipment. Stationary or portable non-patient care furnishings or equipment shall not be stored in an Exit Access Corridor. Any portable equipment such as a gurney, wheelchair, linen care, etc. that is not actively used within a 30 minute time period is considered "Stored". The facility's fire plan and training program shall address the relocation of these items during a fire. Exit Access Corridors for Health Care Occupancies are those aisles, corridors and ramps required for exit access that are located outside of a "suite of sleeping rooms" greater than 5,000 sq. ft. or "suite of rooms" greater than 10,000 sp. Ft (area is defined as occupiable net floor space). Encroachments on the width of the means of egress in an Exit Access Corridor by stationary objects or furnishings shall not be allowed. The width of the means of egress in an Exit Access Corridor shall be defined by physical means such as corridor walls, columns, or other approved methods. The means of egress may provide both visual and physical barrier design characteristics conducive to establishing a common egress that provides for either a change in floor texture or self-illumination in the dark.

   Alternative consideration: the Means of Egress Requirements for Health Care Occupancies of NFPA 101 (or equivalency per Section 43 of these regulations).

6. Each hospital shall develop a written preventive maintenance plan. This plan shall be available to the Department for review at any time. Such plans shall provide for maintenance as recommended by manufacturer, applicable codes, or designer.

7. The hand washing facilities in visitors' rest rooms and the handwashing facilities used by staff personnel shall be equipped with a soap dispenser, and a towel dispenser.

8. A supply of hot water for patient use shall be available at all times. A weekly hot water temperature log shall be maintained.

9. Heating, ventilating and air-conditioning (HVAC) systems shall be operated, and maintained in a manner to provide a comfortable and safe environment for patients, personnel, and visitors. An air filter change out log shall be maintained.

B. Maintenance and Engineering.

1. The physical plant and equipment maintenance programs shall be under the direction of a person qualified by training and/or experience and licensed where required.

2. Equipment Management Program (EMP). There shall be a preventive maintenance program designed to assure the electrically powered patient care equipment used to monitor, diagnose, or provide therapy, performs properly and safely. This program shall be administered by individuals qualified through training and/or experience or by procuring a contractual maintenance agreement. The following are minimum program elements:

a. A current list of electrically powered patient care equipment shall be maintained regardless of location or ownership;

b. Each device, or identical group of devices, shall have a procedure establishing minimum criteria against which performance and safety are measured. The elements of these procedures shall be based on the manufacturer's directions;

c. Each device shall be tested at intervals of not more than six months unless there is documented evidence that less frequent testing is justified;

d. Historical records documenting acceptable performance as established by the procedures shall be maintained;

e. A program to identify and repair equipment failures shall be maintained;

f. User or owner departments shall be notified of the status of their equipment when it will be out of service more than 24 hours;

g. There are operator and maintenance instructions for each device, or group of similar devices on the electrically powered patient care equipment list; and

h. Individuals shall be trained to operate and maintain equipment used in the performance of their duties. This training shall be documented.

3. Utilities Management Program (UMP). There shall be a preventive maintenance program designed to assure that the physical plant equipment and building systems perform properly and safely. This program shall be administered by individuals qualified through training and/or experience or by procuring a contractual agreement. This program shall consist of at least the following minimum elements:

a. A list of physical plant equipment and/or building system(s) shall be maintained regardless of location or ownership;

b. Equipment and/or building system(s), shall have a procedure establishing minimum criteria against which performance and safety are measured. The elements of these procedures shall be based on the manufacturer's directions and/or the experience of the repair technician or operator;

c. Equipment and/or building system(s), shall be tested, serviced, or inspected at intervals of not more than 12months unless there is documented evidence that less frequent service is justified;

d. Historical records documenting acceptable performance as established by the procedures shall be maintained;

e. A program to identify and repair equipment failures shall be maintained;

f. User or owner departments shall be notified of the status of their equipment or system when it will be out of service for more than 24hours;

g. There shall be operator and/or maintenance instructions for each piece of equipment or building system on the list; and

h. Individuals shall be trained to operate and maintain physical plant equipment and/or building systems. This training shall be documented.

4. Life Safety Management Program (LSM). There shall be a preventive

maintenance program designed to assure that all circuits of fire alarm and detection systems shall be inspected, tested and maintained in accordance with NFPA 72. Analog detection devices that provide automatic self testing are exempt from the quarterly testing requirement. This program shall be administered by individuals qualified through training and/or experience or by procuring a contractual maintenance agreement. This program shall consist of the following minimum elements:

a. A list of all fire protection equipment or component groups shall be maintained;

b. Equipment and/or component groups, shall have a procedure establishing minimum criteria against which performance and safety are measured. The elements of these procedures shall be based on the manufacturer's recommendations and/or the experience of the repair technician or operator;

c. Fans or dampers in air handling and smoke management systems shall be reliable and functional at all times;

d. Automatic fire extinguishing systems shall be inspected and tested annually; actual discharge of the fire extinguishing system is not required. Records documenting acceptable performance as established by the procedures shall be maintained;

e. A program to identify and repair equipment and/or component group failures shall be maintained;

f. Systems for transmitting fire alarms to the local fire department shall be reliable and functional at all times;

g. There shall be operator and maintenance instructions for each piece of equipment and/or component group on the list;

h. Individuals shall be trained to operate and maintain all equipment and/or component group on the list; and

i. Portable fire extinguishers shall be clearly identified.

5. Emergency Procedures Program (EPP). There shall be written emergency procedures or a disaster management plan for utility system disruptions or failures which address the specific and concise procedures to follow in the event of a utility system malfunction or failure of the water supply, hot water system, medical gas system, sewer system, bulk waste disposal system, natural gas system, commercial power system, communication system, boiler or steam delivery system.

a. These procedures shall be kept separate from all other policy and procedure manuals as to facilitate their rapid implementation.

b. These procedures shall contain but are not limited to the following information:

~~a~~1.~~.~~ A method of obtaining alternative sources of essential utilities;

~~b~~2. A method of shutoff and location of valves for malfunctioning systems;

~~c~~3. A method of notification of hospital staff in affected areas; and

~~d~~4. A method of obtaining repair services.

6. Policies and procedures shall include job descriptions and orientation practices for employees.

7. Policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

8. Relevant educational programs shall be conducted at regularly scheduled intervals with no less than six per year. There shall be evidence of ~~written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented~~ program dates, attendance and subject matter.

9. The department director shall ensure that all employees annually attend mandatory educational programs on the fire safety, back safety, infection prevention and control, universal precautions, emergency procedures and disaster preparedness or make provisions to conduct these departmentally.

10. There shall be sufficient supervisory and support personnel to provide maintenance services in relation to the size and complexity of the facility and the services that are provided.

11. An ongoing QA/PI program with a liaison with the Infection Prevention and Control and Safety Committees.

C. Environmental Services.

1. The environmental services shall be under the direction of a person qualified by training and/or experience and licensed where required.

2. There shall be written policies and procedures which include:

   a. Cleaning of the physical plant;

   b. The use, care, and cleaning of equipment; and

   c. Specific cleaning methods used for:

      1) Operating rooms;

      2) Delivery rooms;

      3) Nurseries/infant care units;

      4) Emergency rooms;

      5) Isolation areas; and

      6) Other units as appropriate.

   d. Job descriptions;

   e. Orientation practices;

   f. Safety practices;

   g. Infection prevention and control measures;

   h. Methods used for evaluation of cleaning effectiveness;

   i. Personal hygiene;

   j. The selection of housekeeping and cleaning supplies; and

   k. The proper use of housekeeping and cleaning supplies.

3. The policy and procedure manual shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department and/or person(s) conducting the review.

4. Relevant in-service educational programs shall be conducted at regularly scheduled intervals with no less than six per year. There shall be written documentation with employee signatures, program title/subject, presenter, date, and outline or narrative of presented program.

5. Expendable supplies (i.e., soap, paper products, etc.) shall be stored in a manner that shall prevent their contamination prior to use.

6. Solutions, cleaning compounds, disinfectants, vermin control chemicals, and all other potentially hazardous substances that are used in connection with environmental services shall be:

   a. Kept in containers which accurately reflect at least the following:

      1) Content name;

      2) Concentration of solution;

      3) Expiration date and lot number;

   b. Stored in a secured area. Under no circumstances shall these substances be stored in or near food storage or food preparation areas;

   c. Selected by the director of environmental services or other appointed qualified person. The Infection Prevention and Control Committee shall initially approve the list of chemicals used in the facility and thereafter, any additions or deletions to the list.

7. A designee from this department shall be a member of the Infection Control Committee.

8. The use of common towels and common drinking utensils shall be prohibited.

9. Dry, or untreated dusting, sweeping, or mopping, except vacuum type cleaning shall be prohibited within the facility.

10. There shall be an ongoing QA/PI Program with a mechanism for reporting results.

D. Linen Services.

1. Laundry services shall be under the direction of a person qualified by training and/or experience and licensed where required.

2. There shall be sufficient support personnel to provide linen services in relation to the size and complexity of the facility and the services that are provided.

3. There shall be written policies and procedures which include:

   a. Collection of soiled, wet, and contaminated linen;

   b. Transporting of soiled, wet, and contaminated linen to the laundry service or to a designated area for commercial pick-up;

   c. Storage of soiled, wet, and contaminated linen until laundering or being picked up by the commercial laundry;

   d. Storage of clean linen; and

   e. Specific laundry requirements (type detergent, sours, bleach, time and temperatures used) for washing:

      l) New linen;

      2) Diapers;

      3) Soiled, wet, and contaminated linen.

   f. Personal hygiene;

   g. Evaluation of washing/cleaning effectiveness;

   h. Job descriptions;

   i. Orientation practices for new employees;

   j. Safety practices; and

   k. Infection prevention and control measures.

4. Policies and procedures for Linen Services shall have evidence of ongoing review and/or revision. The first page of the manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.

5. Relevant in-service educational programs shall be conducted at regularly scheduled intervals with no less than six per year. There shall be written documentation with employee signature, program title/subject, presenter, date and outline or narrative of presented program.

6. Facility linen service:

   a. Sorting of soiled laundry shall be done in a designated area;

b. Tables or bins shall be provided for sorting of soiled laundry;

c. Lint traps shall be provided on dryers and shall be cleaned regularly;

d. Prerinsing shall be done in the laundry service not in showers, bathtubs or lavatories;

e. Removal of solid soil shall be done in soiled utility rooms or rooms that are designated for this purpose;

f. Patient clothing may be washed in the patient area if a separate equipped laundry room is available;

g. A rinsing sink shall be provided in the soiled linen area of the laundry;

h. Hot water supplied to laundry areas shall be in accordance with Table 9 of the Appendix;

i. Linen contained in hot water soluble plastic bags (identified as being contaminated) shall be placed directly into the washing machine without being removed from the bag for sorting;

j. A lavatory equipped with wrist action controls, a soap dispenser and a towel dispenser shall be provided in the laundry for use by the personnel;

k. Personnel with infectious disease or open wounds shall not be permitted in the laundry; and

l. Personnel assigned to laundry duties shall wash their hands:

1) After handling wet or soiled laundry;

2) Before leaving the laundry;

3) After using the toilet; and

4) As often as is necessary to maintain good hygiene.

NOTE: Laundry equipment and installation requirements are set forth in Section 64, Physical Facilities, Linen Service.

7. Soiled linen from isolation areas, surgical cases, etc., shall be placed into

impervious bags and, if leakage occurs, bagged into a second bag with proper identification. Suitable precautions shall be taken in transport, handling, and processing.

8. Soiled, wet, and contaminated linens shall be transported in a closed container.

9. Soiled, wet, and contaminated linens shall be stored in closed containers or impervious bags in designated areas off the floor. Areas for storage of soiled, wet, and contaminated linens shall have forced ventilation to the outside of the building.

10. All new clothing, linen and diapers shall be laundered before being used.

11. There shall be a designated area for the storage of clean linens.

12. The linen service within the facility shall have a capacity sufficient to process a continuous supply of clean laundry ready for use.

13. Temperature used in the dryer will depend on the type fabric. An employee shall be present at all times when the dryer is in operation.

14. There shall be an ongoing QA/PI Program with a mechanism for reporting results.

15. Linen Service shall include a written contingency plan indicating an alternative provision that may be followed in the event the laundry is unable to meet the production demand of the facility.

16. Separate containers for the disposal of infectious waste and sharps shall be located in the soiled linen sorting area.

17. Laundry workers handling infectious linens shall wear protective equipment, including but not limited to waterproof, puncture-resistant gloves, protective over-clothing, and where necessary, face shields or goggles.

18. Facilities which do not have linen services:

    a. The facility shall determine that all launderable items are processed in a commercial laundry in accordance with standards set forth in this section and shall conduct annual onsite inspections of the commercial laundry and shall require written verification of compliance by the laundry.

    b. Soiled, wet, and contaminated laundry shall be stored in a

designated area until pick up by the commercial laundry;

c. A designated clean area shall be provided for receiving clean laundry and shall be separate from the soiled linen area;

d. Clean linen shall be packaged and protected from contamination during transportation and storage.

19. Refer to Section 18, Infection Prevention and Control, for additional requirements.

E. Safety Services.

1. There shall be an effective program to enhance safety within the facility and grounds. The program shall be monitored by a Safety Committee appointed by the Administrator. Committee members may be selected from areas such as Administration, Nursing, Maintenance, Housekeeping, Laboratory, Respiratory Care, Rehabilitation Services, the Medical Staff and others as appropriate.

2. The Safety Committee shall meet a minimum four times per year to fulfill safety objectives. Minutes of each meeting shall be recorded and kept in the facility.

3. The Administrator shall designate a specific individual to carry out policies established by the Committee and to gather data for the Committee to study safety related incidents.

4. Safety policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review. Safety policies and procedures shall include:

a. Facility wide hazard surveillance program;

b. Response to medical-device recalls and hazard notices;

c. Safety education;

d. Reporting of all accidents, injuries, and safety hazards;

e. External and internal disaster plans;

f. Fire safety; and

g. Safety devices and operational practices.

5. The orientation program for the facility shall include the importance of general safety, fire safety and the responsibility of each individual to the program.

6. The Safety Committee shall have the following functions:

   a. Monitoring the results of the safety program and analyzing the effectiveness of the program annually;

   b. Monitor fire drills and disaster drills at required intervals;

   c. Conclusions, recommendations, and actions of the committee shall be reported to the Board at a minimum annually; and

   d. Ensuring each department or service shall have a safety policy and procedure manual within their own area that is a part of the overall facility safety manual and establishes safety policies and procedures specific to each area.

7. Fire extinguishers shall be provided in adequate numbers, of the correct type, and shall be properly located and installed. Personnel shall be trained in the proper use of fire extinguishers and equipment. Personnel shall follow procedures in fire containment and evacuating patients in case of fire or explosion. There shall be an annual check of all fire extinguishers by qualified persons in accordance with the applicable sections of the National Fire Protection Association's Standard 10 (NFPA 10). The date the check was made and the initials of the inspector shall be recorded on the fire extinguisher or on a tag attached to the extinguisher.

8. Any fire or disaster event at the facility shall be reported immediately to the Arkansas Department of Health by telephone 501-661-2201 during regular working hours or to 501-661-2136 after normal working hours, holidays and weekends. If any fire(s) or disaster is not reported to the Department, the facility is subject to a fine, refer to item J. of Section 4, Licensure and Codes.

9. There shall be policies and procedures governing the routine methods of handling and storing flammable and explosive agents, particularly in operating rooms, delivery rooms, laundries and in areas where oxygen therapy is administered.

10. There shall be keys available to assure prompt access to all locked areas. All doors shall be devised so they can be opened from the inside of the locked area. Special door locking devices are acceptable in limited areas. Usage is subject to all codes and regulations.

11. All required exit doors shall remain unlocked per NFPA requirements.

12. A list of Material Safety Data Sheets (MSDS) for solutions, cleaning compounds, disinfectants, vermin control chemicals, and other potentially hazardous substances used in connection with the facility shall be readily available to the Safety Committee, Emergency Room, Environmental Services and as directed by facility policy and procedures.

~~TABLE 10~~
~~Newborn Screening Requirements~~

~~All Newborns shall be tested for:~~			
~~1. Newborn Hearing Screening~~			
~~2. Newborn Genetic Screening:~~			
~~PKU Phenylketonuria~~	~~CH Congenital Hypothyroidism~~	~~Galactosemia~~	~~Sickle Cell Anemia*~~
~~For further Information Arkansas Department of Health, Child & Adolescent Health Team Contacts: Newborn Lab Screening: 501-661-2592 Newborn Hearing Screening: 501-661-2459~~			

~~Note: Lab specimens should be mailed promptly to prevent degradation of the specimen and increase the quality of results.~~

~~Reference: Ark. Code Ann. 20-15-302,304~~
~~Ark. Code Ann. 20-15-1104~~
~~Ark. Code Ann. 20-15-1504~~

~~*Non-Caucasians~~

TABLE 3

Temperature and Relative Humidity Requirements

Area Designation	Dry Bulb Temperatures °F [1]	Relative Humidity (%) Minimum-Maximum [2]
Operating Rooms, Delivery Rooms, Endoscopy, and Bronchoscopy	68-73	~~3~~20-60
Newborn Intensive Care and Newborn Nursery Suite	72-78	30-60
Recovery, Intensive Care, Trauma Rooms, Procedure Rooms, and Radiological X-ray (Surgical/Critical Care and Catheterization)	70-75	30-60
Clean Work Room and ETO Sterilizer Room	75	30-60
Sterile Storage	75	70 (max)

[1] Where temperature ranges are indicated, the systems shall be capable of maintaining the rooms at any point within the range. A single figure indicates a heating or cooling capacity of at least the indicated temperature. ~~This is usually applicable when patients may be undressed and require a warmer environment.~~ Nothing in these guidelines shall be construed as precluding the use of temperatures ~~lower~~ different than those noted when the patient's~~=~~ comfort and medical conditions make ~~lower~~ different temperatures desirable. Unoccupied areas such as storage rooms shall have temperatures appropriate for the function intended.

[2] Humidification systems serving anesthetizing locations shall be designed in accordance with NFPA 99 paragraph 5-4.1.1.

TABLE 4

Ventilation, Medical Gas, and Air Flow Requirements in Health Care Facilities[1]

Area Designation	Air Movement Relationship To Adjacent Area	Minimum Air Changes Outside Air Per Hour[3]	Minimum Total Air Changes Per Hour[4,5]	Air Recirculated By Means of Room Unit[7]	All Air Exhausted Directly Outdoor[6]
SURGERY AND CRITICAL CARE AREAS					
Operating/Surgical Cystoscopic Rooms [8,9]	Out	3	15	No	Optional
Delivery Room [8]	Out	3	15	No	Optional
Recovery Room[8]	-	2	6	No	Optional
Critical Care and Intensive Care	-	2	6	No	Optional
Newborn intensive care	-	2	6	No	Optional
Treatment Room[10]	-	-	6	Optional	Optional
Trauma Room[10]	Out	3	15	No	Optional
Anesthesia gas storage	In	-	8	Optional	Yes
Endoscopy	In	2	6	No	Optional
Bronchoscopy [9]	In	2	12	No	Yes
ER Waiting Room	In	2	12	No	Yes [11,12]
Triage	In	-	12	No	Yes[11]
Radiology waiting rooms	In	2	12	Optional	Yes[11, 12]
Procedure room	Out	3	15	No	Optional
NURSING AREAS					
Patient Room	-	2	6[13]	Optional	Optional
Toilet Room	In	-	10	Optional	Yes
Newborn Nursery Suite	-	2	6	No	Optional
Protective environment room [9,14]	Out	2	12	No	Optional
Airborne Infectious Isolation, Bronchoscopy Room[9, 15]	In	2	12	No	Yes
Isolation alcove or anteroom[14,15]	In/Out	-	10	No	Yes
Labor/Delivery/Recovery (LDR)	-	2	6[13]	Optional	Optional
Labor/Delivery/ Recovery/ Post Partum (LDRP) -	-	[2]	6[13]	Optional	Optional
Patient Corridor	-	-	2	Optional	Optional
ANCILLARY AREAS					
Radiology X-ray (Surgical/Critical Care & Catheterization)[16]	Out	3	15	No	Optional
Radiology X-ray (Diagnostic & Treatment)[16]	-	-	6	Optional	Optional
Radiology Darkroom	In	-	10	No	Yes
Lab General [16]	-	-	6	Optional	Optional
Lab Biochemistry[16]	Out	-	6	No	Optional
Lab Cytology	In	-	6	No	Yes
Lab Glass Washing	In	-	10	Optional	Yes
Lab Histology	In	-	6	No	Yes
Lab Microbiology [16]	In	-	6	No	Yes
Lab Nuclear Med	In	-	6	No	Yes
Lab Pathology	In	-	6	No	Yes
Lab Serology	Out	-	6	No	Optional
Lab Sterilizing	In	-	10	Optional	Yes
Autopsy[9]	In	-	[17]12	No	Yes
Nonrefrigerated body holding room	In	-	10	Optional	Yes
Pharmacy	Out	-	4	Optional	Optional

Area Designation	Air Movement Relationship To Adjacent Area	Minimum Air Changes Outside Air Per Hour[3]	Minimum Total Air Changes Per Hour[4,5]	Air Recirculated By Means of Room Unit[7]	All Air Exhausted Directly Outdoor[6]
DIAGNOSTIC AND TREATMENT AREAS					
Examination Room	-	-	6	Optional	Optional
Medication Room	Out	-	4	Optional	Optional
Treatment Room	-	-	6	Optional	Optional
Physical Therapy and Hydrotherapy	In	-	6	Optional	Optional
Soiled Workroom or Soiled Holding	In	-	10	No	Yes
Clean Workroom or Clean Holding	Out	-	4	Optional	Optional
STERILIZING AND SUPPLY AREAS					
ETO Sterilizer Room	In	-	10	No	Yes
Sterilizer Equipment Room	In	-	10	Optional	Yes
Central Supply Soiled or Decontamination Room	In	-	6	No	Yes
Central Supply Clean Workroom[17]	Out	-	4	No	Optional
Sterile Storage	Out	-	4	Optional	Optional
SERVICE AREAS					
Food Preparation Centers[17]	-	-	10	No	Optional
Warewashing	In	-	10	No	Yes
Dietary Day Storage	In	-	2	Optional	Optional
Laundry, General	-	-	10	Optional	Yes
Soiled Linen Sorting and Storage	In	-	10	No	Yes
Clean Linen Storage	Out	-	2	Optional	Optional
Soiled Linen and Trash Chute Room	In	-	10	No	Yes
Bedpan Room	In	-	10	Optional	Yes
Bathroom	In	-	10	Optional	Optional
Janitor's Closet	In	-	10	No	Yes

Notes for Table 4

1. The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of acute care hospitals that directly affect patient care and are determined based on healthcare facilities being predominantly "No Smoking" facilities per Ark. Code Ann.§20-27-704 et seq.. Where smoking may be allowed, ventilation rates will need adjustment. Areas where specific ventilation rates are not given in the table shall be ventilated in accordance with ASHRAE Standard 62, Ventilation for Acceptable Indoor Air Quality; and ASHRAE Handbook-HVAC Applications. Specialized patient care areas, including organ transplant units, burn units, specialty procedure rooms, etc., shall have additional ventilation provisions for air quality control as may be appropriate. OSHA standards and/or NI0SH criteria require special ventilation requirements for employee health and safety within healthcare facilities.

2. Design of the ventilation system shall provide air movement which is generally from clean to less clean areas. If any form of variable air volume or load shedding system is used for energy conservation, it shall not compromise the corridor-to-room pressure balancing relationships or the minimum air changes required by the table. Where the air movement relationship is "In (negative) or Out (positive)", the air movement relationship shall not be reversible. Rooms with reversible airflow provision for the purpose of switching between "In" and "Out" are not acceptable.

3. To satisfy exhaust needs, replacement air from the outside is necessary. Table 4 does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice. Minimum outside air quantities shall remain constant while the system is in operation.

4. Number of air changes may be reduced when the room is unoccupied if provisions are made to ensure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not

indicated as having continuous directional control may have ventilation systems shut down when space Is unoccupied and ventilation is not otherwise needed, if the maximum infiltration or exfiltration permitted in Note 2 is not exceeded and if adjacent pressure balancing relationships arc not compromised. Air quantity calculations shall account for filter loading such that the indicated air change rates are provided up until the time of filter change-out.

5. Air change requirements indicated are minimum values. Higher values should be used when required to maintain indicated room conditions (temperature and humidity), based on the cooling load of the space (lights, equipment, people, exterior walls and windows, etc.).

6. Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas. Note that individual circumstances may require special consideration for air exhaust to the outside, e.g., in intensive care units in which patients with pulmonary infection are treated, and rooms for burn patients.

7. Recirculating room HVAC units refers to those local units that are used primarily for heating and cooling of air, and not disinfection of air. Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." However, for airborne infection prevention and control, air may be recirculated within Individual isolation rooms if HEPA filters are used. Isolation and intensive care unit rooms may be ventilated by reheat induction units in which only the primary air supplied from a central system passes through the reheat unit. Gravity-type heating or cooling units such as radiators or convectors shall not be used m operating rooms and other special care areas. ~~See Appendix A for a description of recirculation units to be used in isolation rooms~~.

8. National Institute for Occupational Safety and Health (NIOSH) Criteria Documents regarding Occupational Exposure to Waste Anesthetic Gases and Vapors, and Control of Occupational Exposure to Nitrous Oxide indicate a need for both local exhaust (scavenging) systems and general ventilation of the areas in which the respective gases are utilized.

9. Differential pressure shall be a minimum of 0.01" water gauge (2.5 Pa). If alarms are installed, allowances shall be made to prevent nuisance alarms of monitoring devices.

10. The term trauma room as used here is the operating room space in the emergency department or other trauma reception area that is used for emergency surgery. The first aid room and/or "emergency room" used for initial treatment of accident victims may be ventilated as noted for the "treatment room." Treatment rooms used for Bronchoscopy shall be treated as Bronchoscopy rooms. Treatment rooms used for cryosurgcry procedures with nitrous oxide shall contain provisions for exhausting waste gases.

11. In a ventilation system that recirculates air, HEPA filters can be used in lieu of exhausting the air from these spaces to the outside. In this application, the return air shall be passed through the HEPA filters before it is introduced into any other spaces.

12. If it is not practical to exhaust the air from the airborne infection isolation room to the outside, the air may be returned through HEPA filters to the air-handling system exclusively serving the isolation room.

13. Total air changes per room for patient rooms, labor/delivery/recovery rooms, and labor/delivery/recovery/postpartum rooms may be reduced to 4 when supplemental heating and/or cooling systems (radiant heating and cooling, baseboard heating, etc.) are used.

14. The protective environment airflow design specifications protect the patient from common environmental airborne infectious microbes (i.e., Aspergillus spores). These special ventilation areas shall be designed to provide directed airflow from the cleanest patient care area to less clean areas. These rooms shall be protected with HEPA filters at 99.97 percent efficiency for a 0.3 micron sized particle in the supply airstream. These Interrupting filters protect patient rooms from maintenance-derived release of environmental microbes from the ventilation system components. Recirculation 11EPA filters can be used to increase the equivalent room air exchanges. Constant volume airflow is required for consistent ventilation for the protected environment. It the facility determines that airborne infection isolation is necessary for protective environment patients, an anteroom shall be provided. Rooms with reversible airflow provisions for the purpose of switching between protective environment and airborne infection isolation functions are not acceptable.

15. The infectious disease isolation room described in these guidelines is to be used for isolating the airborne spread of infectious diseases, such as measles, varicella, or tuberculosis. The design of airborne infection isolation (All) rooms should include the provision for normal patient care during periods not requiring Isolation precautions. Supplemental recirculating devices may be used in the patient room, to increase the equivalent room air exchanges; however, such recirculating devices do not provide the outside air requirements. Air may be recirculated within individual isolation rooms if HEPA filters are used. Rooms with reversible airflow provisions for the purpose of switching between protective environment and All functions are not acceptable.

16. When required, appropriate hoods and exhaust devices for the removal of noxious gases or chemical vapors shall be provided per NFPA 99.

17. Food preparation centers shall have ventilation systems whose air supply mechanisms arc interfaced appropriately with exhaust hood controls or relief vents so that exfiltration or infiltration to or from exit corridors does not compromise the exit corridor restrictions of NFPA 90A, the pressure requirements of NFPA 96, or the maximum defined in the table. The number of air changes may be reduced or varied to any extent required for odor control when the space is not in use.

TABLE 5
Final Occupancy Inspection Check List

Inspector:_____Date:_____

Facility:_____Job:_____

Item	Yes	No	Comments
1. Architect/Engineer=s Certification of Substantial Completion?			
2. Interior finishes development and fire spread rating information?			
3. Fire Protection Systems - Portable fire extinguishers are inspected and tagged, and shop drawing for standpipe/sprinkler systems are available?			
4. Certificate of City Building Inspector?			
5. Certification - fire alarm system, smoke detection system, sprinkler system, and any other fire suppression system has been installed, tested and meets all applicable standards?			
6. **Certification** - medical gas system?			
7. Certification - electrical system has been installed, tested and meets all applicable standards of the NEC, NFPA?			
8. Certification - emergency generator has been installed, tested and meets all applicable standards of the NFPA, NEC?			
9. Certification - mechanical system has been installed, tested, balanced, and approved by the engineer of record?			
10. Certification - communication system(s) has been installed, tested and meets all applicable standards of the NEC, NFPA?			
11. Are there manufacturer=s operation and maintenance manuals with equipment warranties on site for all newly installed equipment or a letter from the general contractor stating that the above items will be turned over to the owner?			
12. Have all applicable pieces of equipment installed during the construction been incorporated into the existing preventive maintenance system? Or, have new maintenance policies and procedures been written to insure that said items are maintained per the manufacturers recommendations?			
13. Are there as-built drawings on site or a letter from the general contractor stating that the as-built drawings will be turned over to the owner?			
14. Are there copies of the Architect=s and Engineer=s final punch lists with verification that all items have been repaired or remedied?			
15. Has the Architect/designer accepted testing and certification of items 5 through 10 above?			

[1]In accordance with the applicable electrical system requirements of NFPA 99, grounding system effectiveness shall be determined for new and renovated equipment by voltage and impedance measurements. Receptacles shall be checked for continuity of the grounding circuit and polarity of the hot and neutral connections.

CERTIFICATION

This will certify that the foregoing revisions to the Rules and Regulations for Critical Access Hospitals in Arkansas were adopted by the State Board of Health of Arkansas at a regular session of said Board held in Little Rock, Arkansas, on the _____ day of _____.

_____
Nathaniel Smith, M.D., MPH
Secretary of Arkansas State Board of Health
Director, Arkansas Department of Health and
State Health Officer

_____
Date