Rules of
Department of Health and Senior Services
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

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Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

19 CSR 30-20.001 Anesthesiologist Assistants in Hospitals

PURPOSE: This rule allows the use of anesthesiologist assistants in hospitals.

(1) Anesthesiologist assistant—A person who meets each of the following conditions:

(A) Has graduated from an anesthesiologist assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency;

(B) Has passed the certifying examination administered by the National Commission on Certification of Anesthesiologist Assistants;

(C) Has active certification by the National Commission on Certification of Anesthesiologist Assistants;

(D) Is currently licensed as an anesthesiologist assistant in the state of Missouri; and

(E) Provides health care services delegated by a licensed anesthesiologist.

(2) Notwithstanding any other rule in this chapter, anesthesia in hospitals shall be administered only by qualified anesthesiologists, physicians or dentists trained in anesthesia, certified nurse anesthetists, anesthesiologist assistants or supervised students in an approved educational program. Notwithstanding the provisions of sections 334.400 to 334.430, RSMo, or the rules of the Missouri State Board of Registration for the Healing Arts, the governing body of every hospital shall have full authority to limit the functions and activities that an anesthesiologist assistant performs in such hospital. Nothing in this section shall be construed to require any hospital to hire an anesthesiologist who is not already employed as a physician prior to August 28, 2003.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. Original rule filed Jan. 16, 2007, effective Aug. 30, 2007.*

**Original authority: 192.006, RSMo 1993, amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.011 Definitions Relating to Hospitals

PURPOSE: This rule defines terminology used throughout this chapter.

(1) ACLS—The American Heart Association's advanced cardiac life support program.

(2) Anesthetizing location—An area or room in which it is intended to administer any flammable or nonflammable inhalation anesthetic agents in the course of examination or treatment.

(3) APLS—The American College of Emergency Physician's advanced pediatric life support program. APLS may be used interchangeably with PALS where required.

(4) ATLS—The American College of Surgeon's advanced trauma life support program.

(5) Authenticate–To prove authorship, for example, by written signature, identifiable initials or computer key. The use of rubber stamp signatures is acceptable only under the following conditions:

(A) The individual whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it; and

(B) The individual places in the administrative office of the hospital, with a copy to the medical records director, a signed statement to the effect that s/he is the only one who has the stamp and is the only one who will use it.

(6) Biological safety cabinet—A containment unit suitable for the preparation of low to moderate risk agents where there is a need for protection of the product, personnel and environment, according to National Safety Foundation, Standard 49.

(7) Board-admissible—That a physician has applied to a specialty board and has received a ruling that s/he has fulfilled the requirements to take the certification examinations. Board certification must be obtained within five (5) years after completion of the residency.

(8) Board-certified—That a physician has fulfilled all requirements, has satisfactorily completed all written and oral examinations and has been awarded a board diploma in a specialty field.

(9) Certified registered nurse anesthetist—A registered nurse who has graduated from a school of nurse anesthesia accredited by the Council on Accreditation of Educational Programs of Nurse Anesthesia or its predecessor and has been certified or is eligible for certification as a nurse anesthetist by the Council on Certification of Nurse Anesthetists.

(10) Chief executive officer—The individual appointed by the governing body to act in its behalf in the overall management of the hospital. Job titles may include administrator, superintendent, director, executive director, president, vice president and executive vice president.

(11) Chief operating officer—The individual appointed by the chief executive officer on behalf of the governing body or the individual who is responsible for the management of one (1) hospital in a multi-hospital organization under the direction of the chief executive officer of the organization.

(12) Class II biological safety cabinet—A ventilated cabinet for personnel, product and environmental protection having an open front with inward airflow for personnel protection, high-efficiency-particulate-air (HEPA)-filtered laminar airflow for product protection and HEPA-filtered exhausted air for environmental protection.

(13) Class 100 environment—An atmospheric environment which contains less than one hundred (100) particles five-tenths (0.5) microns or larger in diameter per cubic foot of air, according to federal standard 209E.

(14) Dentist—An individual who has received a Doctor of Dental Surgery or Doctor of Dental Medicine degree and is currently licensed to practice dentistry in Missouri.

(15) Department—Missouri Department of Health and Senior Services.

(16) Hospital emergency transfer policy—A document that represents the usual and customary practices of a hospital with respect to the transfer of patients. The department uses objective indicators of patient status in relation to hospital capabilities to identify general classifications of patients who should be considered for transfer to a hospital with the necessary capabilities, and indicates the general classifications of patients the hospital has the capabilities to receive through emergency transfer from another hospital. The hospital emergency transfer policy does not supersede the authority of a physician to determine whether patients should be transferred on a case-by-case basis, but serves as an institutional baseline to assist physician staff in providing consistent care decisions and is utilized for quality assurance review.

(17) Independent licensed practitioner—An individual who is a graduate of a professional school and is licensed to practice as a health care provider in Missouri.

(18) Infection control officer—An individual who is a licensed physician, licensed registered nurse, has a bachelor's degree in laboratory science or has similar qualifications and has additional training or education preparation in infection control, infectious diseases, epidemiology and principles of quality improvement.

(19) Infectious waste—Waste capable of producing an infectious disease. For a waste to be infectious, it must contain pathogens with sufficient virulence and quantity so that exposure to the waste by a susceptible host could result in an infectious disease. Infectious waste shall include the following categories:

(A) Blood and blood products—All human blood and blood products including serum, plasma and other components known or suspected to be contaminated with a transmissible infectious agent;

(B) Contaminated surgical, dialysis and laboratory wastes—Wastes generated by surgery, dialysis and laboratory departments in the process of caring for hospital patients who have communicable diseases capable of being transmitted to others via those wastes;

(C) Cultures and stocks of infectious agents and associated biologicals—Cultures and stocks of infectious agents shall be designated as infectious waste because of the high concentrations of pathogenic organisms typically present in these materials. Included in this category are all cultures and stocks of infectious organisms as well as culture dishes and devices used to transfer, inoculate and mix cultures. Also included are animal carcasses, body parts and bedding from animals contaminated with infectious agents;

(D) Isolation wastes—Wastes generated by hospitalized patients who have communicable diseases capable of being transmitted to others via those wastes;

(E) Pathology wastes—Autopsy wastes which consist of tissues, organs, body parts and body fluids that are removed during surgery and autopsy. All these wastes shall be considered infectious waste; and

(F) Sharps—All discarded sharps including hypodermic needles, syringes and scalpel blades. Broken glass or other sharp items that have come in contact with material defined as infectious are included.

(20) Inpatient—A person admitted into a hospital by a member of the medical staff for diagnosis, treatment or care.

(21) Medical services—Those preventive, diagnostic and therapeutic measures performed by, or at the request of, members of the medical staff or an independent licensed practitioner in outpatient services.

(22) Operator—Shall mean any person as defined by section 197.020, RSMo who is licensed or required to be licensed under the provisions of sections 197.020–197.120, RSMo to establish, conduct or maintain a hospital. The term person shall mean any person determined by the department to have the following:

(A) Ultimate responsibility for making and implementing decisions regarding the operation of the hospital; and

(B) Ultimate financial control of the operation of the hospital.

(23) PALS—The American Heart Association's pediatric advanced life support program. PALS may be used interchangeably with APLS where required.

(24) Pharmacist—An individual who is a graduate of a school or college of pharmacy and is currently licensed to practice pharmacy in Missouri.

(25) Physician—An individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently licensed to practice medicine in Missouri.

(26) Podiatrist—An individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Missouri.

(27) Psychologist—An individual who is currently licensed by the State Committee of Psychologists under the provisions of Chapter 337, RSMo.

(28) Qualified dietitian—An individual who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who has the documented equivalent in education, training and experience, with evidence of relevant continuing education.

(29) Qualified medical record administrator—A registered record administrator who has successfully passed an appropriate examination conducted by the American Medical Record Association or who has the document equivalent in education and training.

(30) Qualified medical record technician—An accredited record technician who has successfully passed the appropriate accreditation examination conducted by the American Medical Record Association or who has the documented equivalent in education and training.

(31) Qualified occupational therapist—An individual who is a graduate of an occupational therapy program approved by a nationally recognized accrediting body, or who currently holds certification by the American Occupational Therapy Association as an occupational therapist or who has the documented equivalent in training or experience and is currently competent in the field.

(32) Qualified physical therapist—An individual who is licensed to practice professional physical therapy in Missouri.

(33) Qualified radiologic technologist—An individual who is a graduate of a program in radiologic technology approved by the Council on Medical Education of the American Medical Association or who has the documented equivalent in education and training.

(34) Qualified social worker—A licensed clinical social worker or a person who has a bachelor's degree in social work or a master's degree in social work.

(35) Registered nurse—An individual who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse in Missouri.

(36) Registered or certified respiratory therapist—An individual who has been registered or certified by the National Board for Respiratory Therapy, Inc. after successfully completing all education, experience and examination requirements or an individual who has been registered or certified prior to November 11, 1982, by an organization acceptable to the Department of Health and Senior Services.

(37) Root cause analysis—A process for idenifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

(38) Sentinel event—An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

(39) Special care unit—An appropriately equipped area of the hospital where there is a concentration of physicians, nurses and others who have special skills and experience to provide optimal medical care for critically-ill patients.

(40) Transfer agreement—A document which sets forth the rights and responsibilities of two (2) hospitals regarding the interhospital transfer of patients.

(41) Unit—A functional division or facility of the hospital.

(42) Diversion—A plan to temporarily close a hospital emergency department to ambulance traffic. This may be due to the emergency department being overwhelmed with significantly critically ill or injured patients, or an overwhelming number of minor emergency patients, to the extent that the hospital is unable to provide quality care or protect the health or welfare of the patients it serves. A diversion also may be implemented if the hospital has resource limitations, such as, no available beds in specialty care units or general acute care, no surgical suites or shortages of equipment or personnel.

(A) Defined service area—The geographic area served by a defined group of hospitals and emergency services. In areas where there is a community-based emergency medical services diversion plan, the service area(s) defined as the catchment area by the plan will be the defined service area(s). In areas where there is not a community-based emergency medical services diversion plan, the defined service area will be a twenty (20)-mile radius from a hospital.

(43) Immediate and serious threat—Having caused, or is likely to cause, serious injury, harm, impairment, or death to a patient.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154 and 197.293, RSMo Supp. 2005. This rule was previously filed as 13 CSR 50-20.011. Original rule filed June 2, 1982, effective Nov. 11, 1982. Amended: Filed June 2, 1987, effective Sept. 11, 1987. Amended: Filed Aug. 16, 1988, effective Dec. 29, 1988. Amended: Filed Nov. 21, 1995, effective July 30, 1996. Amended: Filed Oct. 6, 1998, effective April 30, 1999. Amended: Filed June 28, 2001, effective Feb. 28, 2002. Amended: Filed Sept. 20, 2005, effective April 30, 2006.*

**Original authority: 192.006, RSMo 1993; amended 1995; 197.080, RSMo 1953, amended 1993, 1995; 197.154, RSMo 2000; and 197.293, RSMo 2000, 2004*

19 CSR 30-20.015 Administration of the Hospital Licensing Program

PURPOSE: This rule formalizes the hospital licensing policies being carried out by the Department of Health. It prescribes procedures for the review of hospital records, acceptance of plans of deficiency correction and suspension of a hospital license.

(1) Persons intending to operate a hospital shall submit information to the Department of Health and Senior Services, as set out in the application form (MO 580-0007(8-01)) included herein. Within thirty (30) days after receipt of the application, the applicant will be notified of any omitted information or documents. After sixty (60) days any incomplete application is null. Each application for license to operate a hospital shall be accompanied by the appropriate licensing fee required by section 197.050, RSMo. Each license shall be issued for the premises and persons named in the application.

(2) Each license shall be issued only for the premises and persons named in the application. A license, unless sooner revoked, shall be issued for a period of up to a year. If during the period in which a license is in effect, a licensed operator which is a partnership, limited partnership, or corporation undergoes any of the following changes, whether by one (1) or by more than one (1) action, the operator shall within fifteen (15) working days of such change apply for a new license:

(A) With respect to a partnership, a change in the majority interest of general partners;

(B) With respect to a limited partnership, a change in the general partner or in the majority interest of limited partners;

(C) With respect to a corporation, a change in the persons who own, hold or have the power to vote the majority of any class of securities issued by the corporation. If the corporation does not have stock, a change of owner occurs when the emerging entity has one (1) federal tax number; or

(D) The board of directors with management control is an entity other than the licensed operator.

(3) An operator of two (2) or more licensed hospitals may submit application to the Department of Health to operate the hospitals as a single licensed hospital. The two (2) or more licensed hospitals may be separated by a distance which can be traveled in no more than one (1) hour by customary ground transportation in normal weather conditions. The operator shall designate a permanent hospital base from which the one (1)-hour travel distance is determined. If the application is approved, the hospitals may be named on the licensure application and a single license issued. Also, an operator of a licensed hospital may submit a proposal to provide, at a minimum, all of the required patient care services at a geographical location which at the time of the proposal is not a part of the licensed hospital. The location shall be within a one (1)-hour travel distance by customary ground transportation in normal weather conditions. Before the Department of Health approves the application, the applicant shall submit an operational proposal to the director of the Department of Health for approval. At a minimum the proposal shall include:

(A) A description of the patient care services that will be provided at each geographical location and how they will be integrated with patient care services at other geographical locations which will be operated under the single license. The description shall include justification to support the applicant's allegation that the combined patient care hospital services will exceed the current benefits that are derived by the community(ies) where each individual currently licensed hospital is located. Or, if the operator currently is not providing the service within the geographical location contained in the proposal, there shall be evidence the service is needed in that location;

(B) A description of the organizational structure of the proposed single licensed hospital;

(C) Documentation of evidence that the hospital's facilities in each geographical location named in the proposal will be owned or leased by the same operator and that the services are operated under common management;

(D) Assurance that the hospital's operation in each geographical location will be held out to the public under a common name;

(E) Assurance the hospital's services in each geographical location will be subject to the bylaws and operating decisions of the same governing body;

(F) Assurance that members of the medical staff in each geographical location will be directed by a common medical director and will be subject to the same bylaws and operating decisions of a common medical staff;

(G) Assurance the hospital's operations in each geographical location will be administered by a common chief executive officer through appropriate delegation of duties;

(H) Assurance the licensed hospital's services in each geographical location will be integrated and, when services are provided at multiple locations, that they will be supervised by a common director who is provided

with adequate assistance in supervision of the services;

(I) Assurance that the single licensed hospital's medical records department is integrated and the records are easily accessible to patient care staff;

(J) Assurance the applicant's proposal is not in violation of other federal, state and local regulations;

(K) Assurance that the applicant, either separately at each geographical location or in combination, will provide all required patient care services, including emergency services, in accordance with Chapter 197, RSMo and 19 CSR 30-20.021(3) and in accordance with acceptable standards of practice;

(L) Assurance that services and beds at one (1) geographical location will not be reallocated to another geographical location prior to the operator requesting and obtaining approval from the Certificate of Need program, whenever appropriate, and the Department of Health;

(M) Approval from the Certificate of Need program if the operator's proposal includes a request to provide a patient care service in a geographical location of the hospital which is not currently a part of the hospital's license when the proposal is subject to the Missouri Certificate of Need law, sections 197.300–197.365, RSMo;

(N) Assurance that skilled nursing unit, intermediate care unit and residential care unit services provided within the licensed hospital are physically located at a geographical location of the hospital where all of the required patient care services are provided on-site in accordance with Chapter 197, RSMo and 19 CSR 30-20.021(3);

(O) Assurance that the applicant's proposal will not jeopardize the health and safety of individuals who reside within the geographical locations which will be served by the single licensed hospital. The applicant shall demonstrate that the proposal contains provision for services which exceed or are comparable to the services currently being provided to the community, or will provide adequate justification to convince the Department of Health the service is no longer needed within the geographical location where the service is currently provided; and

(P) Assurance that the applicant presented the proposal at a public hearing within the community where the currently licensed hospital(s) is located. The proposal shall provide evidence that the entire community was adequately notified at least two (2) weeks in advance, of the public hearings. The written record of the hearings, including the community response to the proposal, shall be submitted to the Department of Health as a part of the applicant's proposal. The Department of Health shall be given two (2) weeks advance notice of the public hearings.

(4) The license shall state the maximum licensed bed capacity, the person(s) to whom granted and the date and expiration date and additional information, such as a specialty hospital designation, that the department may require. At least forty-five (45) days prior to the expiration date of an existing license, the department shall notify the operator that the license application is due for renewal. A relicensure application shall be submitted no more than ninety (90) days and not less than thirty (30) days prior to the expiration date of the existing license. Each application for license, except application from governmental units, shall be accompanied by a licensing fee in accordance with section 197.210, RSMo.

(5) Appointed representatives of the Department of Health shall be allowed to inspect a hospital as required in section 197.100, RSMo. The chief executive officer or designee shall grant access to information requested by the department for the purpose of evaluating compliance with hospital licensing requirements. Requested records may include, but are not limited to, incident reports, quality of care reports, peer review reports, committee minutes, policies and procedures, training records, medical records or any other documents which are necessary to complete the inspection. All information and reports obtained by the Department of Health shall be kept confidential as required in section 197.477, RSMo.

(6) Appointed representatives of the Department of Health's Bureau of Hospital Licensing and Certification shall be allowed to review patient medical records and hospital employee personnel records in the course of conducting an investigation of allegations against an employee or previous employees of a hospital or allegations of substandard care regarding a patient transferred to the hospital from another licensed facility. The representatives shall first provide written assurance that information obtained from the patient's medical record or from the employee's personnel record will be maintained confidential.

(7) The operator shall have a written policy pertaining to employees reporting mismanagement of violations of applicable laws and rules. At a minimum the policy shall include the following provisions:

(A) No supervisor or individual with hiring or firing authority in a licensed hospital shall prohibit any of its employees from discussing the operations of the hospital, either specifically or generally, with any representatives of the department; and

(B) No supervisor or individual with authority to hire and fire in a licensed hospital shall prohibit his/her employees from disclosing information which the employee reasonably believes evidences a violation of any applicable state or federal law or regulation. This subsection shall not be construed as—

1. Permitting an employee to leave his/her assigned work areas during normal work hours without following applicable rules and policies pertaining to leaves, unless the employee is requested by the Department of Health to officially appear before department representatives;

2. Authorizing an employee to represent the employee's personal opinions as the opinions of his/her employer; or

3. Precluding the operator from taking appropriate disciplinary actions against any employee.

(8) Inspection. The department shall conduct licensure compliance inspections of hospitals as required by section 197.100, RSMo. Inspections will normally be announced to the facility at least seventy-two (72) hours in advance. Complaint investigations may be unannounced.

(9) Inspection Findings.

(A) Whenever an authorized representative of the department finds, during an inspection, that a hospital is not in compliance with the provisions of the Hospital Licensing Law, sections 197.010–197.120, RSMo, the chief executive officer or designee shall be informed of the general nature of findings in an exit conference conducted prior to the representative's departure from the premises. Within ten (10) working days after each licensing inspection, a written report shall be prepared by the department detailing the specifics of each deficiency. A copy of the report and a written correction order shall be sent to the hospital's chief executive officer or designee. The report shall state each deficiency separately and shall reference the specific statute or administrative rule violated. If the facility believes that deficiencies are not applicable or are not based upon laws or rules, a request for review may be submitted to the office of the director of the department.

(B) Should the findings of the inspection constitute an immediate and serious threat to the safety or health of the patients, public or hospital staff, a condition of substantial noncompliance shall be considered to exist. The department representative shall verbally convey any determination of substantial noncompliance to the chief executive officer or designee at the exit conference. Findings of

substantial noncompliance shall be documented in the normal reporting method described in subsection (9)(A) of this rule.

(C) The following guidelines, applicable to the inspection, shall be used by the licensing representative to determine if a finding during an inspection constitutes an immediate and serious threat to the health and safety of one (1) or more patients. The guidelines used to determine immediate and serious threat serve only as guides for authorized department representatives to use when making the determination.

1. Failure to protect from abuse—

A. Serious injuries such as head trauma or fractures;

B. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault;

C. Unexplained serious injuries that have not been investigated;

D. Staff striking or roughly handling an individual;

E. Staff yelling, swearing, gesturing or calling an individual derogatory names;

F. Bruises around the breast or genital area; or

G. Suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising.

2. Failure to prevent neglect—

A. Lack of timely assessment of individuals after injury;

B. Lack of supervision for individual with known special needs;

C. Failure to carry out doctor's orders;

D. Repeated occurrences such as falls which place the individual at risk of harm without intervention;

E. Access to chemical and physical hazards by individuals who are at risk;

F. Access to hot water of sufficient temperature to cause tissue injury;

G. Non-functioning call system without compensatory measures;

H. Unsupervised smoking by an individual with a known safety risk;

I. Lack of supervision of cognitively impaired individuals with known elopement risk;

J. Failure to adequately monitor individuals with known severe self-injurious behavior;

K. Failure to adequately monitor and intervene for serious medical/surgical conditions;

L. Use of chemical/physical restraints without adequate monitoring;

M. Lack of security to prevent abduction of infants;

N. Improper feeding/positioning of individual with known aspiration risk;

O. Inadequate supervision to prevent physical altercations; or

P. Lack of appropriate use, care planning or monitoring of patients when any type of retraint, including but not limited to physical or chemical restraint, is utilized.

3. Failure to protect from psychological harm—

A. Application of chemical/physical restraints without clinical indications;

B. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; or

C. Lack of intervention to prevent individuals from creating an environment of fear.

4. Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed—

A. Administration of medication to an individual with a known history of allergic reaction to that medication;

B. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions;

C. Administration of contraindicated medications;

D. Pattern of repeated medication errors without intervention;

E. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or

F. Lack of timely and appropriate monitoring required for drug titration.

5. Failure to provide adequate nutrition and hydration to support and maintain health—

A. Food supply inadequate to meet the nutritional needs of the individual;

B. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values;

C. Withholding nutrition and hydration without advance directive; or

D. Lack of potable water supply.

6. Failure to protect from widespread nosocomial infections; e.g. failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or failure to identify and treat nosocomial infections—

A. Pervasive improper handling of body fluids or substances from an individual with an infectious disease;

B. High number of infections or contagious diseases without appropriate reporting, intervention and care;

C. Pattern of ineffective infection control precautions; or

D. High number of nosocomial infections caused by cross contamination from staff and/or equipment/supplies.

7. Failure to correctly identify individuals—

A. Blood products given to wrong individual;

B. Surgical procedure/treatment performed on wrong individual or wrong body part;

C. Administration of medication or treatments to wrong individual; or

D. Discharge of an infant to the wrong individual.

8. Failure to safely administer blood products and safely monitor organ transplantation—

A. Wrong blood type transfused;

B. Improper storage of blood products;

C. High number of serious blood reactions;

D. Incorrect cross match and utilization of blood products or transplantation organs; or

E. Lack of monitoring for reactions during transfusions.

9. Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations—

A. Nonfunctioning or lack of emergency equipment and/or power source;

B. Smoking in high risk areas;

C. Incidents such as electrical shock, fires;

D. Ungrounded/unsafe electrical equipment;

E. Widespread lack of knowledge of emergency procedures by staff;

F. Widespread infestation by insects/rodents;

G. Lack of functioning ventilation, heating or cooling system placing individuals at risk;

H. Use of non-approved space heaters, such as kerosene, electrical, in resident or patient areas;

I. Improper handling/disposal of hazardous materials, chemicals and waste;

J. Locking exit doors in a manner that does not comply with NFPA 101;

K. Obstructed hallways and exits preventing egress;

L. Lack of maintenance of fire or life safety systems; or

M. Unsafe dietary practices resulting in high potential for food-borne illnesses.

10. Failure to provide initial medical screening, stabilization of emergency medical conditions and safe transfer for individuals and women in active labor seeking emergency treatment—

A. Individuals turned away from emergency room (ER) without medical screening exam;

B. Women with contractions not medically screened for status of labor;

C. Absence of ER or obstetrical (OB) medical screening records;

D. Failure to stabilize emergency medical condition; or

E. Failure to appropriately transfer an individual with an unstabilized emergency medical condition.

(10) Settlement Agreement.

(A) Ten (10) working days following receipt of the written inspection report, the chief executive officer or designee shall provide the department with a written plan for correcting the cited deficiencies or a request for reconsideration of the deficiency. The plan of correction shall specify the means the hospital will employ for correcting the cited deficiencies and the date that each corrective measure will be completed. If a request for reconsideration is submitted, the request shall contain rationale or documentation to provide evidence that the deficiency should not have been cited. Failure of the facility to submit a plan of correction or a request for reconsideration of the deficiency acceptable to the director of the department or designee—within the time frame specified—shall be grounds for the department to suspend the facility's license if there remains a substantial failure to comply with the requirements established under sections 197.010–197.120, RSMo and 19 CSR 30-20.011–19 CSR 30-20.070. The operator has the right to appeal the department's decision in accordance with section 197.071, RSMo.

(B) Upon receipt of the required plan of correction for achieving licensure compliance, the department shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the department shall notify the chief executive officer or designee, in writing, and indicate that implementation of the plan should proceed. If the plan is not acceptable, the department shall notify the chief executive officer or designee, in writing, and indicate the reasons why the plan is not acceptable. Within ten (10) working days from the receipt of the notice, a revised, acceptable plan of correction shall be provided to the department.

(11) Follow-up Inspections. Upon expiration of the target dates for correction of deficiencies specified in the approved plan of correction, the department may make a follow-up inspection to determine whether the required corrective measures have been acceptably accomplished. If the follow-up inspection finds the facility fails to comply with the provisions of the Hospital Licensing Law, sections 197.010–197.120, RSMo and 19 CSR 30-20.011–19 CSR 30-20.070, the department may take action to suspend or to revoke the operator's license to operate the hospital. The operator has the right to appeal the department's decision in accordance with section 197.071, RSMo.

(12) If, for a period in excess of fourteen (14) days, a facility ceases to provide patient care or to otherwise operate as a hospital within the definition of section 197.020.2, RSMo, except in the case of a strike, an act of God or written approval of the department, the facility shall surrender its license to the department. The facility shall not operate again as a hospital until an application for a hospital license is submitted with assurance that the facility complies with the requirements in 19 CSR 30-20.030 and the Department of Health issues a license.

(13) Requested Suspension of License. If any hospital wishes to cease operation for a period of time but retain its current hospital license, the Department of Health, upon written request from the licensed operator, may grant approval for suspension of the hospital's license for a specified time.

(A) Not less than fourteen (14) days prior to cessation of patient services at the hospital, the licensed operator shall submit to the department a written request for continuance.

(B) The written request for the suspension of the license shall include the reasons for cessation of patient services, the anticipated length of cessation of patient services, what safeguards the hospital will institute to provide security to the institution, the preventive maintenance measures used to assure that all equipment will be kept in good working order and evidence that the hospital is financially solvent to meet the conditions of the request and will remain so throughout the period of cessation of patient services.

(C) Approval may be granted only for the suspension of a hospital's current license if the cessation of patient services is for one (1) of the following reasons:

1. The renovation of the hospital's facility to upgrade to current licensure standards and to correct licensure or federal certification physical plant deficiencies;

2. The transfer of the operation of the hospital to a new operator to allow sufficient time for the new operator to obtain a new license; or

3. Other reasons which will not result in a deterioration of the hospital physical plant or its programs and which will be in the best interest of the citizens it serves.

(D) The suspension of a hospital's current license shall not exceed ninety (90) days beyond the date of cessation of patient services for ownership transfer. The suspension of a hospital's current license shall not exceed one hundred eighty (180) days beyond the date of cessation of patient services for renovation construction. The department may not grant more than one (1) suspension to a hospital's licensed operator within any twelve (12)-month period and shall grant no suspension for a period of more than one hundred eighty (180) days from the date of cessation of inpatient services.

(E) No inpatients shall be housed within the hospital from the initial date of cessation of inpatient services until operation of the hospital is restored with Department of Health approval.

(F) No inpatient services shall be provided in the hospital during the period of time that inpatient services are discontinued.

(G) When suspension of the license is requested for a renovation or construction proposal, the licensed operator shall submit plans for the renovation to the department for review and shall have received the department's approval of those plans prior to the date of cessation of patient services at the hospital.

(H) The licensed operator shall notify the department no less than fourteen (14) days prior to the resumption of inpatient services that the hospital is ready for review/inspection for approval to reoccupy the hospital with inpatients.

(I) Within ten (10) working days of notification, the department shall respond in writing to the licensed operator with the findings of its review/inspection for the resumption of licensed hospital services at the hospital.

(14) Involuntary Suspension or Revocation of the License.

(A) Whenever the department determines that substantial noncompliance exists in a hospital, the department may immediately suspend or revoke the license of the facility or order cessation of use of any portion of the noncompliant services or buildings.

(B) The department shall document its action in writing in addition to the report detailing the findings of the inspection. A copy shall be submitted to the hospital's chief executive officer or designee.

(C) The hospital shall expedite corrections required to relieve the involuntary suspension or revocation.

(D) The operator may elect to seek appeal or relief from the Administrative Hearing Commission in accordance with section 197.071, RSMo, or the operator may elect to first request a review of the action by the office of the director of the department.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
HEALTH FACILITY REGULATION
P.O. BOX 570
JEFFERSON CITY, MISSOURI 65102-0570

APPLICATION FOR HOSPITAL LICENSE

☐ INITIAL APPLICATION ☐ RENEWAL APPLICATION

In accordance with the requirements of the Missouri Hospital Licensing Law (sections 197.010 through 197.120, RSMo), application is hereby made for a license to conduct and maintain a hospital (see "Definitions," section 197.020, subsection 2., RSMo).

DO NOT WRITE IN THIS SPACE

LICENSE NO.
DATE
CERTIFICATE NO.
DATE MAILED

NAME OF HOSPITAL (NAME TO APPEAR ON LICENSE) TELEPHONE NO.

ADDRESS (STREET AND NUMBER) (CITY) (ZIP CODE) (COUNTY)

CHIEF EXECUTIVE OFFICER (FULL NAME) (TITLE)

NEXT IN CHARGE (FULL NAME) (TITLE)

TYPE OF FACILITY
☐ GENERAL HOSPITAL ☐ SPECIALTY (SPECIFY REHABILITATION, MENTAL, ETC.)

OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)

A. GOVERNMENTAL
☐ DISTRICT
☐ COUNTY
☐ CITY-COUNTY
☐ CITY
☐ OTHER (EXPLAIN)

B. NON-GOVERNMENTAL

NON-PROFIT
☐ CHURCH OPERATED
☐ CHURCH AFFILIATED
☐ OTHER NON-PROFIT

PROPRIETARY
☐ INDIVIDUAL
☐ PARTNERSHIP
☐ CORPORATION

NAME OF GOVERNING BODY

CHIEF OFFICER OF GOVERNING BODY (FULL NAME) (TITLE)

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

FISCAL YEAR MO DAY TO MO DAY

COMPLETED AND RETURNED MOST RECENT ANNUAL SURVEY OF MISSOURI HOSPITALS? (FOR RENEWAL APPL. ONLY) ☐ YES ☐ NO

PROFESSIONAL DATA

ACTIVE STAFF ► NUMBER ☐ MEDICAL ☐ OSTEOPATHIC ☐ JOINT

RADIOLOGIST (NAME) ☐ FULL-TIME ☐ PART-TIME

PATHOLOGIST (NAME) ☐ FULL-TIME ☐ PART-TIME

DIR. OF NURSING SERVICE (NAME)

DIR. MEDICAL RECORDS (NAME)

DIR. DIETARY SERVICE (NAME)

DIR. PHYSICAL PLANT (NAME)

ACCREDITED? ☐ YES ☐ NO

ACCREDITED BY ☐ JCAH ☐ AOA

APPLIED FOR ACCREDITATION? ☐ YES ☐ NO

SCHOOL OF NURSING ☐ YES ☐ NO

APPROVED FOR RESIDENT-INTERN TRAINING ☐ YES ☐ NO

NUMBER OF RESIDENTS

NUMBER OF INTERNS

MO 580-0007 (8-01) HL-11

BED DESIGNATION BY SERVICES (INDICATE TOTAL NUMBER OF BEDS IN EACH CATEGORY)				
MEDICAL SURGICAL	ALCOHOL/DRUG ABUSE	LTC TOTAL _____	NEONATAL ICU	OTHER (SPECIFY SERVICE)
OBSTETRICAL	PSYCHIATRIC	SKILLED NURSING _____ INTERMEDIATE CARE _____	NURSERY BASSINETS	
PEDIATRIC	ICU-CCU	REHABILITATION	TOTAL BEDS	NUMBER

NOTE: ANY CHANGES IN TOTAL BED COMPLEMENT SINCE LAST APPLICATION (INCREASE OR DECREASE) MUST BE FULLY EXPLAINED.

CERTIFICATION

STATE OF MISSOURI

City of _____ } ss.
County of _____ }

_____ and _____
CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OR PARTNERSHIP — HOSPITAL CHIEF EXECUTIVE OFFICER

being duly sworn by me on _____ oath, deposes and says that _____ have read the foregoing application and that
HIS - THEIR — HE - THEY

the statements contained therein are correct and true and of _____ knowledge; and further gives assurance of the ability and
HIS - THEIR

intention of the _____ to comply with the regulations and codes
LEGAL NAME OF OPERATING CORPORATION

promulgated under the Missouri Hospital Licensing Law (sections 197.010 through 197.120, RSMo).

It is further certified that the _____ will comply with all recommendations
HOSPITAL NAME

for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and Senior Services and submitted to said Hospital.

Signed _____
CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP

Signed _____
HOSPITAL CHIEF EXECUTIVE OFFICER

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF	YEAR	USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

MO 580-0007 (8-01)

AUTHORITY: sections 192.006, 197.080, and 197.293, RSMo 2000. This rule was previously filed as 13 CSR 50-20.015. Original rule filed April 9, 1985, effective July 11, 1985. Amended: Filed Nov. 4, 1992, effective June 7, 1993. Amended: Filed Nov. 21, 1995, effective July 30, 1996. Amended: Filed Oct. 6, 1998, effective April 30, 1999. Amended: Filed June 28, 2001, effective Feb. 28, 2002. Amended: Filed April 30, 2004, effective Dec. 30, 2004.*

**Original authority: 192.006, RSMo 1993, amended 1995, 197.080, RSMo 1953, amended 1993, 1995; and 197.293, RSMo 2000.*

19 CSR 30-20.021 Organization and Management for Hospitals
(Rescinded February 29, 2008)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2005. This rule was previously filed as 13 CSR 50-20.021 and 19 CSR 10-20.021. Original rule filed June 2, 1982, effective Nov. 11, 1982. Amended: Filed April 9, 1985, effective Sept. 28, 1985. Amended: Filed June 2, 1987, effective Sept. 11, 1987. Amended: Filed Nov. 16, 1987, effective March 26, 1988. Amended: Filed June 14, 1988, effective Oct. 13, 1988. Amended: Filed Aug. 16, 1988, effective Dec. 29, 1988. Amended: Filed Nov. 21, 1995, effective July 30, 1996. Amended: Filed Oct. 6, 1998, effective April 30, 1999. Amended: Filed June 28, 2001, effective Feb. 28, 2002. Amended: Filed April 30, 2004, effective Dec. 30, 2004. Emergency amendment filed Sept. 1, 2005, effective Sept. 11, 2005, expired March 9, 2006. Amended: Filed Feb. 1, 2006, effective July 30, 2006. Rescinded: Filed June 27, 2007, effective Feb. 29, 2008.

19 CSR 30-20.030 Construction Standards for New Hospitals

PURPOSE: This rule establishes up-to-date construction standards for new hospitals to help ensure accessible, functional, fire-safe and sanitary facilities.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) New Hospital General Requirements.

(A) A new hospital is one for which plans are submitted to the Department of Health for review and approval after November 11, 1982 for the construction of a new facility, expansion or renovation of an existing hospital or the conversion of an existing facility not previously and continuously licensed as a hospital under Chapter 197, RSMo. A new hospital shall be designed to provide all of the facilities required by this rule and arranged to accommodate all of the functions required by this rule and to provide comfortable, sanitary, fire-safe, secure and durable facilities for the patients. In major alteration projects and additions to an existing licensed hospital, only that part of the total hospital affected by the project is subject to this rule.

(B) These minimum requirements are not intended in any way to restrict innovations and improvements in design, construction or operating techniques. Plans and specifications and operational procedures which contain deviations from these requirements may be approved if it is determined that the purposes of the minimum requirements have been fulfilled. Some facilities may be subject to the requirements of more than one (1) regulating agency. While every effort has been made to ensure coordination, facilities making requests for changes in services and request for new construction or renovations are cautioned to verify requirements of other agencies involved.

(C) Requests for deviations from the requirements of this rule shall be in writing to the Department of Health. Approvals for deviations shall be in writing and both requests and approvals shall become a part of the permanent Department of Health records for the facility.

(D) Alterations or additions to existing hospitals shall be programmed so construction will minimize disruptions of existing functions. Access to exits and fire protections shall be maintained so the safety of the occupants will not be jeopardized during construction.

(E) The owner of each new facility or the owner of an existing facility being added to or undergoing major alterations shall provide a program—scope of services—which describes space requirements, staffing patterns, departmental relationships and other basic information relating to the objectives of the facility. The program may be general but it shall include a description of each function to be performed, approximate space needed for these functions and the interrelationship of various functions and spaces. The program also shall describe how essential services can be expanded in the future as the demand increases. Appropriate modifications or deletions in space requirements may be made when services are shared or purchased, provided the program indicates where the services are available and how they are to be provided.

(2) Planning and Construction Procedure.

(A) Plans and specifications shall be prepared for the construction of all new hospitals and additions to and major remodeling of existing hospitals. The plans and specifications shall be prepared by an architect or a professional engineer licensed to practice in Missouri.

(B) Construction shall be in conformance with plans and specifications approved by the Department of Health. The Department of Health shall be notified within five (5) days after construction begins. If construction of the project is not started within one (1) year after the date of approval of the plans and specifications, the plans and specifications shall be resubmitted to the Department of Health for its approval and shall be amended, if necessary, to comply with the then current rules before construction work commences.

(3) General Design.

(A) Site.

1. The facility shall be located so it is reasonably accessible to the community served, close to where competent medical and professional consultation is readily available and where employees can be recruited and retained.

2. Fire lanes shall be provided and kept clear to provide immediate access for the fire fighting equipment.

3. Paved roads shall be provided within the lot lines to provide access to the main entrance, emergency entrance, entrances serving community activities and to service entrances, including loading and unloading docks for delivery trucks. Hospitals having an organized emergency service shall have the emergency entrance well marked to facilitate entry from the public roads or streets serving the site. Access to the emergency entrance shall not conflict with other vehicular traffic or pedestrian traffic. Paved walkways shall be provided for necessary pedestrian traffic.

4. Documentation of parking needs shall be provided by the hospital as part of the program.

(B) Special Design Considerations for the Handicapped.

1. One-half (1/2) of one percent (1%) of bed capacity or two (2) parking spaces, whichever is greater, shall be provided for handicapped visitors. Parking spaces for handicapped staff members shall be provided as required. Parking spaces for handicapped persons shall be at least twelve feet (12') wide and on level grade. Parking spaces for handicapped shall be located so there is access to sidewalks without going behind other parked cars.

2. Walkways and curbs from the street or parking spaces to the building entrance shall be designed to facilitate travel by people in wheelchairs or on crutches.

3. Parking spaces and one (1) or more entrances to a facility shall be designed to facilitate the building's use by handicapped persons.

4. At least one (1) primary grade-level entrance to the building shall be arranged to be fully accessible to handicapped persons.

5. At least one (1) drinking fountain, one (1) toilet and one (1) hand washing facility shall be available on each floor for physically handicapped patients and staff. At least one (1) wheelchair shower shall be provided in the patient area. Floors where the handicapped are specifically excluded from the entire area, such as boiler rooms, need not meet these requirements.

6. A public telephone, drinking fountain and toilets with hand washing facilities accessible to handicapped visitors shall be located in the hospital.

7. In an alteration project and additions to an existing hospital, only that portion of the total hospital affected by the project, including that part of adjacent areas used for access by the handicapped, must comply with paragraphs (3)(B)1.–6. of this rule.

(4) General Design of Nursing Unit—Adult Medical, Surgical and Post-Partum Care (except special care areas such as recovery rooms, intensive care units and psychiatric units).

(A) Every room shall have direct access to a corridor, shall have a window and shall contain a lavatory, closets and electrical and mechanical facilities. No room shall contain more than four (4) beds. No bed shall have more than one (1) bed between it and the window wall. The room area exclusive of toilet rooms, closets, lockers, wardrobes, alcoves or vestibules shall be not less than one hundred (100) square feet in a single-bed room nor less than eighty (80) square feet for each bed in a multi-bed room. The ceiling shall be not less than eight feet (8') above the floor.

(B) Every bed shall have aisles at least three feet (3') wide on both sides. The aisle between adjacent beds may serve both beds and may serve as access to facilities serving both beds. Each aisle between a bed and wall shall serve as access only to facilities serving the adjacent bed, except the window and the heating unit. An aisle, not less than four feet (4') wide in multi-bed rooms and not less than three feet (3') wide in single-bed rooms, shall be provided at the foot of each bed. Aisles shall be continuous and clear of any built-in equipment with the exception of a heating or air-conditioning unit not more than three feet (3') high and extending not more than nine inches (9") into a side aisle. A unit combining a side table and electrical facilities specially designed for convenience to the patient and for convenient access for patient care may be installed in a side aisle.

(C) Each bed in a multi-bed room shall be provided with cubicle curtains or equivalent facilities arranged to contain adjacent floor space and to provide intermittent visual privacy, but shall not restrict patient access to the lavatory and toilet.

(D) One (1) or more windows, with sash not more than three feet (3') above the floor and with gross area not less than ten percent (10%) of the floor area of the room, shall be provided. If the building has an engineered smoke control system which complies with *Standard for Air Conditioning and Ventilating Systems 1978* published by the National Fire Protection Association, windows are not required to be operable. Otherwise, at least one (1) window or screened vent to the outside in each patient room shall be operable. Operable windows may be operable by a tool located in the nursing unit. Operable windows not restricted to emergency use shall be equipped with screens. Windows shall be exposed to an outside area not less than thirty feet (30') horizontally opposite the window and containing no construction which would further diminish the exposure of the window to natural light.

(E) Access to the corridor shall be either direct or through a vestibule and through one (1) or more doors. A single door leaf may be used if it is at least forty-four inches (44") wide. If double doors are used, both leaves shall equal at least forty-four inches (44") and one (1) leaf shall be at least thirty-two inches (32") wide. Doors shall not swing into the corridor unless recessed to avoid intrusion into the flow of traffic. The door hardware shall permit entry and egress without the use of hands. The toilet door shall swing out except when equipped with emergency rescue hardware.

(F) A toilet is required adjacent to each room with direct access without entering the corridor. It shall contain a water closet with a bedpan cleanser and also may contain a lavatory. It may serve more than one (1) room, but in no case more than four (4) beds. A lavatory equipped with a faucet with gooseneck spout and wrist blades shall be provided in each room. The lavatory shall be accessible without entering a toilet unless the toilet serves only one (1) bed.

(G) A separate closet or built-in wardrobe, suitable for hanging full-length garments on clothes hangers and for storage of personal effects, shall be provided for each bed.

(H) General lighting, switchable at the door, shall be sufficient to provide a light intensity of fifteen (15) foot-candles in all parts of the room. A nonswitchable night light, arranged to avoid shining in the patients' eyes, shall be provided. A reading light, switchable from the bed, shall be provided for each bed. The toilet light shall be switchable at the toilet door. A switchable light shall be provided at each lavatory. All switches for lighting in patient areas shall be of the quiet operating type. Duplex grounding type convenience outlets shall be provided as follows: one (1) on each side of each bed in the headwall for clinical equipment, one (1) at each lavatory and at least one (1) outlet on each wall space in the room. If television and electric beds are installed, grounding type receptacles shall be provided for each.

(I) The nurses' call system shall be installed in accordance with subparagraphs (26)(F)1.A.–F. of this rule.

(J) Oxygen supply outlets and clinical suction outlets shall be accessible from each bed in accordance with paragraph (27)(F)3. of this rule.

(K) At least one (1) room in the hospital shall meet the following isolation requirements:

1. Entrance from the corridor shall be through an anteroom which contains facilities to assist staff in maintaining aseptic conditions. The anteroom shall contain a lavatory or sink equipped for handwashing, storage spaces for clean and soiled materials and gowning facilities;

2. The door to the room shall have a viewing panel for observation from the anteroom; and

3. A private toilet containing a water closet and a tub or shower shall be provided. A handwashing facility shall be located in the toilet or in the patient room.

(L) If suitable psychiatric facilities are not available in the community, at least one (1) room shall be equipped to provide for disturbed patients needing close supervision.

This room shall be designed to minimize the potential for escape, injury or suicide. The door to this room shall swing outward and be recessed so it does not intrude on the flow of traffic.

(5) A service area shall be located in or be readily available to each nursing unit. The location and disposition of each service area will depend upon the number and types of beds to be served. Each service area may be arranged and located to serve more than one (1) nursing unit, but at least one (1) service area shall be provided on each nursing floor. In addition to a nurses' station, nurses' office, equipment storage room, charting facilities and staff toilet facilities, service areas shall include:

(A) Janitors' closet with mop sink, mop rack and space for equipment;

(B) A medicine preparation area containing a work counter with sink, refrigerator and locked storage for biologicals and drugs;

(C) At least one (1) treatment room with handwashing sink for each floor. If all patient rooms are single, this room may be omitted;

(D) A clean workroom or clean holding room. The clean workroom shall contain a work counter and handwashing and storage facilities including cart parking space. The clean holding room shall be part of a system for storage and distribution of clean and sterile supply materials and shall be similar to the clean workroom except that the work counter and handwashing facilities may be omitted;

(E) A soiled workroom or soiled holding room. The soiled workroom shall contain a clinical sink or equivalent flushing rim fixture, work counter with a sink suitable for handwashing, waste receptacle and linen receptacle. A soiled holding room shall be part of a system for collection and disposal of soiled materials and shall be similar to the soiled workroom except that the clinical sink and work counter may be omitted;

(F) Clean linen storage space in a separate closet or as a designated area within the clean workroom or holding room. If a closed cart system is used, storage may be in an alcove;

(G) A nourishment station with a sink, refrigerator, storage cabinets, icemaker, ice dispenser and equipment for serving nourishments between meals;

(H) Space for parking stretchers and wheelchairs located out of the path of normal traffic; and

(I) In nursing units, bathtubs or showers shall be provided at the rate of one (1) for each twelve (12) beds which are not otherwise served by bathing facilities within patients' rooms. Each tub or shower shall be in an individual room or enclosure which provides space for the private use of the bathing fixture and for drying and dressing. At least one (1) shower on each patient floor shall have space for a wheelchair. At least one (1) shower shall be provided for each twelve (12) beds in post-partum units.

(6) Special Care Units.

(A) Special care patients may be housed in single-bed rooms or in multi-bed rooms. If multi-bed rooms are provided, at least one (1) single-bed room shall be provided for each unit. In any case, one (1) room shall be set up for isolation techniques.

(B) All beds shall be arranged to permit direct visual observation by nursing staff or patient shall be electronically monitored.

(C) Natural lighting by windows shall be available to each patient. One (1) window may serve more than one (1) patient space, but not more than two (2). Window sills shall not be more than three feet (3') above the floor. Unless the building is designed with an engineered smoke control system in accordance with *Standard for Air Conditioning and Ventilating Systems 1978* published by the National Fire Protection Association, at least one (1) window in each room shall be operable. The use of a tool located in the unit is acceptable for window operation.

(D) Clearance between beds in multi-bed rooms shall not be less than six feet (6'). Clearance between the bed and adjacent wall shall not be less than three feet (3') and a clear aisle of at least four feet (4') shall be provided between the foot of the bed and wall. Single-bed rooms or solid wall cubicles shall have a minimum clear area of one hundred twenty (120) square feet and a minimum dimension of ten feet (10').

(E) Viewing panels shall be provided in doors and walls for observation of patients. Glazing in viewing panels shall be nonshattering glass.

(F) A handwashing lavatory shall be provided in each patient's room. In multi-bed rooms, a lavatory is to be provided at a ratio of no less than one (1) lavatory for each six (6) beds.

(G) Each special care unit shall have a toilet facility which is directly accessible from the unit. In multi-bed rooms, toilets are to be provided at a ratio of one (1) toilet for each six (6) beds. Portable water closet units may be used.

(H) Individual lockers shall be provided for the storage of patients' clothing and personal effects. Lockers shall be large enough to permit hanging of full-length garments.

(I) A separate waiting room shall be provided for visitors to special care patients unless the special care unit is on the same floor as the main waiting room.

(J) A clean workroom with work counter handwashing facility and storage space shall be provided unless an alternate system for storage and distribution of clean and sterile supplies is approved.

(K) A work counter with a sink, waste receptacle and linen receptacle shall be provided unless it can be shown that the soiled holding room is part of a system for collecting soiled materials.

(L) Facilities for flushing and washing bedpans shall be provided within the unit.

(M) A nourishment station with counter, sink, ice dispenser and refrigerator shall be located in or adjacent to the unit.

(N) Storage space for equipment shall be provided. Space shall be provided in the unit for emergency equipment and supplies.

(O) A medicine preparation facility containing a work counter with sink, refrigerator and locked storage for biologicals and drugs shall be provided.

(P) A toilet room equipped with water closet and lavatory shall be provided for staff. A lounge shall be provided for staff. Facilities for safekeeping of coats and personal belongings of personnel shall be provided.

(Q) A janitors' facility shall be located within or adjacent to the special care unit.

(7) Emergency Facilities.

(A) As a minimum, hospitals shall provide the following:

1. A sheltered entrance at grade level accessible to the pedestrian and a sheltered ambulance unloading area;

2. At least one (1) treatment room with handwashing facilities, cabinets, medication storage space, work counter, suction and oxygen outlets, X-ray film illuminator and space for storage of emergency equipment;

3. A patient's toilet convenient to the treatment room; and

4. A janitors' closet.

(B) Hospitals providing a fully equipped emergency service shall have, in addition to paragraphs (7)(A)1., 2. and 4. of this rule, the following:

1. A reception and control area convenient to the emergency entrance, waiting room and treatment rooms;

2. Public waiting space with toilet facilities, public telephone and drinking fountain;

3. Storage space for wheelchairs and stretchers out of line of traffic;

4. Clean supply storage space and clean utility facilities; and

5. Soiled work area containing a clinical sink, work counter with handwashing facility and waste and soiled linen receptacles.

(8) Surgical Facilities.

(A) If surgical facilities are provided, the number of operating rooms, recovery beds and the size of the service areas shall be based on the scope of services to be provided.

(B) The surgical suite shall be located and arranged to preclude unrelated traffic through the suite.

(C) Each general operating room shall have a minimum clear area of three hundred sixty (360) square feet exclusive of fixed and movable cabinets and shelves. The minimum dimension shall be eighteen feet (18'). Ceilings shall be at least nine feet six inches (9'6") high to accommodate surgical lights.

(D) Operating rooms for surgical cystoscopic and other endoscopic procedures shall have a minimum clear area of two hundred fifty (250) square feet exclusive of fixed and movable cabinets and shelves.

(E) A control station located to permit visual surveillance of all traffic which enters the operating suite shall be provided.

(F) An emergency communications system connecting the operating rooms and the surgical suite control station shall be provided.

(G) A high speed autoclave shall be conveniently located to serve all operating rooms.

(H) Space for the storage and preparation of medications shall be provided.

(I) A minimum of one (1) scrub station shall be provided for each operating room.

(J) A soiled workroom for the exclusive use of the surgical suite staff or a soiled holding room, that is part of a system for collection and disposal of soiled material, shall be provided. The soiled workroom shall contain a clinical sink or equivalent flushing-type fixture, work counter with a double sink, sink equipped for handwashing, waste receptacle and linen receptacle. A soiled holding room shall be similar to the soiled workroom except that the work counter may be omitted.

(K) A clean workroom or a clean supply room shall be provided. A clean workroom is required when clean materials are assembled within the surgical suite prior to use. A clean workroom shall contain a work counter, sink equipped for handwashing and space for clean and sterile supplies. A clean supply room shall be provided when the program defines a system for the storage and distribution of clean and sterile supplies which would not require the use of a clean workroom.

(L) A separate room shall be provided for storage of flammable anesthetics unless the use of flammable anesthetics is prohibited in writing by hospital board action.

(M) An anesthesia workroom for cleaning, testing and storing anesthesia equipment shall be provided. It shall contain a work counter and sink.

(N) Storage space for equipment and supplies shall be provided.

(O) Appropriate areas shall be provided in the surgical suite for male and female personnel to change clothes. The areas shall contain lockers, showers, toilets, handwashing lavatories and space for donning scrub suits and boots. These areas shall be arranged to provide a one (1)-way traffic pattern so that personnel entering from outside the surgical suite can shower, change and move directly into the surgical suite. Similarly, space shall be designed for the removal of scrub suits and boots in the change area so that personnel using it will avoid physical contact with clean personnel.

(P) Space outside the flow of traffic shall be provided for storage of stretchers.

(Q) A janitors' closet containing a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite.

(R) At least one (1) post-anesthesia recovery room shall be provided. This room shall contain a nurses' station, a drug distribution station, clinical gases, handwashing facilities, clinical sink and storage space.

(S) If the program defines an outpatient surgery load, separate areas shall be provided where outpatients can change clothing. This shall include a waiting room, lockers, toilets, handwashing lavatories and a clothing change or gowning area with a traffic pattern similar to that of the staff clothing change area in subsection (8)(O) of this rule.

(T) If outpatient surgical procedures are performed, a separate recovery area with handwashing facilities shall be provided for those patients not subjected to general anesthesia.

(9) Obstetrical Facilities.

(A) If obstetrical facilities are provided, the number of delivery rooms, labor rooms and recovery beds and the size of the service areas shall depend upon the estimated obstetrical workload as described in the program. The post-partum patient area and the obstetrical suite shall be located and arranged to preclude unrelated traffic through the suite.

(B) Each delivery room shall have a minimum clear area of three hundred (300) square feet exclusive of fixed and movable cabinets and shelves. The minimum dimensions shall be sixteen feet (16'). Ceilings shall be at least nine feet six inches (9'6") high. An emergency communication system shall connect the delivery room with the obstetrical suite control station. Separate resuscitation facilities, including electrical outlets, oxygen outlets, suction outlets and clinical air, shall be provided for newborn infants.

(C) Labor beds shall be provided at the rate of two (2) for each delivery room. In facilities having only one (1) delivery room, two (2) labor rooms shall be provided; and one (1) labor room shall be large enough to function as an emergency delivery room with a minimum of one hundred sixty (160) square feet and shall have at least two (2) oxygen and two (2) suction outlets. All other labor rooms shall be single-bed or two (2)-bed rooms with a minimum clear area of one hundred (100) square feet in single-bed rooms and eighty (80) square feet per bed in two (2)-bed rooms.

(D) Each labor room shall contain a lavatory equipped for handwashing. Each labor room shall have access to a toilet room without entering the corridor. One (1) toilet room may serve two (2) labor rooms.

(E) At least one (1) shower shall be provided for labor room patients.

(F) In facilities having or expecting to have more than one thousand five hundred (1,500) births annually, a recovery room containing not less than two (2) beds shall be provided. This room shall contain handwashing facilities, clinical sink and storage space for supplies and equipment. The room shall be designed to provide at least three feet (3') clear on each side of each recovery bed.

(G) A control station located to permit visual surveillance of all traffic which enters the obstetrical suite shall be provided.

(H) A supervisor's office or station shall be provided.

(I) A high speed autoclave shall be conveniently located to serve all delivery rooms.

(J) A janitors' closet containing a floor receptor or service sink, mop rack and space for equipment shall be provided exclusively for the obstetrical suite.

(K) A nurses' toilet and lounge shall be located near the labor rooms.

(L) Scrub stations shall be provided at the ratio of one (1) for each delivery room.

(M) A soiled workroom or soiled holding room for the exclusive use of the obstetrical suite staff shall be provided. The soiled workroom shall contain a clinical sink or equivalent flushing-type fixture; work counter with double sink, waste receptacle and linen receptacle. A soiled holding room shall be similar to the soiled workroom except that the work counter may be omitted.

(N) A clean workroom or clean supply room shall be provided. A clean workroom with a work counter with sink and storage space for clean and sterile supplies is required when materials are assembled in the obstetrical suite.

(O) An equipment storage room shall be provided. Space shall be assigned for stretcher parking.

(P) Appropriate change areas shall be provided for male and female personnel working within the obstetrical suite. The areas shall contain lockers, showers, toilets, lavatories equipped for handwashing and space for donning scrub suits and boots. These areas shall be arranged to provide a one (1)-way traffic pattern so that personnel entering from outside the obstetrical suite can shower, change and move directly into the obstetrical suite. The space for removal of scrub suits and boots in the change area shall be designed so that personnel using it can avoid contact with clean personnel.

(10) Normal Infant Nursery (if required by program).

(A) The nursery(ies) shall be located in the post-partum nursing unit and as close as possible to the delivery suite. Nurseries shall be located and arranged to preclude unrelated traffic.

(B) No nursery shall open directly into another nursery. If doors are provided to nurseries for emergency evacuation, they shall be operable only from the nursery side and be recessed so as not to swing out into the corridor.

(C) The number of bassinets shall exceed the number of obstetric beds by ten percent (10%) to accommodate multiple births, extended hospitalizations and fluctuating patient loads. When a rooming-in program is used, the total number of bassinets may be reduced, but a nursery must still be provided.

(D) Each nursery shall contain no more than sixteen (16) bassinets.

(E) At least twenty-four (24) square feet of clear floor area shall be provided for each bassinet. At least two feet (2') shall be maintained between each bassinet and an aisle space of at least three feet (3') shall be maintained.

(F) An examining, treatment and work space room with facilities for charting, storage and handwashing shall be provided adjacent to the nursery(ies).

(G) At least one (1) handwashing facility with knee- or foot-action controls and gooseneck spout shall be provided in each nursery.

(H) Space shall be provided for street clothing, cabinets for clean gowns and receptacles for used gowns and other soiled material. This may be a part of the work space mentioned in subsection (10)(F) of this rule if sufficient space is provided.

(I) Observation windows shall be provided between the nursery and the corridor and the nursery and the workroom. Glazing shall be nonshattering glass.

(J) A janitors' closet shall be provided for the exclusive use of the nursery area. It shall contain a floor receptor or service sink and storage space for equipment and supplies.

(K) A room with handwashing facilities shall be provided where mothers may be given instructions and demonstrations in methods of feeding, bathing and dressing their infants.

(11) Observation Nursery (if required by program).

(A) The observation nursery shall provide for infants suspected of having a condition not conducive to care in the normal infant nursery. Normal infants born at home or in-transit may be admitted to the normal infant nursery. If a private post-partum room is provided, the suspect infant may be housed with the mother until it can be admitted to the normal nursery or transferred to another facility.

(B) Floor space shall be provided at the rate of thirty (30) square feet for each bassinet. At least one (1) observation bassinet shall be provided.

(C) At least one (1) handwashing lavatory with knee- or foot-action controls and gooseneck spout shall be provided in the observation nursery. Work space designed for the normal nurseries may serve the observation nursery.

(12) Continuing care, intermediate care and intensive care nursery facilities shall be designed as required by the functional needs of each program. The minimum floor area per infant station shall be forty (40) square feet.

(13) Pediatric Facilities.

(A) If a hospital's program provides for the design and operation of a pediatric unit, it shall be located where the noise will not intrude on the care of others.

(B) Pediatric patient rooms shall comply with requirements established in subsection (6)(D) of this rule when used for hospital beds. Patient rooms used for cribs shall contain a minimum of sixty (60) square feet of clear area for each crib with no more than six (6) cribs in each room.

(C) The nursing station shall be designed to permit observation and communication between small children and the staff.

(D) Toilet facilities, drinking fountains and furniture shall be designed for small children.

(E) Equipment, such as the nurses' call, shall be simple to operate and switches and plugs for critical equipment shall be located out of reach of young patients.

(F) At least one (1) interview room shall be located in or adjacent to the pediatric unit.

(G) A minimum of two hundred (200) square feet of storage space shall be provided within or adjacent to the unit.

(H) At least one (1) isolation room with toilet, sink, shower or tub shall be provided.

(I) An anteroom with sink wrist controls shall provide access to the isolation room from the corridor.

(J) A nurses' station, with a nurses' lounge, physicians' charting area and a medication room shall be provided. The medication room shall have access only through the nurses' station.

(K) A treatment room shall be provided and equipped with an examination table and counter with sink. A treatment room is not required in those nursing units with all private rooms.

(L) An activity room with at least one hundred fifty (150) square feet of space shall be provided.

(M) Clean and soiled workrooms as described in subsections (5)(D) and (E) of this rule shall be provided.

(N) A janitors' facility shall be provided for each pediatric unit.

(O) Showers shall be provided at a ratio of one (1) shower for each ten (10) beds. In addition, one (1) tub room shall be provided.

(14) Dietary Facilities.

(A) Food service facilities shall be designed and equipped to meet the requirements of the scope of services outlined in the program.

(B) To implement the type of food service selected, the following facilities shall be provided and designed:

1. Receiving area;

2. Storage space including cold storage for four (4) days' supply;

3. Space and equipment for food preparation to facilitate efficient food preparation and to provide for a safe and sanitary environment;

4. Conveniently located handwashing facilities;

5. Space for tray assembly and distribution carts;

6. Dining space;

7. Ware washing space located separately and isolated from food preparation and serving area;

8. Three (3)-compartment sinks for pot washing;

9. Storage areas and washing facilities for cans, carts and mobile tray conveyors;

10. Waste stored so it is inaccessible to insects and rodents and accessible to the outside for pickup or disposal;

11. Office space for manager of dietary service accessible to food production area;

12. Staff toilets with handwashing facilities immediately available;

13. Janitors' closet with floor receptor or a service sink and storage space for equipment; and

14. Dietary facilities which comply with 19 CSR 20-1.010.

(15) Radiology.

(A) Space shall be provided for diagnostic and therapeutic purposes as stated in the program.

(B) As a minimum, the radiology suite shall contain the following:

1. Radiographic room. Radiation protection requirements of X ray and gamma-ray installations shall be in accordance with 19 CSR 20-10.010–19 CSR 20-10.190;

2. Film-processing facilities and film-storage facilities;

3. Office and viewing areas;

4. Toilet with handwashing facilities. A toilet shall be accessible from each fluoroscopy room without entering the general corridor;

5. Dressing area;

6. Waiting room or alcove and a control station; and

7. A holding area for stretcher patients which is out of the direct line of normal traffic.

(16) Laboratory.

(A) Laboratory facilities shall be provided in the hospital or through an effective contract arrangement with another laboratory service acceptable to the Department of Health to meet the workload described in the program.

(B) The following minimum services shall be available in the hospital:

1. Laboratory work counter with sink, vacuum, gas and electric services;

2. Handwashing sink;

3. Storage cabinets;

4. Blood storage facilities with temperature recorder and alarms;

5. Urine collection room with water closet and lavatory; and

6. Blood collection facilities with a work counter, handwashing facilities and space for patient seating.

(17) Pharmacy Facilities.

(A) The size and type of services to be provided in the pharmacy will depend upon the type of drug distribution system to be used in the hospital and whether the hospital proposes to provide, purchase or share pharmacy services with other hospitals or other medical facilities. This shall be described in the program.

(B) As a minimum, the following functional areas shall be provided:

1. Dispensing area with handwashing facilities;

2. Editing or order review area;

3. Office and record storage area; and

4. Storage areas for bulk and active supplies, a refrigerator, a vault for narcotics, acceptable safe space for volatile liquids and an area for parental admixtures if appropriate.

(18) Outpatient Clinic Services.

(A) The extent of administrative, clinical and diagnostic facilities provided shall be determined by the services contemplated and the estimated patient load as described in the program.

(B) If the facility is designed as an integral part of the hospital and is intended to serve inpatients as well as outpatients, all applicable requirements relating to general hospital facilities shall apply.

(C) Facilities shall be designed and arranged so they are available and accessible to the physically handicapped.

(D) The entrance shall be at grade level and sheltered from the weather.

(E) The lobby shall include wheelchair storage space, reception and information counter or desk, waiting space, public toilet facilities, public telephone and drinking fountain.

(F) General purpose examination rooms shall have minimum floor areas of eighty (80) square feet, excluding spaces such as vestibule, toilet, closet and work counter. A lavatory or sink equipped for handwashing and a counter or shelf space for writing shall be provided.

(G) Treatment rooms for minor surgical and cast procedures shall have a minimum floor area of one hundred twenty (120) square feet with a minimum room dimension of ten feet (10'). The minimum floor area shall not include spaces used for vestibule, toilet, closet and work counter. A lavatory or sink equipped for handwashing and a counter or shelf space for writing shall be provided.

(H) A nurses' station with a communication system and facilities for charting and storage of clinical records shall be provided.

(I) There shall be a drug storage area.

(J) A clean workroom or clean holding room shall be provided as described in subsection (5)(D) of this rule.

(K) A soiled workroom or soiled holding room shall be provided as described in subsection (5)(E) of this rule.

(19) Central Services.

(A) A separate receiving-decontamination room shall be provided with work space and equipment for cleaning medical and surgical equipment and for disposal of nonreusable material. Handwashing facilities shall be provided. A soiled cart parking space shall be provided.

(B) A clean workroom with space and equipment for sterilizing medical and surgical equipment and supplies shall be provided. At least two (2) pressure sterilizers designed to maintain two hundred fifty degrees Fahrenheit (250°F) or one hundred twenty-one degrees Celsius (121°C) at fifteen pounds (15 lbs.) pressure shall be provided.

(C) Space is to be provided for storage of clean supplies, sterile supplies and clean equipment.

(D) Clean cart-storage space and cart-sanitizing facilities shall be provided.

(20) The area for medical records shall include: review and dictating space; work areas for sorting, recording or microfilming records; storage area for records; and office space for the medical record administrator.

(21) Elevators.

(A) All hospitals having patient-care facilities located on any floor other than the main entrance floor shall have electric or electro-hydraulic elevators.

(B) Numbers of Elevators.

1. At least two (2) hospital-type elevators shall be installed where patient-care facilities are located on any floor other than the main entrance floor.

2. In hospitals with more than two hundred (200) beds located on floors other than the main entrance floor, the number of elevators shall be determined from a study of the hospital operation and the estimated vertical transportation requirements.

(C) Details.

1. Cars of hospital-type elevators shall have inside dimensions that will accommodate a patient bed and attendants and shall be at least five feet (5') wide and eight feet (8') deep. The car door shall have a clear opening of not less than four feet (4').

2. Elevators shall be equipped with an automatic leveling device of the two (2)-way automatic maintaining type with an accuracy of plus or minus one-half inch (± 1/2").

3. Elevators, except freight elevators, shall be equipped with a two (2)-way special service switch to permit cars to bypass all landing button calls and be dispatched directly to any floor.

4. Elevator controls, alarm buttons and telephones shall be accessible to wheelchair occupants.

5. Elevator call buttons, controls and door safety stops shall be of a type that will not be activated by heat or smoke.

6. Elevator hoistway doors shall be rated to maintain the integrity of the enclosure.

(22) Linen and Refuse Chutes (if provided).

(A) Service openings to chutes shall not be located in corridors or passageways but shall be located in a room having a fire-resistance construction of not less than one (1) hour. Doors to the rooms shall be not less than three-fourths (3/4)-hour labeled doors and equipped with a closing device.

(B) Service openings for chutes shall have approved self-closing one and one-half (1 1/2)-hour labeled fire doors.

(C) The minimum diameter of gravity chutes shall be not less than two feet (2").

(D) Chutes shall discharge directly into collection rooms separate from the incinerator, laundry or other services. Separate collection rooms shall be provided for trash and for linen. The enclosure construction for the rooms shall have a fire-resistance of not less than one (1) hour. Doors to these collection rooms shall be three-fourths (3/4)-hour labeled fire doors.

(E) Gravity chutes shall extend full diameter through the roof with provisions for continuous ventilation, as well as for fire and smoke ventilation. Openings for fire and smoke ventilation shall have an effective area of not less than that of the chute diameter and shall terminate not less than four feet (4') above the roof and not less than six feet (6') clear of other vertical surfaces.

(23) Dumbwaiters, Conveyors and Material Handling Systems (if provided).

(A) Dumbwaiters, conveyors and material handling systems, excluding pneumatic tubes, shall not open directly into a corridor or exitway but shall open into a room enclosed by construction having a fire-resistance of not less than one (1) hour and provided with a three-fourths (3/4)-hour labeled fire door with a self-closing device.

(B) Service-entrance doors to vertical shafts containing dumbwaiters, conveyors and material handling systems shall be rated to maintain the integrity of the vertical shaft.

(C) Where horizontal conveyors and material handling systems penetrate fire-rated walls, openings shall be provided with one and one-half (1 1/2)-hour labeled fire doors. Where they penetrate smoke partitions, openings shall be provided with three-fourths (3/4)-hour labeled fire doors.

(24) Fire Prevention and Protection for New and Existing Facilities.

(A) If a facility is located outside of a service area or range of a public fire department, arrangements shall be made to have the nearest fire department respond in the case of fire. A copy of the agreement shall be kept on file in the facility and a copy shall be forwarded to the Department of Health. If the agreement is changed, a copy shall be forwarded to the Department of Health.

(B) General Operating Requirements.

1. Every required exit, exit access or exit discharge shall be maintained free of any obstructions or impediments at all times.

2. Automatic extinguishment systems, fire detection and alarm systems, smoke containment and evacuation systems, exit lighting, fire and smoke doors and other equipment required by this rule shall be tested at intervals not to exceed six (6) months and shall be continuously maintained in proper operating condition.

3. Fire-retardant protective coatings shall be applied to paneling and other materials at intervals as necessary to maintain the required flame-retardant properties.

4. All draperies, curtains and cubicle curtains shall be inherently flame retardant or treated and maintained to retard flame.

5. A written fire safety and evacuation plan shall be available to all personnel. The plan shall provide for the protection of all persons in the event of fire and for their evacuation to areas of refuge in or outside the building when necessary. All employees shall be periodically instructed and kept informed respecting their duties under the plan.

6. Fire drills shall be held at least quarterly for each shift and shall include the simulated use of fire alarm signals and simulation of emergency fire conditions. The movement of patients is not required.

7. Smoking shall be prohibited in any room, ward or compartment where flammable liquids, combustible gases or oxygen are used or stored and in any other hazardous location. The areas shall be posted with NO SMOKING signs.

8. The policies shall prohibit smoking throughout the hospital other than in specific designated areas where smoking may be permitted.

9. Combustible decorations are prohibited unless they have been treated to retard flame.

10. Wastebaskets and other waste containers shall be of noncombustible material.

11. Class A portable fire extinguishers shall be provided and located to provide the capability to fight fires in ordinary combustible material such as wood, cloth, paper and rubber. Class B and Class C portable fire extinguishers shall be provided and located to provide the capability to fight fires from flammable liquids, gases or grease and in energized electrical equipment. Portable fire extinguishers rated ABC may be used in lieu of Class A, Class B and Class C fire extinguishers. Special situations such as computer rooms may require specific types of fire extinguishers.

12. Fire extinguishers shall be recharged after use or as indicated by inspection.

(C) Life Safety Requirements.

1. New facilities, additions to existing facilities and alterations to existing facilities built in accordance with Chapters 5, 6, 7 and 12 of the *Life Safety Code 1981, Standards for the Installation of Air Conditioning and Ventilating Systems 1978* and *Standard for the Installation of Sprinkler Systems 1980*, all published by the National Fire Protection Association, shall be considered to be in full compliance with this rule if they also comply with subparagraph (24)(C)2.A. of this rule.

2. As a minimum, all new hospitals, additions to existing hospitals and alterations to existing facilities shall comply with the following:

A. An automatic extinguishment system shall be installed in accordance with the *Standard for the Installation of Sprinkler Systems 1980* published by the National Fire Protection Association. Operating rooms, X-ray rooms, delivery rooms, telephone equipment rooms, electrical switchgear and distribution rooms and special care areas may be exempted from sprinkler coverage, provided they are separated from other areas by one (1)-hour fire-resistive construction and provided with smoke detectors;

B. Health care buildings of only one (1) story in height shall be constructed according to one (1) of the following types: I (443); I (332); II (111); II (222); II (000) or III (210) as described in the *Standard Types Building Construction 1979* published by the National Fire Protection Association. All buildings with more than one (1) level below the level of exit discharge shall have all lower levels separated from the level of exit discharge by at least Type II (111) construction;

C. Buildings two (2) stories or more in height shall be of Type I (443), Type I (332) or Type II (222) construction as described in the *Standard Types Building Construction 1979* published by the National Fire Protection Association;

D. Stairways, ramps, elevators hoistways, light or ventilation shafts, chutes and other vertical openings between stories shall be enclosed with construction having at least a one (1)-hour fire-resistance rating in buildings up to and including three (3) stories. In buildings of more than three (3) stories, all

vertical openings shall be enclosed with construction having a two (2)-hour fire-resistance rating;

E. Doors in stair enclosures shall be self-closing and shall be kept in a closed position. Exit doors shall bear a sign visible only in the direction of exit travel stating FIRE EXIT, KEEP DOOR CLOSED;

F. All interior walls and partitions shall be of noncombustible materials;

G. Openings for the passage of ducts, pipes or conduits in floors, walls or partitions that are required to have fire- or smoke-resisting capability shall be protected by filling the space between the penetrating item and the barrier with material which will maintain the rating of the barrier;

H. Types of exits shall be limited to—doors leading directly outside the building, interior stairs, smoke-proof towers, horizontal exits, and exit passageways;

I. At least two (2) exits of the types described in paragraphs (24)(C)2.–4. of this rule shall be provided for each floor or fire section of the building. These exits shall be remote from each other;

J. Horizontal exits.

(I) At least thirty (30) net square feet per patient shall be provided within the aggregated area of corridors, patient rooms, treatment rooms, lounge and other low hazard areas on each side of the horizontal exit. On floors other than patient floors, at least six (6) square feet per occupant shall be provided on each side of the horizontal exit for the total number of occupants in adjoining compartments.

(II) Partitions in a horizontal exit shall have a two (2)-hour fire rating and doors shall have a one and one-half (1 1/2)-hour fire rating.

(III) A single door may be used in a horizontal exit if it serves one (1) direction only and is at least forty-four inches (44") wide.

(IV) A horizontal exit in a corridor eight feet (8') or more in width serving as a means of egress from both sides of the exit shall have the opening protection by a pair of swinging doors each arranged to swing in the opposite direction from the other, with each door leaf being at least forty-four inches (44") wide.

(V) A vertical vision panel twenty-four inches by four inches (24" × 4") of wire glass in steel frame shall be provided in each horizontal exit door. Center mullions are prohibited;

K. Every patient sleeping room shall have an exit access door leading directly to an exit-access corridor unless there is an exit door opening directly to the outside from the room at ground level. One (1) adjacent room, such as a sitting or anteroom, may intervene if all doors along the means of egress are equipped with nonlockable hardware and if the intervening room is not used to serve as an exit access for more than eight (8) patient sleeping beds. This requirement shall not apply to special care units with supervised nursing care;

L. Aisles, corridors and ramps required for exit access from inpatient areas in a hospital shall be at least eight feet (8') in clear and unobstructed width. Aisles, corridors and ramps in areas not intended for the housing, treatment or use of patients may be a minimum of forty-four inches (44") in clear and unobstructed width;

M. Rooms and any suite of rooms of more than one thousand (1,000) square feet shall have at least two (2) exit access doors remote from each other;

N. Patient sleeping rooms may be subdivided with noncombustible partitions, provided that the arrangement allows for direct and constant visual supervision by nursing personnel. Rooms which are so subdivided shall not exceed five thousand (5,000) square feet. If the space is equipped with an electrically supervised smoke detection system, direct visual supervision is not required;

O. Every corridor shall provide access to at least two (2) approved exits. Means of egress shall not pass through any intervening rooms or spaces other than corridors or lobbies;

P. Every exit or exit access shall be so arranged that no corridor, aisle or passageway has a pocket or dead end exceeding thirty feet (30');

Q. Travel distance between any patient room door and an exit shall not exceed one hundred fifty feet (150'). Travel distance between any point in a room and an exit shall not exceed two hundred feet (200') and travel distance between any point in a hospital sleeping room or suite and an exit access door of that room or suite shall not exceed fifty feet (50');

R. All required exit ramps or stairs shall discharge directly to the outside at grade or be arranged so travel is through an exit passageway discharging to the outside at grade;

S. Doors leading directly to the outside of the building may be subject to locking from the room side provided the door can be opened from the inside without the use of a key;

T. Soiled linen rooms, paint shops, trash collection rooms and rooms or spaces, including repair shops used for the storage of combustible supplies and equipment in quantities deemed hazardous by the Department of Health, shall be separated from adjacent areas by construction having a one (1)-hour fire-resistance rating;

U. Laboratories employing quantities of flammable, combustible or hazardous materials which are considered a severe hazard shall be protected in accordance with the *Safety Standards for Laboratories in Health-Related Institutions 1980* published by the National Fire Protection Association;

V. Walls and ceilings throughout shall have a Class B interior finish with one (1) exception: individual rooms of not over four (4) patients in capacity may have a Class C interior finish in accordance with Section 6-5 of the *Life Safety Code 1981* published by the National Fire Protection Association;

W. Floors throughout the facility shall have a Class II interior floor finish as described in Section 6-5 of the *Life Safety Code 1981* published by the National Fire Protection Association;

X. Corridors shall be separated from all other areas by partitions. Partitions shall be of noncombustible construction and may terminate the suspended ceiling. Corridor partitions shall form tight joints with the ceiling;

Y. Vision panels in corridor partitions shall be constructed to resist the passage of smoke;

Z. Doors in corridor partitions shall be constructed to resist the passage of smoke and shall be provided with latches of a type suitable for keeping the door tightly closed;

AA. Smoke barriers shall be provided, regardless of building construction type, to divide into at least two (2) compartments every story used by inpatients for sleeping or treatment or any story having an occupant load of fifty (50) or more persons and to limit on any story the length and width of each smoke compartment to no more than one hundred fifty feet (150'). Horizontal exits may serve as smoke barriers;

BB. Smoke barriers shall have a fire-resistance rating of at least one (1) hour;

CC. Doors in smoke barriers shall be substantial doors, such as one and three-fourth inches (1 3/4") thick solid-bonded core wood or construction that will resist fire for at least twenty (20) minutes. Each door leaf shall have a wireglass vision panel not exceeding one thousand two hundred ninety-six (1,296) square inches in metal frames. Corridor openings in smoke barriers shall be protected by a pair of swinging doors, each door to swing in a direction opposite from the other. The minimum door leaf width shall be forty-four inches (44"); and

DD. Doors in smoke barriers shall be self-closing or they may be held open by an

automatic release device which shall be connected to a manual alarm system, an automatic smoke detection system and a complete automatic fire-extinguishing system. Activation of any of these three (3) systems shall initiate the closing action of all doors by zone or throughout the entire facility.

(25) Construction.

(A) Every building and every portion of it shall be designed and constructed to sustain all dead and live loads in accordance with accepted engineering practices and standards.

(B) Foundations shall rest on natural solid bearing if a satisfactory bearing is available at reasonable depths. Proper soil-bearing values shall be established in accordance with recognized standards. If solid bearing is not encountered at practical depths, the structure shall be supported on driven piles or drilled piers designed to support the intended load without detrimental settlement; except that one (1)-story buildings may rest on a fill designed by a soils engineer. When engineered fill is used, site preparation and placement of fill shall be done under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certify its compliance with the job specifications. All footings shall extend to a depth not less than one foot (1') below the estimated maximum frost line.

(26) Electrical Systems.

(A) General Requirements.

1. Materials used in installations shall be listed as complying with standards of Underwriters' Laboratories, Inc. or a similar recognized agency where the standards have been established.

2. After completion, all electrical systems shall be tested and demonstrated to show satisfactory compliance with the specified performance criteria and installation requirements. A written record of the results of performance tests made on special systems and equipment shall be furnished to the owner. Special systems shall include: high voltage cable "hi-pot" direct current test, isolated power systems leakage currents, conductive floors resistance values, equi-potential grounding systems continuity tests, fire alarm and smoke detection systems, emergency and disaster loud-speaker systems, patient emergency call system, all other alarm systems, and standby emergency generator power, lighting and automatic transfer systems.

(B) Two (2) separate sources for electrical supply, a normal source and an alternate source, shall be provided. The normal source shall supply full-load requirements continuously with the alternate source supplying power on an emergency basis to selected circuits when normal power supply is interrupted. One (1) alternate source shall be an on-site engine-driven generator facility utilizing on-site fuel.

(C) Switchgear and Switchboards.

1. Incoming line switchgear for primary voltage electrical services or distribution switchboards for secondary voltage electrical services shall consist of dead-front metal enclosed assemblies of automatic circuit breakers or fused switches arranged to provide service-disconnecting means and overcurrent and short-circuit protection for entrance feeders and for distribution feeder conductors.

2. Switchgear, switchboards, panelboards, switches and other equipment of the main service and distribution systems for both normal and emergency power shall be installed in separate dry, ventilated rooms which have a one (1)-hour fire rating and are reserved exclusively for electrical equipment. Piping of utility service systems carrying water or other liquids shall not be installed in the electrical equipment room.

3. Ratings of switchgear and switchboard assemblies shall ensure that maximum available short-circuit currents are safely interrupted.

(D) Panelboards.

1. Panelboards supplying lighting and receptacle and appliance-branch circuits shall be located on the same floor as the loads they serve. Each outlet shall be located no farther than one hundred feet (100') from its supplying panelboard.

(E) Standby Emergency Electric Service.

1. An on-site engine-driven emergency generator utilizing on-site fuel shall be provided to deliver electrical power during an interruption of normal power supply. There shall be sufficient fuel on site to ensure continuous operation for twenty-four (24) hours.

2. Engine-generators shall be installed in separate dry, ventilated rooms which have a one (1)-hour fire rating and are reserved exclusively for the engine-generator system equipment. Piping of utility service systems carrying water or other liquids which are not serving the engine-generator system shall not be installed within the engine-generator room.

3. Standby emergency generators shall be installed and arranged so that full voltage and frequency is available and supplying power to emergency loads within ten (10) seconds after normal power is interrupted.

4. Automatic emergency electric service shall be provided to elements of the distribution system as follows:

A. Circuits essential for the safety of patients and personnel shall include:

(I) Illumination of means of egress;

(II) Illumination for exit signs and exit directional signs;

(III) Task illumination for major electrical equipment, major mechanical equipment, pumps, elevator machinery, telephone switchboard and standby generator;

(IV) Alarm systems including fire alarms activated by manual stations, waterflow alarm devices of the sprinkler system, fire and smoke detecting systems and alarms required for blood banks and medical gas systems;

(V) Paging or speaker systems if intended for communication of emergency and disaster calls during outage of normal power. Radio transceivers where installed for emergency use shall be capable of operating for at least one (1) hour upon total failure of both normal and emergency power; and

(VI) General illumination and at least one (1) receptacle in the vicinity of standby generators;

B. Circuits essential to care, treatment and protection of patients shall include:

(I) Task illumination and at least one (1) receptacle serving the following areas and functions related to patient care: anesthetizing locations, infant nurseries with a minimum of one (1) receptacle for each station, medication preparation areas, pharmacy dispensing areas, psychiatric patient areas, treatment rooms, nurses station, angiographic room, cardiac catheterization room, emergency treatment rooms, human physiology laboratories and the headwall of each patient room; and

(II) Task illumination and all receptacles for—operating rooms, delivery rooms and labor rooms and recovery rooms, special care units, acute hemodialysis rooms, postoperative recovery areas, nurses' call systems, bone and tissue banks, telephone equipment room, closets and blood banks;

C. Power circuits which serve the following equipment shall be arranged for automatic connection to the standby emergency service: central suction systems serving medical and surgical functions; clinical air systems serving medical and surgical functions, if installed; sump pumps and other equipment required to operate for the safety of major equipment; fire pump, if installed; and smoke ventilation and evacuation systems, if installed; and

D. Power circuits shall be arranged for either delayed automatic or manual

connection to the standby emergency electrical service for the following equipment:

(I) Equipment for comfort heating of operating, delivery, labor and recovery rooms; special care areas; nurseries; and general patient rooms. If the comfort heating system of a facility utilizes electricity as the energy source, standby emergency electric service shall be connected to the heating equipment of rooms, corridors and other spaces in which general care patients are located;

(II) One (1) or more elevators selected to provide service to all floors. Throw-over facilities shall be provided to permit temporary operation of all elevators for the release of patients or other persons from elevator cabs which may be trapped between floors;

(III) Supply and exhaust ventilating systems for surgical and obstetrical delivery suites, infant nurseries, isolation rooms, emergency treatment spaces and laboratory fume hoods;

(IV) Hyperbaric and hypobaric facilities, if provided; and

(V) Automatically operated doors.

5. Receptacles connected to the standby emergency electrical system shall be permanently and distinctively identified in a uniform manner.

6. All wiring for equipment and systems essential to the safety of patients and personnel and for care, treatment and protection of patients shall be kept entirely independent of all other wiring, and equipment and shall not enter the same raceways, boxes or cabinets with other wiring, except when located in transfer switches and in exit or emergency lighting fixtures or in a common junction box attached to exit or emergency lighting fixture.

(F) Nurses' Call Systems.

1. Patient nursing units.

A. In general, patient areas and each patient room shall be served by at least one (1) calling station and each bed shall be provided with a call button. Two (2) call buttons serving adjacent beds may be served by one (1) calling station.

B. A nurses' call emergency station button or switch shall be provided for patients' use at each toilet, bath, sitz bath and shower room intended for patient use. The station shall be accessible to a collapsed patient lying on the floor. Inclusion of a pull cord will satisfy this requirement.

C. Calls shall register at a nurse station or other floor unit station to indicate location of call placed and shall actuate a visible signal in the corridor at the patients' room door, in the clean workroom, the soiled workroom and the nourishment station of the nursing unit.

D. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections.

E. In rooms containing two (2) or more calling stations, indicating lights shall be provided at each station.

F. Nurses' calling systems which provide two (2)-way communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operating.

2. In special care units such as intensive care or coronary care where patients are under constant surveillance, the nurses' calling system may consist of a bedside station that will actuate an audible and visual signal that can be readily observed.

3. Patient treatment specialty areas.

A. Emergency calling stations which may be used to summon assistance shall be provided in—operating rooms; delivery and labor rooms, recovery rooms, nurseries and special care units.

B. Each toilet intended for patient use within diagnostic and treatment areas shall be provided with an emergency call station which shall activate an audible and visual signal within the unit.

(G) Lighting Systems.

1. All spaces occupied by people, machinery and equipment within buildings, approaches to buildings and parking lots shall be equipped with artificial lighting.

2. Operating and delivery rooms shall have general lighting in addition to local lighting provided by special lighting units at the surgical and obstetrical tables. Each fixed special lighting unit at the tables, except for portable units, shall be connected to an independent circuit.

3. Nursing unit corridors shall have general illumination with provisions for reduction of light level at night.

4. Emergency lighting requirements shall be in accordance with paragraphs (26)(E)1.–4. of this rule and the *Standard for Essential Electrical Service for Health Care Facilities 1977* published by the National Fire Protection Association.

(H) Convenience Receptacles.

1. Patient areas.

A. As a minimum, each patient room shall have one (1) duplex grounding-type receptacle located in the headwall on each side of each bed. One (1) duplex receptacle between beds of a two (2)-patient room may satisfy requirements for one (1) side of each bed. One (1) duplex grounding-type receptacle shall be provided for television, if used; one (1) for the electric bed, if used; and one (1) for each inside wall.

B. Nurseries shall have not less than one (1) duplex grounding-type receptacle for each bassinet station.

C. Receptacles in each pediatric and psychiatric room shall be of the safe type or shall be provided with an on-off switch control located outside the patient sleeping room at a controlled or supervised location.

2. Corridors.

A. Duplex grounding-type receptacles of at least twenty (20) amperes for general use and for floor cleaning equipment shall be located approximately fifty feet (50') apart in all corridors.

B. Receptacles in corridors of pediatric and psychiatric units shall be of the safety type or shall be controlled by switches located at a nurses' station or other secure location.

3. Anesthetizing locations.

A. Each operating and delivery room shall have at least three (3) receptacles. Receptacles in anesthetizing areas shall comply with the *Standard for Inhalation Anesthetics 1980* published by the National Fire Protection Association.

B. In each anesthetizing location where line voltage mobile X ray is used, an additional receptacle distinctively marked for X-ray use shall be provided.

C. All electrical equipment and devices, receptacles and wiring shall comply with the *Standards for Inhalation Anesthetics 1980* published by the National Fire Protection Association.

4. Special areas.

A. X-ray installations. Fixed and mobile X-ray equipment installations shall conform to Article 517 of *The National Electrical Code 1981* published by the National Fire Protection Association.

B. X-ray film illuminator units. At least one (1) double unit shall be installed in each operating room and in the X-ray viewing room of the radiology department.

C. Ground-fault interrupters. The electrical circuit(s) to equipment in wet areas shall be provided with five (5) milliampere ground fault interrupters. Wet areas include hydrotherapeutic tanks, if used, hydro-massage tubs, if used, and other locations identified by hospital administration. Where ground fault interrupters are used in critical areas, provision shall be made to ensure that other essential equipment will not be affected by a single interruption.

D. When the program requires a special grounding system to be installed in special care areas, the system shall comply with Article 517 of *The National Electrical Code*

1981 published by the National Fire Protection Association.

(I) Fire Detection and Alarm Systems.

1. Approved, electrically supervised manual and automatic detection and alarm systems shall be provided in accordance with Chapter 12 of *Life Safety Code 1981* published by the National Fire Protection Association.

2. Manual alarm initiating devices shall be installed in the following locations: each exit from the fire area but no farther than one hundred fifty feet (150') from any point on the floor and installations shall be located so that no more than one hundred fifty feet (150') of horizontal distance on the same floor must be traveled to reach a station; at each nurses' station or other patient care control station and at the telephone switchboard.

A. Automatic smoke detectors shall be installed in all corridors throughout the building spaced no more than seventy-five feet (75') apart and no more than thirty feet (30') from the ends of corridors. The automatic smoke detection system shall be electrically interconnected with the fire alarm system and the sprinkler system.

B. Water-flow switches of the sprinkler systems shall be connected into the fire alarm system to function as an automatic alarm initiating device.

3. Alarm signals shall provide audible indication of fire and shall be located and of a character that they can be effectively heard in all areas of the building above the ambient noise level of normal occupancy conditions.

4. Operation of any alarm initiating device, either manual or automatic, shall cause the following actions to automatically occur within a building: all alarms shall be activated on the fire floor, on the floor above and on the floor below; alarms shall be activated in at least one (1) continuously supervised location; an alarm shall be transmitted to the fire department or to an approved central station located outside the premises; zone annunciators shall be energized to indicate location of alarm initiation; smoke doors shall release and close on the fire floor, on the floor above and on the floor below; smoke dampers shall release and close on the fire floor to isolate the smoke zone and smoke ventilation and evacuation systems, if installed, shall be activated.

5. Zone annunciators shall be located at the switchboard and in at least one (1) continuously supervised location.

6. The smoke ventilation and evacuation system, if installed, shall be designed so operation of a manual pull station will not actuate it.

(27) Mechanical Systems.

(A) General Requirements.

1. Prior to completion and acceptance of the facility, all heating, ventilating and air-conditioning systems shall be tested, balanced and operated to demonstrate to the owner or his/her representative that the installation and performance of these systems conform to the requirements of the plans and specifications.

2. Upon completion of the contract, the owner shall be furnished with a complete set of manufacturer's operating, maintenance and preventive maintenance instructions and parts lists and procurement information with numbers and description for each piece of equipment and test results. The owner also shall be provided with instruction in the operational use of systems and equipment.

3. The heating, ventilating and air-conditioning system shall be capable of providing the temperatures and humidifies in the following areas:

Area Designation	Temperature		Relative Humidity (%)	
	F°	C°	Min.	Max.
Operating Rooms	68–76	20–24	50	60
Delivery Rooms	70–76	21–24	50	60
Recovery Rooms	75	24	30	60
Intensive Care Rooms	72–78	22–26	30	60
Nursery Units	75	24	30	60
Special Care Nursery Unit	75–80	24–27	30	60
Patient Care, Treatment, Diagnostic and Related Areas	72–78	22–26	30	60

4. The heating system shall be capable of maintaining an indoor winter temperature of seventy-five degrees Fahrenheit (75°F) in all other areas occupied by inpatients. The heating system shall be capable of maintaining an indoor winter temperature of seventy-two degrees Fahrenheit (72°F) in all nonpatient areas.

5. The boiler plant shall have the capacity to supply the normal utility requirements of all systems and equipment.

6. The number and arrangement of boilers shall be such that when one (1) boiler breaks down or is shut down for routine maintenance the remaining boiler(s) shall be capable of carrying the normal building load.

7. The boilers may be fired by coal, fuel oil, natural gas, liquid propane gas or electricity. All boilers shall be suitable for dual fuel firing with the standby fuel stored on-site. The amount of on-site fuel storage shall be adequate for ninety-six (96) hours of continuous firing at design load. In the case of electric boilers or total electric installations, the dual fuel requirement may be waived depending on the type of electric service and sources of supply to the building.

8. If coal-fired boilers are used, stack effluent shall comply with both state and federal environmental standards.

9. Boiler feed pumps, heating circulating pumps, condensate return pumps and fuel oil pumps shall be furnished in duplicate to provide normal and standby service.

10. Steam boiler plants operating above twenty pounds per square inch (20 psi) shall be designed to supply zero (0) oxygen boiler feedwater to the boilers.

11. Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and to limit temperatures in working stations to no more than ninety-seven degrees Fahrenheit (97°F).

(B) Heating, Ventilating and Air-Conditioning Systems.

1. All air supply, return and exhaust systems shall be mechanically operated.

2. All heating, ventilating and air-conditioning systems shall be designed to maintain general pressure relationships and ventilation rates as shown in Table 1 in paragraph (27)(B)3. of this rule.

3. See Table 1.

4. Constant volume systems shall be used in all areas of the hospital listed in Table 1 in paragraph (27)(B)3. of this rule; variable air-volume systems may be used in areas not listed in this table and where direct patient care is not affected. Consideration may be given to special design innovations in areas of Table 1, provided that pressure relationship as an indication of direction of air flow and total number of air changes during occupied periods in those areas listed in Table 1 are maintained.

Table 1
General Pressure Relationship and Ventilation of Certain Hospital Areas

Area Designation	Pressure Relationship to Adjacent Areas	Minimum Air Changes of Air per Hour Supplied to Room	Minimum Total Air Changes per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated Within Room Units
Operating Room (for recirculating air system)	P	5	25	Optional	No
Operating Room (all-outdoor-air system)	P	15	15	Yes	No
Trauma Room	P	5	12	Optional	No
Examination and Treatment Room	E	2	6	Optional	Optional
Delivery Room	P	5	12	Optional	No
Nursery Unit	P	5	12	Optional	No
Recovery Room	P	2	6	Optional	No
Intensive Care	P	2	6	Optional	No
Patient Room	E	2	2	Optional	Optional
Patient Room Corridor	E	2	2	Optional	Optional
Isolation Room		2	6	Yes	No
Isolation Room—Alcove or Anteroom		2	10	Yes	No
Examination Room	E	2	6	Optional	Optional
Medication Room	P	2	4	Optional	Optional
Pharmacy	P	2	4	Optional	Optional
Treatment Room	E	2	6	Optional	Optional
X-ray Fluoroscopy	N	2	6	Yes	No
X-ray, Other Diagnostic Rooms	V	2	6	Optional	Optional
Physical Therapy and Hydrotherapy	N	2	6	Optional	Optional
Soiled Workroom or Soiled Holding	N	2	10	Yes	No
Clean Workroom or Clean Holding	P	2	4	Optional	Optional
Autopsy	N	2	12	Yes	No
Darkroom	N	2	10	Yes	No
Nonrefrigerated Body Holding Room	N	Optional	10	Yes	No
Toilet Room	N	Optional	10	Yes	No
Bedpan Room	N	Optional	10	Yes	No
Bathroom	N	Optional	10	Yes	No
Janitor's Closet	N	Optional	10	Yes	No
Sterilizer Equipment Room	N	Optional	10	Yes	No
Linen and Trash Chute Rooms	N	Optional	10	Yes	No
Laboratory, General	N	2	6	Optional	Optional
Laboratory, Media Transfer	P	2	4	Optional	No
Food Preparation Centers	E	2	10	Yes	No
Warewashing	N	Optional	10	Yes	No
Dietary Day Storage	V	Optional	2	Optional	No
Laundry, General	V	2	10	Yes	No
Soiled Linen Sorting and Storage	N	Optional	10	Yes	No
Clean Linen Storage	P	Optional	2	Optional	Optional
Anesthesia Storage Central Services	V	Optional	8	Yes	No
Soiled or Decontamination Room	N	2	6	Yes	No
Clean Workroom	P	2	4	Optional	Optional
Equipment Storage	V	Optional	2	Optional	Optional

P = Positive N = Negative E = Equal V = May Vary

For maximum energy conservation, use of a recirculated filtered air system is preferred. An all-outdoor-air system may be used, where required by local codes, provided that appropriate heat recovery procedures are utilized for exhaust air. Heat recovery systems should be utilized where appropriate, especially for those areas where all air is required to be exhausted to the outside. Requirements for outdoor air changes may be deleted or reduced and total air changes per hour supplied may be reduced to 25% of the figures listed when the affected room is unoccupied and ***unused*** provided that indicated pressure relationship is maintained. In addition, positive provisions such as an interconnect with room lights must be included to insure that the listed ventilation rates including outdoor air are automatically resumed upon reoccupancy of the space. This exception does not apply to certain areas such as toilets and storage which would be considered as in use even though unoccupied.

Rooms normally used for diagnostic X rays and only ***occasionally*** for fluoroscopic procedures may utilize recirculated air without requirements for all air to be exhausted directly to outdoors.

5. Wall intake boxes are prohibited as an acceptable means of introducing the required two (2) air changes of outside air into patient rooms. If incremental, electrohydronic or fan coil units are used, a separate system of one hundred percent (100%) outside air properly tempered year-round shall be used to introduce outside air to the patient rooms. This air quantity shall equal the amount of air being exhausted from the patient room's toilet room, but in no case shall it be less than two (2) air changes per hour. If incremental heating, ventilating and air conditioning units are used, the ventilating air passages shall be permanently closed.

6. Outside air intakes shall be located no less than twenty-five feet (25') from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical clinical suction discharges and plumbing vent stacks or from areas which may collect vehicular exhaust and other noxious fumes. Plumbing and vacuum vents that terminate above the level of the top of the air intake may be located as close as ten feet (10'). The bottom of outside air intakes serving central systems shall be located no less than six feet (6') above ground level, or if installed above the roof, no less than three feet (3') above the roof level.

7. All air supplied to operating rooms, delivery rooms and nurseries shall be delivered at or near the ceiling of the area served. All air returned from operating rooms, delivery rooms and nurseries shall be removed near the floor level.

8. At least two (2) return air outlets located remote from each other shall be provided in each operating and delivery room.

9. The bottoms of ventilation (supply and return) openings shall not be less than six inches (6") above the floor of any room except as indicated in paragraph (27)(B)7. of this rule.

10. Corridors shall not be used to supply air to or exhaust air from any room, except that air from corridors may be used to ventilate bathrooms, toilet rooms, janitors' closets and small electrical or telephone closets opening directly onto corridors provided that ventilation can be accomplished by undercutting of doors.

11. Medical isolation rooms and intensive care rooms may be ventilated by induction units if the induction units contain only a reheat coil and if only the primary air supplied from a central system passes through the reheat coil.

12. All central ventilation of air-conditioning systems shall be equipped with filters having efficiencies no less than those specified in Table 2 in paragraph (27)(B)16. of this rule. Where two (2) filter banks are required, filter bank number 1 shall be located upstream of the air-conditioning equipment and filter bank number 2 shall be downstream of the supply fan, recirculating spray water systems, water reservoir-type humidifiers and cooling coils. Drift eliminators shall be used downstream of cooling coils to prevent the carry-over of moisture from the cooling coils to filter bank number 2. Where terminal filters are used in operating rooms and delivery rooms, the second filter bank may be located immediately downstream of the first filter bank.

13. Where only one (1) filter bank is required, it shall be located upstream of the air-conditioning equipment unless an additional pre-filter is employed. In this case, the pre-filter shall be upstream of the equipment and the main filter may be located farther downstream.

14. Filter frames shall be durable and carefully dimensioned and shall provide an airtight fit with the enclosing ductwork. All joints between filter segments and the enclosing ductwork shall be gasketed or sealed to provide a positive seal against air leakage.

15. A manometer shall be installed across each filter bank serving sensitive areas or central air systems.

16. **Table 2**

Filter Efficiencies for Central Ventilation and Air-Conditioning Systems in General Hospitals

Area Designation	Minimum Number of Filter Beds	Filter Efficiencies	
		Filter Bed #1	Filter Bed #2
		(%)	(%)
Operating Rooms, Delivery Rooms, Nurseries, Recovery Rooms and Intensive Care Units	2	25	90
Patient Care, Treatment, Diagnostic and Related Areas	2	25	90*
Food Preparation Areas and Laundries	1	80	–
Administrative, Bulk Storage and Soiled Holding Areas	1	25	–

*May be reduced to 80% for systems using all-outdoor-air.

17. Ducts which penetrate construction intended for X-ray or other ray protection shall not impair the effectiveness of the protection.

18. Fire and smoke dampers shall be constructed, located and installed in accordance with the *Standard for the Installation of Air Conditioning and Ventilating Systems 1978* published by the National Fire Protection Association. All fire and smoke dampers shall be accessible for servicing.

19. Supply, return air and exhaust ducts which pass through a smoke partition shall be provided with dampers at the partition and controlled to close automatically to prevent flow of air or smoke when a smoke detector located in the duct or at the smoke partition is actuated. Dampers shall be equipped with remote control reset devices. On high-velocity systems, a time delay shall be provided so the fan will be stopped prior to damper closing. Engineered smoke evacuation systems will be considered for approval on a case-by-case basis.

20. If the air changes required in Table 1 in paragraph (27)(B)3. of this rule do not provide sufficient air for use by hoods and safety cabinets, additional make-up air shall be provided as necessary to maintain the required room pressure relationship.

21. Laboratory hoods shall meet the following general requirements: have an average face velocity of not less than seventy-five feet (75') per minute, be connected to an exhaust system which is separate from the building exhaust system, have an exhaust fan located at the discharge end of the system and have an exhaust duct system of noncombustible corrosion-resistant material designed to meet the planned usage of the hood.

22. Each laboratory hood which processes infectious or radioactive materials shall have a minimum face velocity of one hundred feet (100') per minute, shall be connected to an independent exhaust system shall have filters with a ninety-nine and ninety-seven one-hundredths percent (99.97%) efficiency in the exhaust stream; and shall be designed and equipped to permit the safe removal, disposal and replacement of contaminated filters.

23. Duct systems serving hoods in which radioactive strong oxidizing agents are used shall be constructed of stainless steel for a minimum distance of ten feet (10') above the hood and shall be equipped with washdown facilities.

24. Exhaust hoods in food preparation centers shall comply with the requirements of *The Standards for the Installation of Equipment for the Removal of Smoke and Grease-Laden Vapors From Commercial Cooking Equipment 1980* published by the National Fire Protection Association. All hoods and cooktop surfaces shall be equipped with automatic fire suppression systems, automatic fan controls and fuel shutoff.

25. The ventilation system for anesthesia storage rooms shall comply with *The*

Standard for Inhalation Anesthetics 1980 published by the National Fire Protection Association.

(C) Piping systems shall be run in spaces that are generally accessible for maintenance and repair. Piping shall be installed with adequate provision for expansion and contraction and securely supported from the structure.

1. Reverse return piping systems shall be utilized where necessary to maintain water temperatures.

2. Connections between dissimilar metals shall be equipped with insulating unions or flanges.

3. Valves shall be installed in branches from mains or risers in order to isolate sections of both the hot or chilled water systems. All risers shall be equipped with drain valves and vent cocks.

4. Valves shall be installed at all equipment connections for ease in servicing equipment.

(D) Duct systems shall be fabricated and installed in accordance with the *Standard for Installation of Air Conditioning and Ventilating Systems 1978* published by the National Fire Protection Association.

(E) Insulation.

1. Insulation shall be installed in accordance with the *Commercial and Industrial Insulation Standards Manual* of the Midwest Insulating Contractors Association (MICA).

2. Insulation shall be provided for the following: boilers, smoke breeching and stacks; steam supply and condensate return piping; hot water piping above one hundred degrees Fahrenheit (100°F) and all hot water heaters, generators and converters; chilled water piping, refrigerant piping and other process piping and equipment operating with fluid temperatures below the ambient dew point; water supply and drainage piping on which condensation may occur; air ducts and casings with outside surface temperature below the ambient dew point or temperature above eighty degrees Fahrenheit (80°F); and other piping, ducts and equipment necessary to maintain the efficiency of the systems.

3. Insulation on cold surfaces shall include an exterior vapor barrier.

4. Insulation, including finishes and adhesives on the exterior surfaces of ducts, pipes and equipment, shall have a flame spread rating of twenty-five (25) or less and a smoke developed rating of fifty (50) or less in accordance with the *Standard for Installation of Air Conditioning and Ventilating Systems 1978* published by the National Fire Protection Association.

5. Linings and coatings, adhesives and insulation on exterior surfaces of pipes and ducts in building spaces used as air supply plenums shall have a flame spread rating of twenty-five (25) or less and a smoke developed rating of fifty (50) or less as determined by an independent testing laboratory in accordance with the *Standard for Surface Burning Characteristics of Building Materials 1979* published by the National Fire Protection Association.

6. Duct linings shall not be used in systems supplying operating rooms, delivery rooms, recovery rooms, nurseries, isolation rooms and intensive care units unless terminal filters of at least ninety percent (90%) efficiency are installed downstream of the linings.

(F) All new hospitals shall be equipped with central-piped oxygen and clinical suction systems. Consideration also shall be given to installing central-piped nitrous oxide, nitrogen, clinical air, carbon dioxide and natural gas.

1. All medical gases shall be installed in accordance with the *Standard For Nonflammable Medical Gas Systems 1977* published by the National Fire Protection Association.

2. All medical gas piping shall be identified in some manner by the following color code: oxygen—green, nitrous oxide—light blue, clinical air—yellow, carbon dioxide—gray, nitrogen—black, and clinical suction—yellow.

3. Oxygen and clinical suction outlets shall be installed as outlined in Table 3.

Table 3
Station Outlets for Oxygen and Vacuum (Suction) Systems

Location	Oxygen	Clinical Suction
Patient Room for Adult Medical, Surgical and Postpartum Care and for Pediatrics	A	A
Examination and Treatment Room for Nursing Unit	B	B
Patient Room for Intensive Care	C	C
Nursery and Pediatric Nursery	A	A
General Operating Room	F	F
Cystoscopy and Special Procedure Room	D	D
Recovery Room for Surgical and Obstetrical Patients	E	E
Delivery Room	F	G
Labor Room	A	A
Treatment Room for Emergency Care	D	D
Autopsy Room	—	D
Anesthesia Workroom	—	D

A—One outlet accessible to each bed. One outlet may serve two beds.
B—One outlet. Portable equipment for the administration of oxygen and suction may be considered acceptable in lieu of a piped system.
C—Two outlets for each bed or provide one outlet with Y fitting.
D—One outlet.
E—One outlet for each bed.
F—Two outlets.
G—Three outlets.

4. A separate dedicated waste anesthesia gas exhaust system shall be provided, except nonflammable waste anesthesia gases may be connected into the clinical suction system provided the anesthesia gases are not detrimental to the clinical suction pumps and the pumps are vented directly to the atmosphere.

(G) Plumbing Systems.

1. All plumbing systems shall be designed and installed in accordance with applicable state and local codes.

2. Plumbing fixtures.

A. Plumbing fixtures shall be of nonabsorptive acid-resistant material.

B. The water supply spout for a lavatory and sink located in patient care area shall be mounted so that its discharge point is a minimum distance of five inches (5") above the rim of the fixture. All fixtures used by medical and nursing staff and all lavatories used by patients and food handlers shall be trimmed with valves which can be operated without the use of hands. When blade handles are used for this purpose, they shall not exceed four and one-half inches (4 1/2") in length, except that handles on scrub sinks and clinical sinks shall be not less than six inches (6") long. All lavatories and sinks shall be equipped with stop valves.

C. Clinical sinks shall have a bedpan flushing device and shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.

D. Showers and tubs shall be provided with nonslip surfaces.

E. All scrub sinks shall be equipped with knee- or foot-operated controls.

F. Water closets in patient areas shall be quiet operating types.

G. Stools in patient, diagnostic and treatment areas shall be the elongated bowl type with nonreturn stops, backflow preventers and silencers. Seats shall be the split type.

H. Bedpan flushing devices shall be provided in each patient toilet room except those in psychiatric units, alcohol abuse units and other ambulatory care facilities.

3. Water supply systems.

A. The water supply systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

B. Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

C. Backflow preventers and vacuum breakers shall be installed on hose bibbs, laboratory sinks, janitors' sinks, bedpan-flushing attachments, autopsy tables and on all other fixtures to which hoses or tubing can be attached.

D. The water supply system shall be designed to provide hot water at each hot water outlet at all times. Hot water at showers and bathing facilities shall not exceed one hundred ten degrees Fahrenheit (110°F). Hot water at handwashing facilities shall not exceed one hundred twenty degrees Fahrenheit (120°F).

4. Hot water-heaters and tanks. Hot water heating equipment shall have sufficient capacity to supply water at the temperatures and amounts indicated in Table 4. Water temperatures are to be taken at hot water point of use of inlet to processing equipment.

Table 4
Hot Water Use

	Clinical	Dietary	Laundry
Gallons (per hour per bed)	6 1/2	4	4 1/2
Liters (per second per bed)	.007	.004	.005
Temperatures (°F)	110	120*	160**
Temperature (°C)	43	49*	71**

*The rinse water temperature of automatic warewashing equipment shall be one hundred eighty degrees Fahrenheit (180°F).
**Sufficient hot water is to be delivered to the laundry to maintain this temperature in the washing machine during the entire wash and rinse period.

5. Consideration shall be given to the use of water softeners to soften domestic hot water and boiler water make-up whenever the water supply exceeds five (5) grain hardness.

6. Drainage systems.

A. Drain lines from sinks in which acid wastes may be poured shall be fabricated from an acid-resistant material.

B. Drain lines serving automatic blood cell counters shall be of carefully selected material to prevent undesirable chemical reactions between blood count wastes and plumbing system materials such as copper, lead, brass and solder.

C. Drainage piping shall not be installed in an exposed location in operating and delivery rooms, recovery rooms, nurseries, food preparation centers, food service facilities, food storage areas and other critical areas; special precautions shall be taken to protect any of these areas from possible leakage or condensation from necessary overhead drainage piping systems. These special precautions include requiring noncorrosive semi-circular drip troughs with a minimum four inch (4")-outside diameter to be installed under the drainage pipe in the direction of slope to a point where the pipe leaves the protected space and terminates at that point—usually at a wall. The trough shall be supported with noncorrosive strap hangers and screws from the pipe above. Trough joints and hanging screw penetrations shall be sealed to maintain watertight integrity throughout.

D. Floor drains shall not be installed in general operating and delivery rooms. Flushing rim-type floor drains may be installed in cystoscopic operating rooms.

E. Building sewers shall discharge into a community sewerage system when available. If such a system is not available, a facility providing sewage treatment shall conform to 10 CSR 20-6.010.

(28) Service Facilities.

(A) Space shall be provided for the maintenance engineer's office, maintenance shop and storage for building maintenance supplies.

(B) Service entrances to receiving rooms shall be protected from the weather.

(C) General storage space excluding space for receiving and the purchasing office shall be provided at the rate of twenty (20) square feet per bed for the first four hundred (400) beds and ten (10) square feet per bed for all additional beds. Off-site storage space is acceptable, however, one-half (1/2) of the required storage space shall be located in the hospital. General storage shall be concentrated in one (1) area.

(D) Space and facilities shall be provided for the sanitary storage and disposal of waste.

(E) If an incinerator is provided, it shall be separated as required in subparagraph (24)(C)2.T. of this rule.

AUTHORITY: sections 192.005.2 and 197.080, RSMo 1986. This rule was previously filed as 13 CSR 50-20.031 and 19 CSR 10-20.031. Original rule filed June 2, 1982, effective Nov. 11, 1982. Amended: Filed June 14, 1988, effective Oct. 13, 1988.*

**Original authority: 192.005.2, RSMo 1985 and 197.080, RSMo 1953.*

19 CSR 30-20.040 Definitions Relating to Long-Term Care Units in Hospitals

PURPOSE: This rule defines terminology used throughout 19 CSR 30-20.050 and 19 CSR 30-20.060.

(1) Ambulatory resident. An ambulatory resident shall mean a resident who is capable mentally and physically of negotiating a normal path to safety using assistive devices or aides when necessary, including ascent and descent of stairs.

(2) Competency evaluation program. The completion of the state training agency's formerly required one hundred thirty-five (135)-hour nursing assistant training course before January 1, 1989 and the successful completion of the state training agency's special four (4)-hour retraining program, which includes taking and passing the final examination to the nursing assistant training course as required in 13 CSR 15-13.010(7)(J); a challenge to the final examination of the nursing assistant training course in accordance with 13 CSR 15-13.010(7)(B)5.; or enrolling in and successfully completing the one hundred seventy-five (175)-hour nursing assistant training course as described in 13 CSR 15-13.010(6).

(3) Intermediate care unit. Any unit other than a residential care unit or skilled nursing unit which is utilized by a hospital to provide twenty-four (24)-hour accommodation, board, personal care and basic health and nursing care services under daily supervision of a licensed nurse.

(4) Licensed nurse. A practical nurse or a registered nurse.

(5) Long-term care unit. A unit attached to or contained within a hospital that is operated solely or in combination as a skilled nursing unit, an intermediate care unit or a residential care unit.

(6) Nonambulatory resident or bed patient. A nonambulatory resident or bed patient is a person who is confined to bed eighty percent (80%) of the time or who is unable to reposition him/herself in a chair unaided.

(7) Nursing assistant. An employee, including a nurse aid or orderly, who is assigned to a long-term care unit of a hospital to provide or assist in providing direct resident health care services under the supervision of a nurse licensed under the Nursing Practice Act, Chapter 335, RSMo.

(8) Nursing assistant trainee. An individual newly employed full-time or part-time in a long-term care unit as a nursing assistant who has not successfully completed an approved nurse assistant training program and who has not been employed as a nursing assistant in the hospital's long-term care unit for more than four (4) months.

(9) Nursing assistant training program. A program, as described in 13 CSR 15-13.010 and approved by the Missouri Division of Aging, for training nursing assistants who are employed in long-term care units.

(10) Practical nurse. An individual who is licensed to practice as a practical nurse in Missouri.

(11) Registered nurse. An individual who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse in Missouri.

(12) Resident. A person who by reason of aging, illness, disease or physical or mental infirmity requires care and services furnished by a long-term care unit and who resides in this a unit and is cared for, treated or accommodated there for a period exceeding twenty-four (24) consecutive hours.

(13) Residential care unit. Any unit other than an intermediate care unit or skilled nursing unit which is utilized by a hospital to provide twenty-four (24)-hour accommodation, board, personal care and protective oversight, including nursing care during short-term illness or recuperation.

(14) Skilled nursing unit. Any unit other than a residential care unit or an intermediate care unit which is utilized by a hospital to provide for twenty-four (24)-hour accommodation board and skilled nursing care and treatment services. Skilled nursing care and treatment services are those services commonly performed by or under the supervision of a registered nurse for individuals requiring twenty-four (24) hours-a-day care by licensed nursing personnel.

(15) State registry. A record maintained by the state training agency which contains the identity of all individuals who have satisfied requirements to be nursing assistants in Missouri and which shall be utilized to determine if an applicant is qualified to fill the position of a nursing assistant in a long-term care unit.

(16) State training agency. The Missouri Division of Aging is the agency designated as responsible for administering the state nursing assistant training program and for administering the state registry.

(17) Training agency. An organization approved by the state training agency to sponsor the nursing assistant training program.

(18) Training and competency evaluation program. The completion of the state training agency's one hundred seventy-five (175)-hour nursing assistant training course or a challenge to the final examination of the nursing assistant training course in accordance with 13 CSR 15-13.010(7)(B)5.

AUTHORITY: sections 192.005.2 and 197.080, RSMo 1986. This rule was previously filed as 13 CSR 50-20.040 and 19 CSR 10-20.040. Original rule filed Nov. 29, 1982, effective March 11, 1983. Amended: Filed May 31, 1989, effective Aug. 24, 1989.*

**Original authority: 192.005.2, RSMo 1985 and 197.080, RSMo 1953.*

19 CSR 30-20.050 Standards for the Operation of Long-Term Care Units in Hospitals

PURPOSE: This rule establishes standards for the administration, nursing staff and overall operation of long-term care units in hospitals to provide a high level of care.

(1) Requests for deviations from the requirements of this rule shall be in writing to the Department of Health. Approvals for deviations shall be in writing and both requests and approvals shall be made a part of the permanent Department of Health records for a facility.

(2) Swing beds located in the acute part of a hospital which may be used intermittently for long-term care are exempt from the requirements of this rule.

(3) Administration.

(A) A long-term care unit shall be licensed as part of the hospital in which it is located or attached. The hospital governing body shall be the legal authority for the long-term care unit and shall be responsible for the overall planning, directing, control and management of the activities and functions of the long-term care unit.

(B) The administration of the long-term care unit shall be the responsibility of the chief executive officer of the hospital. This authority may be delegated to a qualified assistant in accordance with the governing body bylaws of the hospital.

(C) Visiting Hours.

1. Regular daily visiting hours shall be established and posted.

2. Relatives or guardians and clergy, if requested by the resident or family, shall be allowed to see critically-ill residents at any time in keeping with the orders of the physician.

(D) Medical records shall comply with 19 CSR 30-20.021(3)(D). All medical orders shall be renewed at least monthly.

(E) If the minimum staffing as required in sections (5)–(7) of this rule does not meet the needs of the residents, the Department of Health shall inform the administrator, in writing, how many additional personnel are needed and of what type and shall give the basis for this determination.

(F) All residents shall have a comprehensive, accurate, standardized assessment completed within fourteen (14) days of admission. The assessment is to be completed utilizing the resident assessment instrument developed by the Health Care Financing Administration for use in long-term care facilities. The instrument includes a uniform minimum data set (MDS) of care screening and assessment elements, common definitions for these elements and utilization guidelines. The assessment shall be documented on the MDS and shall include applicable resident assessment protocols. An assessment shall become the basis for the care and treatment to be provided.

(4) Nursing Assistant Orientation.

(A) The chief executive officer of the hospital shall assure that individuals who are newly employed as nursing assistants in the long-term care unit receive an in-service orientation. At a minimum, the orientation shall include an explanation of: the organizational structure of the long-term care unit, the unit's policies and procedures, the unit's philosophy of care, a description of the resident population, job responsibilities and employee rules, information on communicable diseases, infection control procedures, resident rights and emergency protocols. The hours of orientation may be applied to the nursing assistant training course if conducted in accordance with 13 CSR 15-13.010(6)(B).

(B) New employees of long-term care units who are nursing assistant trainees shall be allowed to provide direct nursing care to residents only if they have received training and have demonstrated competency with regard to the specific care being provided. A licensed nurse shall be responsible for verifying the

competency and for documenting this in the trainee's personnel file. The in-service orientation program shall be supervised by a licensed nurse who is on duty in the unit at the time the orientation is provided.

(C) Nursing assistant trainees shall be clearly identified so that residents, family members, visitors and staff are aware that they are in training.

(5) Competency Evaluation of Nursing Assistants. The chief executive officer of the hospital shall be responsible for assuring that all nursing assistants who were employed and trained as nursing assistants before July 1, 1989 complete a competency evaluation program before January 1, 1990.

(6) Training and Competency Evaluation Program.

(A) The chief executive officer of the hospital shall be responsible for assuring that all nursing assistants employed in the long-term care unit after July 1, 1989 shall have completed or will complete the training and competency evaluation program.

(B) Individuals may be employed as nursing assistant trainees in a long-term care unit in order to complete the nursing assistant training and competency evaluation program. This period of training cannot exceed four (4) months from the date of employment.

(7) Orientation In-Service Training and Continuing Education.

(A) The chief executive officer of the hospital shall assure the development of an in-service orientation and continuing education program offered by qualified instructors for the development of all personnel in the long-term care unit that is appropriate to their job functions. Orientation for all new personnel shall begin the first day of employment in the long-term care unit and shall cover, at a minimum, prevention and control of infection and hospital policies and procedures, including emergency protocol, job responsibilities, lines of authority, confidentiality of patient information, resident's rights and preservation of patient dignity.

(B) The continuing education program for nursing assistants shall focus on basic nursing skills, personal care skills, mental health and social service needs and basic restorative services.

(8) Training Record. Written records of the employee's training shall be maintained in the employee's personnel file.

(9) Medical Care.

(A) Medical care in long-term care units shall be under the direction of a physician member of the medical staff and appointed by the governing body.

(B) Each resident shall have the privilege of selecting his/her own physician consistent with hospital medical staff bylaws.

(C) Each resident shall be visited by the attending physician as often as medically necessary but no less than every sixty (60) days.

(D) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of medical care in the long-term care unit.

(10) Skilled Nursing Unit.

(A) A skilled nursing unit as defined in 19 CSR 30-20.040(10) shall have a registered nurse on duty eight (8) hours a day and seven (7) days a week.

(B) The nursing service administrator shall be responsible for the quality of nursing care supervision of personnel providing nursing care and for a program of in-service education for nursing personnel.

(C) Skilled nursing units shall employ nursing personnel in sufficient numbers and sufficiently qualified to meet the needs of the residents. Exclusive of supervisory staff, the minimum ratio of nursing staff engaged in direct patient care and treatment to residents shall be as follows:

Time	Ratio of Staff to Residents*
7 a.m. to 3 p.m. (day)	1 staff person for each 10 residents plus 1 additional staff person for any remainder of 6 or more residents
3 p.m. to 11 p.m. (evening)	1 staff person for each 15 residents plus 1 additional staff person for any remainder of 8 or more residents
11 p.m. to 7 a.m. (night)	1 staff person for each 20 residents plus 1 additional staff person for any remainder of 11 or more residents

*The number of residents is based on occupied beds.

(D) On the day shift there shall be a registered nurse on duty; on both evening and night shifts there shall be a licensed practical nurse or a registered nurse on duty.

(E) A registered nurse shall be available in the hospital to assist during the time a licensed practical nurse is in charge.

(F) In a multi-story facility, at least one (1) direct-care staff person shall be on duty at all times for each occupied floor.

(G) All skilled nursing units shall comply with subsections (11)(G)–(I) of this rule.

(11) Intermediate Care Unit.

(A) An intermediate care unit as defined in 19 CSR 30-20.040(2) shall have either a registered nurse or a licensed practical nurse in charge of the unit.

(B) When the person in charge is a licensed practical nurse, a registered nurse shall be available in the hospital for the supervision of patient care.

(C) A licensed nurse shall be available in the hospital for assistance to the unit twenty-four (24) hours a day, seven (7) days a week.

(D) The minimum ratios of staff engaged in direct patient care, exclusive of supervisory staff, shall be the minimum ratios required in subsection (5)(C) of this rule.

(E) One (1) of the nursing personnel on the day shift shall be a licensed nurse.

(F) In a multi-story facility, at least one (1) direct-care staff shall be on duty at all times on each occupied floor.

(G) All medications shall be administered by a licensed nurse or physician.

(H) A physical examination by a physician shall be completed and recorded on the clinical record of each resident, preferably before admission, but not later than seven (7) days after admission, unless the resident is accompanied on admission from a hospital or other long-term care unit by a record of a physical examination completed within the past six (6) months. Physical examinations shall be performed at least annually.

(I) The unit shall not knowingly admit or continue to care for residents whose needs cannot be met by the unit directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. Seriously disturbed mentally-ill residents shall not be admitted or retained unless the unit can provide the care the resident needs. Provision shall be made for the care of residents with a communicable disease either in the hospital or in a suitable room in the unit. Infection control policies and procedures shall be followed.

(12) Residential Care Units.

(A) Policies and procedures shall be written to include at least medications, medical treatment and outside privileges.

(B) Nursing personnel shall have access to the legal name of each resident and the name and telephone number of each resident's physician and next of kin or responsible party in the event of emergency.

(C) At least one (1) staff person at least eighteen (18) years of age shall be on duty at all times.

(D) There shall be one (1) licensed nurse on duty at least (8) hours per week for every thirty (30) residents plus one (1) additional

licensed nurse on duty at least eight (8) hours per week for any remainder of sixteen (16) or more residents.

(E) Only ambulatory residents shall be admitted to the residential care unit.

(F) Those residents who require the use of a walker or wheelchair shall be housed on a floor which has direct exit at grade or which has a ramp with a slope not greater than one to twelve (1:12) leading to grade or which has no more than two (2) steps to grade. The steps shall have a handrail. Those residents who use a wheelchair shall be able to reach the equipment unassisted and demonstrate the ability to transfer to and from a wheelchair without assistance.

(13) Resident's Rights and Grievance Procedures for Long-Term Care Units.

(A) A complete copy of each official notification from the Department of Health of violations, deficiencies, licensure approvals, disapprovals and responses shall be retained and made available at the unit for inspection when requested by staff, residents, families or legal representatives of the residents and the public.

(B) Each resident shall be informed of his/her rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. A copy of all the information shall be posted in a conspicuous location in the facility and copies shall be available to anyone requesting the information. Prior to or at the time of admission, a copy of the information shall be provided to each resident or his/her designee, next of kin or legal guardian.

(C) Each resident shall be informed in writing, prior to or at the time of admission and during his/her stay, of services available in the unit and of related charges, including any charges for services not covered under the federal or state programs or not covered by the facility's per-diem rate.

(D) Each resident shall be informed by a physician of his/her health and medical condition unless medically contraindicated (as documented by a physician in the resident's record); shall be given the opportunity to participate in the planning of his/her total care and medical treatment and to refuse treatment; and shall participate in experimental research only upon his/her informed written consent.

(E) Each resident shall be transferred or discharged only for medical reasons, for his/her welfare or that of other residents or for nonpayment for his/her stay.

(F) Each resident shall be encouraged and assisted, throughout his/her period of stay, to exercise his/her rights as a resident and as a citizen and to this end may voice grievances and recommend changes in policies and services to facility staff or to outside representatives of his/her choice and shall be free from restraint, interference, coercion, discrimination or reprisal.

(G) Each resident may manage his/her personal financial affairs and, to the extent that the facility assists in the management, may have his/her personal financial affairs managed in accordance with section (9) of this rule.

(H) No resident shall be mentally or physically abused. Each resident shall be free from chemical and physical restraints except when the restraints are authorized in writing by a physician for a specific period of time or when the restraints are necessary in an emergency to protect the resident from injury to him/herself or others. In an emergency, physical restraints may be authorized by a registered nurse. This action shall be reported promptly to a physician, always within twenty-four (24) hours.

(I) Each resident shall be assured confidential treatment of all information contained in his/her records, including information contained in an automatic data bank; his/her written consent shall be required for the release of information to persons not otherwise authorized under law to receive it.

(J) Each resident shall be treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs.

(K) No resident shall be required to perform services for the unit that are not included for therapeutic purposes in the plan of care.

(L) Each resident may communicate, associate and meet privately with persons of his/her choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive his/her personal mail unopened.

(M) Each resident may participate in activities of social, religious and community groups at his/her discretion, unless contraindicated for reasons documented by a physician in the resident's medical record.

(N) Each resident may retain and use his/her personal clothing and possessions as space permits.

(O) If married, a resident shall be insured privacy for visits by his/her other spouse; if both are residents in the facility, they shall be permitted to share a room unless medically contraindicated.

(P) Each resident shall be allowed to purchase or rent any goods or services not included in the per-diem or monthly rate as long as the quality and delivery of those goods or services conform with policies and procedures of the hospital.

(14) Personal Funds and Property of Residents.

(A) No hospital shall be required to hold any personal funds or money in trust unless some other governmental agency placing residents in the facility makes this requirement.

(B) Authorizations by the resident, his/her designee or legal guardian for the hospital to use the personal funds of the resident shall be in writing and kept with the resident's record or with the personal funds account.

(C) When a resident is admitted, s/he and his/her next of kin or legal guardian shall be provided with a statement explaining the resident's rights regarding personal funds.

(D) Resident's personal funds that are held in trust shall be kept separate from the hospital funds.

(E) There shall be a written account for each resident showing receipts to and disbursements from the personal funds of each resident.

(F) A written statement of all receipts and disbursements showing the current balance shall be given on a quarterly basis to the resident, his/her designee or legal guardian.

(G) When personal funds and possessions held in trust by the hospital are returned to the resident or his/her designee or guardian before or after the resident's discharge, the resident or his/her designee or guardian shall give the hospital a receipt for the funds and possessions returned.

(H) There is no duty on the part of the hospital to invest a resident's funds held in trust or to increase the principal.

(I) Any owner, manager, employee or affiliate of an owner who receives any personal property or anything else with a value of ten dollars ($10) or more from a resident shall give the resident a written statement giving the date it was received, from whom it was received and its estimated value.

(J) No owner, manager, employee or affiliate of an owner, in one (1) calendar year, shall receive any personal property or anything else with a total value exceeding one hundred dollars ($100) from a resident of any facility. This does not apply to bequests.

(K) The recordkeeping and other requirements of section (14) of this rule apply only to those personal possessions and funds which the facility accepts to hold in trust for the resident and does not apply to other possessions residents have in their rooms or bring into the facility.

AUTHORITY: sections 192.005.2 and 197.080, RSMo 1986. This rule was previously filed as 13 CSR 50-20.050 and 19 CSR 10-20.050. Original rule filed Nov. 29, 1982, effective March 11, 1983. Amended: Filed May 31, 1989, effective Aug. 24, 1989. Amended: Filed July 12, 1991, effective Feb. 6, 1992.*

**Original authority: 192.005.2, RSMo 1985 and 197.080, RSMo 1953.*

19 CSR 30-20.060 Construction Standards for New Long-Term Care Units in Hospitals

PURPOSE: This rule establishes up-to-date construction standards for new long-term care units in hospitals to help ensure accessible, functional, fire-safe and sanitary facilities.

(1) New Long-Term Care General Requirements.

(A) A new long-term care unit is one for which plans are submitted to the Department of Health for review and approval after the effective date of this rule for the construction, expansion or renovation of a unit or the conversion of an existing unit not previously and continuously utilized as a long-term care unit. New long-term care units and additions to and major alterations of existing licensed long-term care units shall be designed to provide all of the facilities required by this rule. Those facilities shall be arranged to accommodate with maximum convenience all of the functions required by this rule; and to provide comfortable, sanitary, fire-safe, secure and durable facilities for the patients. In any major alteration project or addition to an existing long-term care unit, only those parts of a unit affected by the project or addition are subject to this rule.

(B) The minimum requirements of this rule are not intended in any way to restrict innovations and improvements in design, construction or operating techniques. Plans and specifications and operational procedures which contain deviations from these requirements may be approved if it is determined that the purposes of the minimum requirements have been fulfilled. Some facilities may be subject to the requirements of more than one (1) regulating agency. While every effort has been made to ensure coordination, facilities making requests for changes in services and requests for new construction or renovations are cautioned to verify requirements of other agencies involved.

(C) Requests for deviations from the requirements of this rule shall be in writing to the Department of Health. Approvals for deviations shall be in writing and both requests and approvals shall become a part of the permanent Department of Health records for the facility.

(D) Alterations or additions to existing units shall be programmed so construction will minimize disruptions of existing functions. Access to exits and fire protection shall be maintained so the safety of the occupants will not be jeopardized during construction.

(E) The owner of each new unit or the owner of an existing unit being added to or undergoing major alterations shall provide a program, scope of services, which describes space requirements, staffing patterns, departmental relationships and other basic information relating to the objectives of the unit. The program may be general but it shall include a description of each function to be performed, approximate space needed for those functions and the interrelationship of various functions and spaces. The program also shall describe how essential services can be expanded in the future as the demand increases. Appropriate modifications or deletions in space requirements may be made when services are shared or purchased provided the program indicates where the services are available and how they are to be provided.

(F) Swing beds located in the acute part of the hospital which may be used intermittently for long-term care patients are exempt from the requirements of this rule.

(2) Planning and Construction Procedures.

(A) Plans and specifications shall be prepared for the construction of all new long-term care units in hospitals and additions to and major remodeling of existing long-term care units. The plans and specifications shall be prepared by an architect or a professional engineer licensed to practice in Missouri.

(B) Construction shall be in conformance with plans and specifications approved by the Department of Health. The Department of Health shall be notified within five (5) days after construction begins. If construction of the project is not started within one (1) year after the date of approval of the plans and specifications, the plans and specifications shall be resubmitted to the Department of Health for its approval and shall be amended, if necessary, to comply with the then current rules before construction work commences.

(3) General Design of Long-term Care Units.

(A) All new long-term care units shall comply with 19 CSR 30-20.030(3)(B)5. and 6.

1. Grab bars or handrails shall be provided adjacent to all bathtubs, within all showers, on at least one (1) side of all water closets and located in proper positions to facilitate the bodily movements of residents.

2. Lavatories shall be positioned to be accessible to wheelchair residents and shall not have cabinets underneath or any other unnecessary obstruction to the maneuverability of wheelchairs.

3. Mirrors shall be provided in each resident room or adjoining toilet room. Mirrors shall be a least three feet (3') high and located with the bottom edge no more than three feet four inches (3'4") above the floor or framed tilting mirrors may be used.

(B) All new long-term care units shall comply with 19 CSR 30-20.030(4)(A)–(J) with one (1) exception: intermediate-care units and residential-care units are not required to comply with subsection (4)(J).

(C) All new long-term care units shall comply with 19 CSR 30-20.030(5)(A)–(I).

(D) A separate public area for a long-term care unit shall be provided and shall include a waiting room, public toilets for each sex and a public telephone.

(E) An office shall be provided for the licensed nurse supervisor of the unit.

(F) Recreation, occupational therapy, activity and residents' dining space shall be provided at a ratio of at least thirty (30) square feet for each resident.

(G) A personal care room with barber and beauty shop facilities shall be provided.

(H) General storage rooms shall be provided as follows: ten (10) square feet per bed for the first fifty (50) beds; plus eight (8) square feet per bed for the next twenty-five (25) beds; plus five (5) square feet per bed for any additional beds. No storage room shall have less than one hundred (100) square feet of floor space. Storage space for residents' clothes and for outdoor equipment is required but may be undivided in the minimum area required for general storage.

(I) If the long-term care unit is designed to have its own dietary facilities, the dietary facilities shall comply with 19 CSR 30-20.030(14).

(J) If elevators are located in the long-term care unit, they shall comply with 19 CSR 30-20.030(21).

(K) Handrails shall be provided on both sides of all corridors, aisles and stairways. Corridor handrails shall have ends returned to the wall.

(4) Fire Prevention and Protection. All new and existing facilities shall comply with 19 CSR 30-20.030(24)(A) and (B).

(5) All new units, additions to existing units and major alterations to existing units shall

comply with the life safety requirements in 19 CSR 30-20.030(24)(C).

(6) All new units, additions to existing units and major alterations to existing units shall comply with the construction requirements in 19 CSR 30-20.030(25).

(7) All new units, additions to existing units and major alterations to existing units except residential-care units shall comply with the electrical requirements in 19 CSR 30-20.030(26)(E)5. and 6.; (F)1.; (G)1., 3. and 4.; (H)1.A. and 2.A.; and (I).

(8) All new units, additions to existing units and major alterations to existing units except residential-care units shall comply with mechanical requirements in 19 CSR 30-20.030(27).

AUTHORITY: sections 192.005.2 and 197.080, RSMo 1986. This rule was previously filed as 13 CSR 50-20.060 and 19 CSR 10-20.060. Original rule filed Nov. 29, 1982, effective March 11, 1983.*

**Original authority: 192.005.2, RSMo 1985 and 197.080, RSMo 1953.*

19 CSR 30-20.070 Standards for Registration as a Hospital Infectious Waste Generator

PURPOSE: This rule establishes standards and procedures for the registration of hospitals to ensure a high level of public safety in the handling and disposal of infectious waste.

(1) Application for Registration as a Hospital Infectious Waste Generator.

(A) Annually every hospital shall submit to the Department of Health an application for registration as an infectious waste generator. Forms for the application shall be furnished by the Department of Health.

(B) Each application shall include:

1. An operational plan for the handling and treatment of infectious waste as specified in 19 CSR 30-20.020(5)(D)1.

2. A statement that the applicant understands and complies with sections 260.200-260.245, RSMo; 19 CSR 30-20.010; 19 CSR 30-20.020; and 10 CSR 80; and

3. The signature of the hospital's chief executive officer and the director of the infectious waste management program.

(C) The application shall be submitted annually, three (3) months previous to the registration date. It shall be reviewed and denial or acceptance given within thirty (30) days after the Department of Health receives the application. If denied, specific reasons, with references, shall be given for the denial.

(D) The date of annual registration of a licensed hospital as an infectious waste generator shall be the hospital license renewal date and a nonlicensed hospital shall be assigned an annual registration date.

AUTHORITY: sections 197.080, RSMo 1986 and 260.203, RSMo Supp. 1992. Original rule filed Aug. 15, 1988, effective Dec. 29, 1988.*

**Original authority: 197.080, RSMo 1953 and 260.203, RSMo 1986, amended 1988, 1992.*

MISSOURI DEPARTMENT OF HEALTH
BUREAU OF HOSPITAL LICENSING AND CERTIFICATION
INFECTIOUS WASTE GENERATOR REGISTRATION APPLICATION FOR MISSOURI HOSPITALS

P.O. BOX 570
JEFFERSON CITY, MO 65102

FOR OFFICE USE ONLY
DATE APPL. REC'D.
REGISTRATION NO.
DATE MAILED

Pursuant to the requirements of 260.203 RSMo., application is hereby made for registration as an infectious waste generator.

NAME OF HOSPITAL (NAME TO APPEAR ON REGISTRATION) | DATE OF APPLICATION

ADDRESS (STREET AND NUMBER, CITY, ZIP CODE) | TELEPHONE NUMBER

CHIEF EXECUTIVE OFFICER (FULL NAME) | TITLE

NEXT IN CHARGE (FULL NAME) | TITLE

OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)

A. GOVERNMENTAL
- ☐ DISTRICT
- ☐ COUNTY
- ☐ CITY-COUNTY
- ☐ CITY
- ☐ STATE
- ☐ FEDERAL
- ☐ OTHER (EXPLAIN)

B. NON-GOVERNMENTAL

NON-PROFIT
- ☐ CHURCH OPERATED
- ☐ CHURCH AFFILIATED
- ☐ OTHER NON-PROFIT

PROPRIETARY
- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ CORPORATION

NAME OF GOVERNING BODY

CHIEF OFFICER OF GOVERNING BODY (FULL NAME)

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

FISCAL YEAR | TOTAL CAPACITY OF HOSPITAL (INCLUDE STAFFED AND NON-STAFFED NURSING UNITS) BEDS

CERTIFICATION

HOSPITAL CHIEF EXECUTIVE | DIRECTOR, INFECTIOUS WASTE MANAGEMENT PROGRAM

AND

being duly sworn by me on _____ (HIS/HER/THEIR) oath, deposes and says that _____ (HE/SHE/THEY) have read the foregoing application and that the statements contained therein are correct and true and of _____ (HIS/HER/THEIR) knowledge; and further gives assurance of the ability and intention of the _____ (LEGAL NAME OF OPERATING CORPORATION) to comply with the rules promulgated under 260.203 RSMo.

Having read and understood 19 CSR 30 Chapter 20, 22, or 24 (as applicable), 260.200 - 260.245 RSMo. and 10 CRS 80. _____ (I/WE) further certify that the _____ (HOSPITAL NAME) will comply with these sections and all required corrections and/or improvements deemed necessary following reviews and inspections by the Missouri Department of Health.

SIGNATURES

HOSPITAL CHIEF EXECUTIVE OFFICER ▶ | DIRECTOR, INFECTIOUS WASTE MANAGEMENT PROGRAM ▶

NOTARY PUBLIC EMBOSSER SEAL

STATE OF | COUNTY (OR CITY OF ST. LOUIS)

SUBSCRIBED AND SWORN BEFORE ME, THIS _____ DAY OF _____ 19 _____

USE RUBBER STAMP IN CLEAR AREA BELOW.

NOTARY PUBLIC SIGNATURE | MY COMMISSION EXPIRES

NOTARY PUBLIC NAME (TYPED OR PRINTED)

MO 580-1246 (10-88) HL-8 (10-88)

19 CSR 30-20.080 Governing Body of Hospitals

PURPOSE: This rule defines governing body and establishes standards for the governing body of hospitals.

(1) The governing body is defined as an individual owner(s), partnership, corporate body, association or public agency having legal responsibility for the operation of a hospital subject to provisions of sections 197.020–197.120, RSMo.

(2) The governing body shall be the legal authority in the hospital and shall be responsible for the overall planning, directing, control and management of the activities and functions of the hospital.

(3) The governing body shall establish and adopt bylaws to provide for the appointment of a qualified chief executive officer and members of the medical staff and of the delegation of authority and responsibility to each. A copy of the governing body bylaws and of all amendments or revisions shall be submitted to the Department of Health for its records.

(4) Meetings of the governing body shall be held at regular, stated intervals and at other times necessary for proper operation of the hospital. Minutes of all meetings shall be kept as permanent records, signed and made available to members of the governing body.

(5) Bylaws of the governing body shall provide for the election of officers and for the appointment of standing and special committees necessary to effectively carry out its responsibilities. Written minutes of all committee meetings shall be maintained on a confidential basis.

(6) Bylaws of the governing body shall establish a direct and effective means of liaison among the governing body, the administration and the medical staff.

(7) The governing body shall select and employ a chief executive officer who should be qualified, by education and experience, in the field of hospital or health care administration.

(8) Bylaws of the governing body shall describe and convey authority to the chief executive officer for the administration of the hospital in all its activities. The chief executive officer shall be subject to special policies adopted or specific orders issued by the governing body in accordance with its bylaws.

(9) The Department of Health shall be notified of any change in the appointment of the chief executive officer.

(10) Bylaws of the governing body shall require that the medical staff, hospital personnel and all auxiliary organizations, directly or indirectly, shall be responsible to the governing body through the chief executive officer.

(11) Bylaws of the governing body shall require that a qualified individual be designated by the chief executive officer to act in his/her absence.

(12) Duly appointed representatives of the Department of Health shall be allowed to inspect the hospital as required in section 197.100, RSMo.

(13) Bylaws of the governing body shall provide for the selection and appointment of medical staff members based upon defined criteria and in accordance with an established procedure for processing and evaluating applications for membership. Applications for appointment and reappointment shall be in writing and shall signify agreement of the applicant to conform with bylaws of both the governing body and medical staff and to abide by professional ethical standards. Initial appointments to the medical staff shall not exceed two (2) years. Reappointments, which may be processed and approved at the discretion of the governing body on a monthly or other cyclical pattern, shall not exceed two (2) years.

(14) Bylaws of the governing body shall require that the medical staff develop and adopt medical staff bylaws and rules which shall become effective when approved by the governing body.

(15) The governing body, acting upon recommendations of the medical staff, shall approve or disapprove appointments and on the basis of established requirements shall determine the privileges extended to each member of the staff.

(16) Bylaws of the governing body shall provide that notification of denial of appointment, reappointment, curtailment, suspension, revocation or modification of privileges shall be in writing and shall indicate the reason(s) for this action.

(17) The governing body shall establish mechanisms which assure the hospital's compliance with mandatory federal, state and local laws, rules and standards.

(18) Although independent licensed practitioners are not authorized membership to the medical staff, the governing body may include provisions within its bylaws to grant licensed practitioners clinical privileges, on an outpatient basis, for diagnostic and therapeutic tests and treatment. The privileges shall be within the scope and authority of each practitioner's current Missouri license and practice act.

(A) The provisions shall include a mechanism to assure that independent practitioners who provide services have clinical privileges delineated by the governing body or designee.

(B) The mechanism shall include criteria for a review of an independent practitioner's credentials at least every two (2) years. At a minimum, the criteria shall include documentation of a current license, relevant training and experience, and competency.

(19) The governing body shall establish and implement a mechanism which assures compliance with the reporting requirements in section 383.133, RSMo.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(A). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.082 Chief Executive Officer in Hospitals

PURPOSE: This rule specifies the duties of the chief executive officer of a hospital.

(1) The chief executive officer shall be the direct representative of the governing body and shall be responsible for management of the hospital commensurate with the authority delegated by the governing body in its bylaws.

(2) The chief executive officer shall be responsible for maintaining liaison among the governing body, medical staff and all departments of the hospital.

(3) The chief executive officer shall organize the administrative functions of the hospital through appropriate departmentalization and delegation of duties and shall establish a system of authorization, record procedures and internal controls.

(4) The chief executive officer shall be responsible for the recruitment and employment of qualified personnel to staff the various departments of the hospital and shall insure that written personnel policies and job descriptions are available to all employees.

(5) The chief executive officer shall be responsible for the development and enforcement of written policies and procedures governing visitors to all areas of the hospital.

(6) The chief executive officer shall be responsible for establishing effective security measures to protect patients, employees and visitors.

(7) The chief executive officer shall maintain policies protecting children admitted to or discharged from the hospital. Policies shall provide for at least the following:

(A) A child shall not be released to anyone other than the child's parent(s), legal guardian or custodian;

(B) The social work service personnel shall have knowledge of available social services for unmarried mothers and for the placement of children;

(C) Adoption placements shall comply with section 453.010, RSMo; and

(D) The reporting of suspected incidences of child abuse shall be made to the Division of Family Services as established under section 210.120, RSMo.

(8) The chief executive officer shall be responsible for developing a written emergency preparedness plan. The plan shall include procedures which provide for safe and orderly evacuation of patients, visitors and personnel in the event of fire, explosion or other internal disaster. The plan shall also include procedures for caring for mass casualties resulting from any external disaster in the region.

(9) The emergency plan in section (8) of this rule shall be readily available to all personnel. The chief executive officer is responsible for ensuring all employees shall be instructed regarding their responsibilities during an emergency. Drills for internal disasters, such as fires, shall be held at least quarterly for each shift and shall include the simulated use of fire alarm signals and simulation of emergency fire conditions. Annual drills for external disasters shall be held in coordination with representatives of local emergency preparedness offices. The movement of hospital patients is not required as a part of the drills.

(10) The chief executive officer shall be responsible for carrying out policies of the governing body to ensure that patients are admitted to the hospital only by members of the medical staff and that each patient's general medical condition shall be the primary responsibility of a physician member of the medical staff.

(11) The chief executive officer shall bring to the attention of the chief of the medical staff and governing body failure by members of that staff to conform with established hospital policies regarding administrative matters, professional standards or the timely preparation and completion of each patient's clinical record.

(12) The chief executive officer shall be responsible for developing and maintaining a hospital environment which provides for efficient care and safety of patients, employees and visitors.

(13) The chief executive officer shall be responsible for the development and enforcement of written policies and procedures which prohibit the use of tobacco products throughout the hospital and its facilities. At a minimum, such policies and procedures shall include a description of the area encompassed by the tobacco-free policy; how employees, patients and visitors will be educated and informed about the tobacco-free policy; who is responsible for enforcing the tobacco-free policy and how the tobacco-free policy will be enforced; how the hospital will address an employee's, patient's, or visitor's failure to comply with the tobacco-free policy; and how the hospital, if subject to Medicare Conditions of Participation for Long-Term Care Facilities, will comply with 42 CFR 483.15(b)(3). The chief executive officer shall enforce compliance with the written policies and procedures prohibiting the use of tobacco products throughout the hospital and its facilities beginning one (1) year from the effective date of this amendment.

(14) An annual licensing survey for each fiscal year shall be filed with the department on the survey document provided by the Department of Health and Senior Services. The survey shall be due within two (2) months after the hospital's receipt of the survey.

(15) The chief executive officer shall be responsible for establishing and implementing a mechanism which will assure that patient services provide care or an appropriate referral that is commensurate with the patient's needs. If services are provided by contract, the contractor shall furnish services that permit the hospital to comply with all applicable hospital licensing requirements.

(16) The chief executive officer shall be responsible for establishing and implementing a mechanism to assure that all equipment and physical facilities used by the hospital to provide patient services, including those services provided by a contractor, comply with applicable hospital licensing requirements.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.084 Patients' Rights in Hospitals

PURPOSE: This rule establishes the minimum requirements necessary to assure patients' rights are protected.

(1) The chief executive officer shall be responsible for establishing and implementing a mechanism to assure that patients' rights are protected. At a minimum, the mechanism shall include the following:

(A) The patient has the right to be free from abuse, neglect or harassment;

(B) The patient has the right to be treated with consideration and respect;

(C) The patient has the right to protective oversight while a patient in the hospital;

(D) The patient or his/her designated representative has the right to be informed regarding the hospital's plan of care for the patient;

(E) The patient or his/her designated representative has the right to be informed, upon request, regarding general information pertaining to services received by the patient;

(F) The patient or his/her designated representative has the right to review the patient's medical record and to receive copies of the record at a reasonable photocopy fee;

(G) The patient or his/her designated representative has the right to participate in the patient's discharge planning, including being informed of service options that are available to the patient and a choice of agencies which provide the service;

(H) When a patient has brought personal possessions to the hospital, s/he has the right to have these possessions reasonably protected;

(I) The patient has the right to accept medical care or to refuse it to the extent permitted by law and to be informed of the medical consequences of refusal. The patient has the right to appoint a surrogate to make health

care decisions on his/her behalf to the extent permitted by law;

(J) The patient, responsible party or designee has the right to participate in treatment decisions and the care planning process;

(K) The patient has the right to be informed of the hospital's patient grievance policies and procedures, including who to contact and how; and

(L) The patient has the right to file a formal or informal verbal or written grievance and to expect a prompt resolution of the grievance, including a timely written notice of the resolution. The grievance may be made by a patient or the patient's representative. Any patient service or care issue that cannot be resolved promptly by staff present will be considered a grievance for purposes of this requirement. The written notice of the resolution should include information on the steps taken on behalf of the patient to investigate the grievance, the results of the investigation, and the date the investigation was completed. If the corrective action is still being evaluated, the hospital's response should state that the hospital is still working to resolve the grievance and the hospital will follow-up with another written response when the investigation is complete or within a specified time frame.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(B)17. Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.086 Medical Staff in Hospitals

PURPOSE: This rule specifies the requirements for the organization of the medical staff in a hospital.

(1) The medical staff shall be organized, shall develop and, with the approval of the governing body, shall adopt bylaws, rules and policies governing their professional activities in the hospital.

(2) Medical staff membership shall be limited to physicians, dentists, psychologists and podiatrists. They shall be currently licensed to practice their respective professions in Missouri. The bylaws of the medical staff shall include the procedure to be used in processing applications for medical staff membership and the criteria for granting initial or continuing medical staff appointments and for granting initial, renewed or revised clinical privileges.

(3) No application for membership on the medical staff shall be denied based solely upon the applicant's professional degree or the school or health care facility in which the practitioner received medical, dental, psychology or podiatry schooling, postgraduate training or certification, if the schooling or postgraduate training for a physician was accredited by the American Medical Association or the American Osteopathic Association, for a dentist was accredited by the American Dental Association's Commission on Dental Accreditation, for a psychologist was accredited with accordance to Chapter 337, RSMo and for a podiatrist was accredited by the American Podiatric Medical Association. Each application for staff membership shall be considered on an individual basis with objective criteria applied equally to each applicant.

(4) Each physician, dentist, psychologist or podiatrist requesting staff membership shall submit a complete written application to the chief executive officer of the hospital or his designee on a form approved by the governing body. Each application shall be accompanied by evidence of education, training, professional qualifications, license and and other information required by the medical staff bylaws or policies.

(5) Written criteria shall be developed for privileges extended to each member of the staff. A formal mechanism shall be established for recommending to the governing body delineation of privileges, curtailment, suspension or revocation of privileges and appointments and reappointments to the medical staff. The mechanism shall include an inquiry of the National Practitioner Data Bank. Bylaws of the medical staff shall provide for hearing and appeal procedures for the denial of reappointment and for the denial, revocation, curtailment, suspension, revocation, or other modification of clinical privileges of a member of the medical staff.

(6) Any applicant for medical staff membership who is denied membership or whose completed application is not acted upon in ninety (90) calendar days of completion of verification of credentials data or a medical staff member whose membership or privileges are terminated, curtailed or diminished in any way shall be given in writing the reasons for the action or lack of action. The reasons shall relate to, but not be limited to, patient welfare, the objectives of the institution, the inability of the organization to provide the necessary equipment or trained staff, contractual agreements, or the conduct or competency of the applicant or medical staff member.

(7) Initial appointments to the medical staff shall not exceed two (2) years. Reappointments, which may be processed and approved at the discretion of the governing body on a monthly or other cyclical pattern, shall not exceed two (2) years.

(8) The medical staff bylaws shall provide for—an outline of the medical staff organization; designation of officers, their duties and qualifications and methods of selecting the officers; committee functions; and an appeal and hearing process.

(9) The medical staff bylaws shall provide for an active staff and other categories as may be designated in the governing body bylaws. The medical staff bylaws shall describe the voting rights, attendance requirements, eligibility for holding offices or committee appointments, and any limitations or restrictions identified with location of residence or office practice for each category.

(10) The organized medical staff shall meet at intervals necessary to accomplish its required functions. A mechanism shall be established for monthly decision-making by or on behalf of the medical staff.

(11) Written minutes of medical staff meetings shall be recorded. Minutes containing peer review information shall be retained on a confidential basis in the hospital. The medical staff determine retention guidelines and guidelines for release of minutes not containing peer review materials.

(12) The medical staff as a body or through committee shall review and evaluate the quality of clinical practice of the medical staff in the hospital in accordance with the medical staff's peer review function and performance improvement plan and activities.

(13) The medical staff shall establish in its bylaws or rules criteria for the content of patients' records provisions for their timely completion and disciplinary action for noncompliance.

(14) Bylaws of the medical staff shall require that at all times at least one (1) physician member of the medical staff shall be on duty or available within a reasonable period of time for emergency service.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp.

2007. This rule previously filed as 19 CSR 30-20.021(2)(C). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.088 Central Services in Hospitals

PURPOSE: This rule specifies the manner in which central services shall be organized and integrated in a hospital.

(1) Central services shall be organized and integrated with patient care services in the hospital.

(2) The director of central services shall be qualified by education, training and experience in aseptic technique, principles of sterilization and disinfection and distribution of medical/surgical supplies. The director shall be responsible to an administrative officer or a qualified designee.

(3) Sufficient supervisory and support staff shall be assigned as related to the scope of services provided.

(4) Sufficient space and equipment shall be provided for the safe and efficient operation of the services as determined by the scope of hospital services delivered.

(5) Policies and procedures shall define the activities of all services provided. Sterilization and disinfection standards of practice shall be established. The principles of the Association for Practitioners in Infection Control, Association of Operating Room Nurses, Center for Disease Control and Prevention, American Society for Healthcare Central Service Personnel, Association for the Advancement of Medical Instrumentation, and others may be utilized to establish facility standards of practice for central services.

(6) Written procedures shall specify how items stored in central services can be obtained when central services is considered closed.

(7) Reprocessed packaged item(s) shall be identified as to content, show evidence of sterilization and be labeled indicating the sterilizer used and the load/cycle number. A policy on the shelf life of a packaged sterile item shall be established in accordance with acceptable standards of sterilization and dependent on the quality of the packaging material, storage conditions and the amount of handling of the item.

(8) Central services shall maintain documentation from the manufacturer that packaging material utilized for reprocessing is appropriate for this use. Expiration dates shall comply with the packaging material utilized.

(9) Sterile medical-surgical packaged items shall be handled only as necessary and stored in vermin-free areas where controlled ventilation, temperature and humidity are maintained. The integrity of sterile items shall be maintained throughout reprocessing, storage, distribution and transportation.

(10) Preventive maintenance of equipment shall be done as recommended by the manufacturer or as specified by hospital policy. Records shall be maintained as specified by hospital policy. Records shall include documentation that items processed by steam have undergone sufficient time, temperature and pressure and that items processed by ethylene oxide have undergone sufficient time, temperature, gas concentration and humidity to obtain pathogenic microbial kill.

(11) Ethylene oxide sterilized items shall be aerated as specified by hospital policy based on the manufacturer's recommendations to eliminate the hazards of toxic residue for both patient and staff.

(12) Principles of sterilization and disinfection as approved by the hospital's infection control committee shall apply throughout the hospital when central services activities are decentralized.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(A). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.090 Dietary Services in Hospitals

PURPOSE: This rule specifies the manner in which dietary services shall be organized and integrated in a hospital.

(1) The hospital shall have a full-time employee designated who—

(A) Serves as director of dietary services;

(B) Is responsible for the daily management of the dietary services;

(C) Is qualified by education, training and experience in food service management and nutrition through an approved course for certification by the Dietary Managers Association or registration by the Commission on Dietetic Registration of the American Dietetic Association, or an associate degree in dietetics or food systems management; and

(D) Has documented evidence of annual continuing education.

(2) When the director is not a qualified dietitian, a qualified dietitian shall be employed on a part-time or consultant basis. The dietitian shall make visits to the facility to assist in meeting the nutritional needs of the patients and the scope of services offered.

(3) The qualified dietitian shall ensure that high quality nutritional care is provided to patients in accordance with recognized dietary practices. When the services of a qualified dietitian are used on a part-time or consultant basis, the following services shall be provided on the premises on a regularly scheduled basis:

(A) Continuing liaison with the administration, medical staff and nursing staff;

(B) Approval of planned, written menus, including modified diets; and

(C) Evaluation of menus for nutritional adequacy.

(4) The consultant or part-time dietitian shall assist the director of dietary services to ensure—

(A) Patient and family counseling and diet instructions;

(B) Nutritional screening within three (3) days of admission to identify patients at nutritional risk. The hospital shall develop criteria to use in conducting the nutritional screening and staff who conduct the screening shall be trained to use the criteria;

(C) Comprehensive nutritional assessments within twenty-four (24) hours after screens on patients at nutritional risk, including height, weight and pertinent laboratory tests;

(D) Documentation of pertinent information in patient's records, as appropriate;

(E) Participation in committee activities concerned with nutritional care; and

(F) Planned, written menus for regular and modified diets.

(5) The director of dietary services or his/her designee shall be responsible for—

(A) Representing the dietary service in interdepartmental meetings;

(B) Recommending the quantity and quality of food purchased;

(C) Participating in the selection, orientation, training, scheduling and supervision of

dietary personnel;

(D) Interviewing the patients for food preferences and tolerances and providing appropriate substitutions;

(E) Monitoring adherence to the written planned menu; and

(F) Scheduling dietary services meetings.

(6) When the qualified dietitian serves as a consultant, written reports shall be submitted to and approved by the chief executive officer or designee concerning the services provided.

(7) The director of dietary services shall be responsible for developing and implementing written policies and procedures and for monitoring to assure they are followed. Policies and procedures shall be kept current and approved by the chief executive officer or designee.

(8) Dietary services shall be staffed with a sufficient number of qualified personnel.

(9) Menus shall be planned, written and followed to meet the nutritional needs of the patients as determined by the recommended dietary allowances (RDA) of the Food and Nutrition Board of the National Research Council, National Academy of Sciences or as modified by physician's order.

(10) Diets shall be prescribed in accordance with the diet manual approved by the qualified dietitian and the medical staff. The diet manual shall be available to all medical, nursing and food service personnel.

(11) At least three (3) meals or their equivalent shall be served approximately five (5) hours apart with supplementary feedings as necessary. There shall not be more than fourteen (14) hours between a substantial evening meal and breakfast.

(12) Dietary records shall be maintained which include: food specifications and purchase orders; meal count; standardized recipes; menu plans; nutritional evaluation of menus; and minutes of departmental and in-service education meetings.

(13) The dietary services shall comply with 19 CSR 20-1.010 Sanitation of Food Services Establishments. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance and shall be attractively served at acceptable temperatures. Potentially hazardous foods shall be served at temperatures specified in 19 CSR 20-1.010(4)(I) and (J), (5)(B)1.–3. and (H).

(14) When there is a contract to provide dietary services to a hospital, the hospital is responsible for assuring that contractual services comply with rules concerning dietary services in hospitals.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.092 Emergency Services in Hospitals

PURPOSE: This rule establishes the requirements for emergency services in a hospital.

(1) Each hospital providing general services to the community shall provide an easily accessible emergency area which shall be equipped and staffed to ensure that ill or injured persons can be promptly assessed and treated or transferred to a facility capable of providing needed specialized services. In multiple-hospital communities where written agreements have been developed among the hospitals in accordance with an established community-based hospital emergency plan, individual hospitals may not be required by the Department of Health to provide a fully equipped emergency service.

(2) A hospital shall have a written hospital emergency transfer policy and written transfer agreements with one (1) or more hospitals within its service area which provide services not available at the transferring hospital. Transfer agreements shall be established which reflect the usual and customary referral practice of the transferring hospital, but are not intended to cover all contingencies.

(3) Hospital emergency services shall be under the medical direction of a qualified staff physician who is board-certified or board-admissible in emergency medicine and maintains a knowledge of current ACLS and ATLS standards or a physician who is experienced in the care of critically ill and injured patients and maintains current verification in ACLS and ATLS. In pediatric hospitals, PALS shall be substituted for ACLS. With the explicit advanced approval of the Department of Health, a hospital may contract with a qualified consultant physician to meet this requirement.

(A) That physician shall be responsible for implementing rules of the medical staff relating to patient safety and privileges and to the quality and scope of emergency services.

(B) A qualified registered nurse shall supervise and evaluate the nursing and patient care provided in the emergency area by nursing and ancillary personnel. Supervision may be by direct observation of staff or, at a minimum, the nurse shall be immediately available in the institution.

(C) Any person assigned to the emergency services department administering medications shall be a licensed physician, registered nurse, EMT-paramedic or appropriately licensed or certified allied health practitioner and shall administer medications only within his/her scope of practice except for students who are participating in a training program to become physicians, nurses, emergency medical technician-paramedics who may be allowed to administer medication under the supervision of their instructors as a part of their training. Trained individuals from the respiratory therapy department may be allowed to administer aerosol medications when a certified respiratory therapy assistant is not available.

(4) Any hospital which provides emergency services and does not maintain a physician in-house twenty-four (24) hours a day for emergency care shall have a call roster which lists the name of the physician who is on call and available for emergency care and the dates and times of coverage. A physician who is on call and available for emergency care shall respond in a manner which is reasonable and appropriate to the patient's condition after being summoned by the hospital.

(5) Any hospital with surgical services that also provide emergency surgical services shall have a general surgical call roster which lists the name of the general surgeon who is on call for emergency surgical cases, and the dates and times of coverage. The surgeon who is on call for emergency surgical cases shall arrive at the hospital within thirty (30) minutes of being summoned. Patients arriving at a hospital that does not provide emergency surgical services and are found upon examination to require emergency surgery shall be immediately transferred to a hospital with the necessary services.

(6) All patients admitted to the emergency service shall be assessed prior to discharge by a physician or registered professional nurse.

(7) If discharged from the emergency department, other than to the inpatient setting, the patient or responsible person shall be given

written instructions for care and an oral explanation of those instructions. Documentation of these instructions shall be entered on the emergency service medical record.

(8) There shall be a quality improvement program for the emergency service which includes, but is not limited to, the collection and analysis of data to assist in identification of health service problems, and a mechanism for implementation and monitoring appropriate actions. The quality improvement program shall include the periodic evaluation of at least the following: length of time each patient is in the emergency room, appropriateness of transfers, physician response time, provision for written instructions, timeliness of diagnostic studies, appropriateness of treatment rendered, and mortality.

(9) Written policies shall be adopted to assure that notification procedures are implemented concerning the significant exposure of prehospital emergency personnel to communicable diseases as required in 19 CSR 30-40.047.

(10) The emergency service medical record shall contain patient identification, time and method of arrival, history, physical findings, treatment and disposition and shall be authenticated by the physician. These records, including an ambulance report when applicable, shall be filed under supervision of the medical records department.

(11) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of emergency services.

(12) A hospital shall have a written plan that details the hospital's criteria and process for diversion. The plan must be reviewed and approved by the Missouri Department of Health prior to being implemented by the hospital. A hospital may continue to operate under a plan in existence prior to the effective date of this section while awaiting approval of its plan by the department.

(A) The diversion plan shall:

1. Identify the individuals by title who are authorized by the hospital to implement the diversion plan;

2. Define the process by which the decision to divert will be made;

3. Specify that the hospital will not implement the diversion plan until the authorized individual has reviewed and documented the hospital's ability to obtain additional staff, open existing beds that may have been closed or take any other actions that might prevent a diversion from occurring;

4. Include that all ambulance services within a defined service area will be notified of the intent to implement the diversion plan upon the actual implementation. Ambulances that have made contact with the hospital before the hospital has declared itself to be on diversion shall not be redirected to other hospitals. In areas served by a real time, electronic reporting system, notification through such system shall meet the requirements of this provision so long as such system is available to all EMS agencies and hospitals in the defined service area;

5. Include procedures for assessment, stabilization and transportation of patients in the event that services, including but not limited to, ICU beds or surgical suites become unavailable or overburdened. These procedures must also include the evaluation of services and resources of the facility that can still be provided to patients even with the implementation of the diversion plan;

6. Include procedures for implementation of a resource diversion in the event that specialized services are overburdened or temporarily unavailable; and

7. Include that all other acute care hospitals within a defined service area will be notified upon the actual implementation of the diversion plan. For defined service areas with more than two (2) hospitals, if more than one-half (1/2) of the hospitals implement their diversion plans, no hospital will be considered on diversion. For a defined service area with two (2) hospitals, if both hospitals implement their diversion plans, neither will be considered on diversion. Participation in a real time, electronic reporting system shall meet the notification requirements of this section. If a hospital participates in an approved community wide plan, the community wide plan may set the requirement for the number of hospitals to remain open.

(B) Each incident of diversion plan implementation must be reviewed by the hospital's existing quality assurance committee. Minutes of these review meetings must be made available to the Missouri Department of Health and Senior Services upon request.

(C) The hospital shall assure compliance with screening, treatment and transfer requirements as required by the Emergency Medical Treatment and Active Labor Act (EMTALA).

(D) A hospital or its designee shall report to the department, by phone or electronically, upon actual implementation of the diversion plan. This implementation report shall contain the time the plan will be implemented. The hospital or its designee shall report to the department, by phone or electronically, within eight (8) hours of the termination of the diversion. This termination report shall contain the time the diversion plan was implemented, the reason for the diversion, the name of the individual who made the determination to implement the diversion plan, the time the diversion status was terminated, and the name of the individual who made the determination to terminate the diversion. In areas served by real time, electronic reporting system, reporting through such system shall meet the requirements of this provision so long as such system generates reports as required by the department.

(E) Each hospital shall implement a triage system within its emergency department. The triage methodology shall continue to apply during periods when the hospital diversion plan is implemented.

(F) Any hospital that has a written approved policy, which states that the hospital will not go on diversion or resource diversion, except as defined in the hospital's disaster plan in the event of a disaster, is exempt from the requirements of 19 CSR 30-20.021(3)(C)12.

(G) If a hospital chooses to participate in a community wide plan, the requirements of number of hospitals to remain open, defined service areas, as well as community notification may be addressed within the community plan. Community plans must be approved by the department. Community plans must include that each hospital has a policy addressing diversion and the criteria used by each hospital to determine the necessity of implementing a diversion plan. Participation in a community plan does not exempt a hospital of the requirement to notify the department of a diversion plan implementation.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(C). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.094 Medical Records in Hospitals

PURPOSE: This rule establishes minimum requirements for medical records kept in hospitals.

(1) The director of the medical record services shall be appointed by the chief executive officer or chief operating officer. This director may be a qualified registered record

administrator, an accredited record technician or an individual with demonstrated competence and knowledge of medical record department activities supervised by a qualified consultant who is a registered record administrator or accredited record technician.

(2) Patient care by members of the medical staff, nursing staff and allied health professionals shall be entered in the patient's medical record in a timely manner. Documentation shall be legible, dated, authenticated and recorded in ink, typewritten or recorded electronically.

(3) All orders shall be dated and authenticated by the ordering practitioner and shall be kept in the patient's medical record. Verbal orders shall be authenticated by the prescribing practitioner or attending physician within the time frame that is defined by the medical staff in cooperation with nursing and administration. Authentication shall include written signatures, initials, computer-generated signature codes or rubber stamp signatures by the medical members and authorized persons whose signatures the stamp represents. The use of rubber stamps is discouraged, but where authorized, a signed statement shall be maintained in the administrative offices with a copy in the medical records department stating that the medical staff member whose stamp is involved is the only one who has the stamp and is the only one authorized to use it. The duplication of signature stamps and the delegation of their use by others is prohibited.

(4) Only abbreviations and symbols approved by the medical staff may be used in the medical records. Each abbreviation or symbol shall have only one (1) meaning and an explanatory legend shall be available for use by all concerned. There shall be a list of abbreviations and symbols that shall not be used in handwritten communications.

(5) The medical record of each patient shall be maintained in order to justify admission and continued hospitalization, support the diagnosis, describe the patient's progress and response to medications and services and to facilitate rapid retrieval and utilization by authorized personnel.

(6) Medical records are the property of the hospital and shall not be removed from the hospital premises except by court order, subpoena, for the purposes of microfilming or for off-site storage approval by the governing body.

(7) Written consent of the patient or the patient's legal representative is required for access to or release of information, copies or excerpts from the medical record to persons not otherwise authorized to receive this information.

(8) Patient records shall be considered complete for filing when the required contents are assembled and authenticated. Hospital policy shall define circumstances in which incomplete medical records may be filed permanently by order of the medical record committee.

(9) An inpatient's medical record shall include: a unique identifying record number; pertinent identifying and personal data; history of present illness or complaint; if injury, how the injury occurred; past history; family history; physical examination; admitting diagnosis; medical staff orders; progress notes; nurses' notes; discharge summary; final diagnosis; and evidence of informed consent. Where applicable, medical records shall contain reports such as clinical laboratory, X-ray, consultation, electrocardiogram, surgical procedures, therapy, anesthesia, pathology, autopsy and any other reports pertinent to the patient's care.

(10) Admission forms shall be designed to record pertinent identifying and personal data.

(11) A certificate of live birth shall be prepared for each child born alive and shall be forwarded to the local registrar within seven (7) days after the date of delivery. If the physician or other person in attendance does not certify to the facts of birth within five (5) days after the birth, the person in charge of the institution shall complete and sign the certificate.

(12) When a dead fetus is delivered in an institution, the person in charge of the institution or his/her designated representative shall prepare and, within seven (7) days after delivery, file a report of fetal death with the local registrar.

(13) Medical records of deceased patients shall contain the date and time of death, autopsy permit, if granted, disposition of the body, by whom received and when.

(14) The State Anatomical Board shall be notified of an unclaimed dead body. A record of this notification shall be maintained.

(15) The patient's medical records shall be maintained to safeguard against loss, defacement and tampering and to prevent damage from fire and water. Medical records shall be preserved in a permanent file in the original, on microfilm or other electronic media. Patients' medical records shall be retained for a minimum of ten (10) years, except that a minor shall have his/her record retained until his/her twenty-third birthday, whichever occurs later. Preservation of medical records may be extended by the hospital for clinical, educational, statistical or administrative purposes.

(16) There shall be a mechanism for the review and evaluation on a regular basis of the quality of medical record services.

(17) Should the hospital cease to be licensed, arrangements for disposition of the patient medical records shall be made with nearby hospitals, the patient's physician or a reliable storage company. Notification of the disposition is to be provided to the department.

(18) A history and physical examination shall be completed on each inpatient within twenty-four (24) hours of admission, or a history and physical examination shall have been completed or updated within the seven (7) days prior to admission. A history and physical which is performed up to and no more than thirty (30) days before admission may be utilized provided that the patient is reassessed and an update note is written, signed and dated to reflect the patient's status within seven (7) days prior to, or within twenty-four (24) hours after, admission.

(19) A patient's records shall be completed within thirty (30) days of discharge.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(D). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.096 Nursing Services in Hospitals

PURPOSE: This rule establishes the requirements for nursing services in a hospital.

(1) The nursing service shall be integrated and identified within the total hospital organizational structure.

(2) The nursing service shall have a written organizational structure that indicates lines of authority, accountability, and communication.

(3) The organization of the nursing service shall conform with the variety of patient care services offered and the range of nursing care activities.

(4) Nursing policies and standards of practice describing patient care shall be in writing and be kept current.

(5) Policies shall provide for the collaboration of nursing personnel with members of the medical staff and other health care disciplines regarding patient care issues.

(6) Nursing service policies shall establish an appropriate committee structure to oversee and assist in the provision of quality nursing care. The purpose and function of each committee shall be defined and a record of its activities shall be maintained.

(7) Policies shall make provision for nursing personnel to be participants of hospital committees concerned with patient care activities.

(8) Policies shall be developed regarding the use of overtime. The policies shall be based on the following standards:

(A) Overtime shall not be mandated for any licensed nursing personnel except when an unexpected nurse staffing shortage arises that involves a substantial risk to patient safety, in which case a reasonable effort must be applied to secure safe staffing before requiring the on-duty licensed nursing personnel to work overtime. Reasonable efforts undertaken shall be verified by the hospital. Reasonable efforts shall include pursuing all of the following:

1. Reassigning on-duty staff;

2. Seeking volunteers to work extra time from all available qualified nursing staff who are presently working;

3. Contacting qualified off-duty employees who have made themselves available to work extra time, per diem staff, float pool, and flex team nurses; and

4. Seeking personnel from a contracted temporary agency or agencies when such staffing is permitted by law or an applicable collective bargaining agreement and when the employer regularly uses the contracted temporary agency or agencies;

(B) In the absence of nurse volunteers, float pool nurses, flex team nurses, or contracted temporary agency staff secured by the reasonable efforts as described in subsection (8)(A) and if qualified reassignments cannot be made, the hospital may require the nurse currently providing the patient care to fulfill his or her obligations based on the Missouri Nurse Practice Act by performing the patient care which is required;

(C) The prohibition of mandatory overtime does not apply to overtime work that occurs because of an unforeseeable emergency or when a hospital and a subsection of nurses commit, in writing, to a set, predetermined staffing schedule or prescheduled on-call time. An unforeseeable emergency is defined as a period of unusual, unpredictable, or unforeseeable circumstances such as, but not limited to, an act of terrorism, a disease outbreak, adverse weather conditions, or natural disasters which impact patient care and which prevent replacement staff from reporting for duty;

(D) The facility is prohibited from requiring a nurse to work additional consecutive hours and from taking action against a nurse on the grounds that a nurse failed to work the additional hours or when a nurse declines to work additional consecutive hours beyond the nurse's predetermined schedule of hours because doing so may, in the nurse's judgement, jeopardize patient safety;

(E) Subsection (8)(D) is not applicable if overtime is permitted under subsections (8)(A), (B), and (C);

(F) Nurses required to work more than twelve (12) consecutive hours under subsections (8)(A), (B), or (C) shall be provided the option to have at least ten (10) consecutive hours of uninterrupted off-duty time immediately following the worked time; and

(G) The nursing service shall maintain and make available upon request to the department a list of qualified nurses, nurse registries, and per diem nurses that may be called upon to provide replacement staff in the event of sickness, vacations, vacancies, disasters, and other absences of direct care nursing staff.

(9) The nursing service shall be administered and directed by a qualified registered professional nurse with appropriate education, experience and demonstrated ability in nursing practice and management.

(10) The nursing service administrator shall be responsible to the chief executive officer or chief operating officer.

(11) The nursing service administrator shall be a full-time employee and shall have the authority and be accountable for assuring the provision of quality nursing care for those patient areas delineated in the organizational structure.

(12) The nursing service administrator shall participate in the formulation of hospital policies and the development of long-range plans relating to patient care.

(13) The nursing service administrator, or designee, shall represent nursing at all appropriate meetings of the medical staff and governing board of the hospital.

(14) The nursing service administrator shall be accountable for the selection, promotion and termination of all nursing personnel under the authority of nursing service.

(15) The nursing service administrator shall have sufficient time to perform the necessary managerial duties and functions of the position.

(16) A qualified registered professional nurse shall be designated and authorized to act in the absence of the nursing service administrator.

(17) Nursing personnel shall hold a valid and current license in accordance with sections 335.011–335.096, RSMo.

(18) There shall be a job description for each classification of nursing personnel which delineates the specific qualifications, licensure, certification, authority, responsibilities, functions, and performance standards for that classification. Job descriptions shall be reviewed annually and revised as necessary to reflect current job requirements.

(19) There shall be scheduled annual evaluations of job performance for all classifications of nursing personnel.

(20) All nursing personnel shall be oriented to the hospital, nursing services, their position classification, the use of overtime, and the nursing service regulation 19 CSR 30-20.096. The orientation shall be of sufficient length and content to prepare nursing personnel for their specified duties and responsibilities. Competency shall be validated prior to assuming independent performance in actual patient situations.

(21) For specialized nursing units and those units providing specific clinical services, written policies and procedures, including standards of practice, shall be available and current.

(22) Nursing personnel meetings shall be conducted at intervals necessary for leadership and to communicate management information.

Separate meetings for the various job classifications of personnel may be conducted. Minutes of all meetings shall be maintained and reflect attendance, scope of discussion, and action(s) taken. The minutes shall be filed according to hospital policy.

(23) Every hospital shall develop, implement, and submit to the department by April 1, 2009, and annually thereafter at the start of the hospital's fiscal year, a written hospital-wide staffing plan for nursing services. Every hospital shall have a process that ensures the consideration of input from direct care nursing staff from each unit within the hospital.

(24) The hospital-wide staffing plan for nursing services shall:

(A) Include the number, skill mix, and qualifications of direct care nursing staff needed for each unit of the hospital;

(B) Be based on the expected nursing care required by the unit population and individual needs of each patient. The expected unit population and individual nursing care needs of each patient shall be the major consideration in determining the number and skill mix of direct care nursing staff needed;

(C) Identify relevant factors in each hospital unit including, but not limited to, the number of patients in a unit; intensity of care required; skill and experience of care givers including registered nurses, licensed practical nurses, ancillary personnel, and other members of the patient care team consistent with the level of authority and responsibility delegated under state licensure; admission, discharge, and transfers; nonpatient care duties; geography of a unit; and the availability of technological support; and

(D) Provide for documentation of the actual staffing plan.

(25) Every hospital shall establish nursing sensitive indicators and monitor outcomes of these indicators to evaluate the adequacy of the hospital-wide staffing plan for nursing services. At least one (1) of each of the following three (3) types of outcomes shall be used to evaluate the adequacy of the staffing plan:

(A) Patient outcomes such as patient falls, adverse drug events, injuries to patients, skin breakdown, infection rates, length of stay, or patient readmissions;

(B) Operational outcomes such as work-related injury or illness, vacancy and turnover rates, nursing care hours per patient day, on-call use, or overtime rates; and

(C) Validated patient complaints related to staffing levels.

(26) The hospital shall, in consultation with its direct care nursing staff, monitor and evaluate the hospital-wide staffing plan and nursing sensitive outcomes for effectiveness on a continual basis and revise the plan annually and as necessary.

(27) Each facility shall develop and utilize a methodology which ensures it is staffed with sufficient numbers and skill mix of appropriately qualified direct care nursing staff in each unit to meet the unit population and individualized care needs of the patients. Each unit shall document actual staffing and patient census during every shift.

(28) At a minimum, there shall be a sufficient number of registered professional nurses on duty at all times to provide patient care requiring the judgment and skills of a registered professional nurse and to supervise the activities of all nursing personnel.

(29) There shall be sufficient licensed and ancillary nursing personnel on duty on each nursing unit to meet the needs of each patient in accordance with accepted standards of nursing practice.

(30) Each nursing unit shall post in a visible location on the nursing unit or make available to the patient(s) or patient's authorized representative a copy of the unit's hospital-wide staffing plan for nursing services and documentation of actual daily staffing levels.

(31) Patient care assignments shall be consistent with the qualifications of the nursing personnel and the identified patient needs. Nurses included in the count of direct care nursing staff in a unit of a hospital for purposes of compliance with the hospital-wide staffing plan shall have appropriate licensing, training, and orientation to ensure that the nurses are capable of providing competent nursing care to the patients in the unit. Hospitals shall also verify that nurses included in the count are capable of providing competent nursing care to the patients in the unit. Nurses included in the count shall spend a minimum of seventy-five percent (75%) of their time providing direct patient care.

(32) Documentation in the patient's medical record shall reflect use of the nursing process in the delivery of care throughout the patient's hospitalization.

(33) A registered professional nurse shall assess the patient's needs for nursing care in all settings where nursing care is provided. A nursing assessment shall be completed within twenty-four (24) hours of admission as an inpatient. The registered professional nurse may be assisted in the process by other qualified nursing staff members.

(34) Patient education and discharge needs shall be addressed and appropriately documented in the medical records.

(35) The necessary types and quantities of supplies and equipment shall be available to meet the current needs of each patient. Reference materials pertinent to patient care shall be readily accessible.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and section 197.154, RSMo Supp. 2008. This rule previously filed as 19 CSR 30-20.021(3)(E). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Oct. 22, 2008, effective June 30, 2009.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995, and 197.154, RSMo 2004.*

19 CSR 30-20.097 Safe Patient Handling and Movement in Hospitals

PURPOSE: This rule specifies the requirements for safe patient handling and movement practices in a hospital.

(1) There shall be an active multidisciplinary committee responsible for implementing and monitoring the safe patient handling and movement program. At least one-half (1/2) of the members of the committee shall be front-line non-managerial employees who are involved in patient care handling activities.

(2) This program shall include:

(A) A safe patient handling policy for all shifts that will achieve elimination of manual lifting, transferring, and repositioning of all or most of a patient's weight, except in emergency, life-threatening, or otherwise exceptional circumstances;

(B) A patient-handling hazard assessment that considers such variables as patient-handling tasks, types of nursing units, patient populations, and the physical environment of patient care areas;

(C) A process which assesses patient's needs for safe patient handling and movement;

(D) Educational materials for patients and their families to help orient them to the hospital's safe patient handling program;

(E) An annual evaluation of the program utilizing measurable outcome measures

including but not limited to employee and patient injuries, lost work days, and workers' compensation claims; and

(F) Evidence of changes based on the program evaluation.

(3) All employees involved in patient care handling activities are to be trained and demonstrate competence on safe patient handling policies, equipment, and devices before implementation, annually, and as changes are made to the program.

AUTHORITY: section 197.080, RSMo 2000. Original rule filed April 29, 2011, effective Nov. 30, 2011.*

**Original authority: 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.098 Pathology and Medical Laboratory Services in Hospitals

PURPOSE: This rule establishes the requirements for pathology and medical laboratory services in a hospital.

(1) Provision shall be made, either on the premises or by contract with a reference laboratory, for the prompt performance of adequate examinations in the fields of hematology, clinical chemistry, urinalysis, microbiology, immunology, anatomic pathology, cytology and immunohematology.

(2) The director of the pathology and medical laboratory services shall be a physician who is a member of the medical staff and appointed by the governing body. If the director is not a pathologist, a pathologist shall be retained on a part-time basis as a consultant on-site. Consultation shall be provided no less than monthly. A written report of the consultant's evaluation and recommendations shall be submitted after each visit.

(3) Pathology and medical laboratory services shall be integrated with other hospital services. The pathologist(s) shall have an active role in in-service educational programs and in medical staff functions, the laboratory quality assurance program and shall participate in committees that review tissue, infection control and blood usage.

(4) Laboratory technologists shall have graduated from a medical technology program approved by a nationally recognized body or have documented equivalent education, training and experience. There shall be sufficient qualified laboratory technologists and supportive technical staff currently competent in their field to perform the tests required. Laboratory personnel shall have the opportunity for continuing education.

(5) The laboratory shall perform tests and examine specimens from hospital inpatients only on the order of a medical staff member. The laboratory shall perform tests and examine specimens from any other source only on written request. Test requests received by the laboratory shall clearly identify the patient, the source of the request, the tests required and the date. Requests for examinations of surgical specimens shall contain necessary clinical information.

(6) The laboratory shall maintain complete written instructions for specimen collection and processing, storage, testing and reporting of results. The instructions shall include, but not be limited to, a step-by-step description of the testing procedure, reagent use and storage, control and calibration procedures and pertinent literature references.

(7) Dated reports of all laboratory examinations shall become a part of the patient's medical record. If the original report from a reference laboratory is not part of the patient's record, the original shall be retained and retrievable for a period of not less than two (2) years. Dated reports of tests on outpatients and from referring laboratories shall be sent promptly to the individual or facility ordering the test. Copies of all laboratory tests and examinations shall be retained and retrievable for at least two (2) years.

(8) Instruments and equipment shall be evaluated to insure that they function properly at all times. Records shall be maintained for each piece of equipment, showing the date of inspection, calibration, performance evaluation and action taken to correct deficiencies. Temperatures shall be recorded daily for all temperature-controlled instruments.

(9) Each section of the pathology and medical laboratory shall have a written quality control program to verify accuracy, measure precision and detect error. Quality control results shall be documented and retained for at least two (2) years.

(10) The hospital laboratory shall successfully participate in a proficiency-testing program covering all anatomical and clinical specialties in which the laboratory performs tests and in which proficiency testing is available. Records of proficiency testing shall be maintained for at least two (2) years.

(11) All specimens, except for teeth and foreign objects, removed during a surgical, diagnostic, or other procedure shall be submitted for pathologic examination, except for specimens that have been previously determined to be exempt. Specimens submitted for pathological examination shall be accompanied by pertinent clinical information. Specimens exempted from pathologic examination shall be those for which examination does not add to the diagnosis, treatment or prognosis, shall be determined by the medical staff in consultation with the pathologist, and shall be documented in writing. When the specimen is not submitted for pathological examination, a report of the removal must be present in the patient's medical record. Specimens requiring only a gross description and diagnosis shall be determined by the medical staff in consultation with the pathologist and shall be documented in writing.

(12) An autopsy service shall be available to meet the needs of the hospital. Each autopsy shall be performed by, or under the supervision of, a pathologist or a physician whose credentials document his/her qualifications in anatomical pathology. All microscopic interpretations shall be made by a pathologist who is qualified in anatomical pathology.

(13) At all times there shall be an established procedure for obtaining a supply of blood and blood components. Facilities for the safekeeping and safe administration of blood and blood products shall be provided. Positive patient identification shall be provided through an armband that displays a number or other unique identifying symbol. This armband shall be on the patient before or at the time of drawing the first tube of blood used for transfusion preparation. The refrigerator used for the routine storage of blood for transfusion shall maintain a temperature between one degree and six degrees Celsius (1°–6° C) and this temperature shall be verified by an outside recording thermometer. This refrigerator shall be constantly monitored by an audible and visible alarm that is located in an area that is staffed at all times. The alarm shall be battery-operated or powered by a circuit different from the one supplying the refrigerator. This refrigerator shall be on the power line supplied by the emergency generator.

(14) The hospital shall provide safety equipment for laboratory employees that includes, but is not limited to, gloves. No food, drink, tobacco or personal care items shall be in the laboratory testing area.

(15) The hospital shall provide reports to the

department as required by 19 CSR 10-33.050 and section 192.131, RSMo.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(F). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.100 Pharmacy Services and Medication Management in Hospitals

PURPOSE: This rule establishes the requirements for pharmacy services and medication management in a hospital.

(1) Pharmacy services shall be identified and integrated within the total hospital organizational plan. Pharmacy services shall be directed by a pharmacist who is currently licensed in Missouri and qualified by education and experience. The director of pharmacy services shall be responsible for the provision of all services required in subsection (4)(G) of this rule and shall be a participant in all decisions made by pharmacy services or committees regarding the use of medications. With the assistance of medical, nursing and administrative staff, the director of pharmacy services shall develop standards for the selection, distribution and safe and effective use of medications throughout the hospital.

(2) Additional professional and supportive personnel shall be available for services provided. Pharmacists shall be currently licensed in Missouri and all personnel shall possess the education and training necessary for their responsibilities.

(3) Support pharmacy personnel shall work under the supervision of a pharmacist and shall not be assigned duties that by law must be performed by a pharmacist. Interpreting medication orders, selecting, compounding, packaging, labeling and the dispensing of medications by pharmacy staff shall be performed by or under the supervision of a pharmacist. Interpretation of medication orders by support personnel shall be limited to order processing and shall not be of a clinical nature.

(4) Hours shall be established for the provision of pharmacy services. A pharmacist shall be available to provide required pharmacy services during hours appropriate for necessary contact with medical and nursing staff. A pharmacist shall be on call at all other times.

(5) Space, equipment and supplies shall be available according to the scope of pharmacy services provided. Office or other work space shall be available for administrative, clerical, clinical and other professional services provided. All areas shall meet standards to maintain the safety of personnel and the security and stability of medications stored, handled and dispensed.

(6) The pharmacy and its medication storage areas shall have proper conditions of sanitation, temperature, light, moisture, ventilation and segregation. Refrigerated medication shall be stored separate from food and other substances. The pharmacy and its medication storage area shall be locked and accessible only to authorized pharmacy and supervisory nursing personnel. The director of pharmacy services, in conjunction with nursing and administration, shall be responsible for the authorization of access to the pharmacy by supervisory nursing personnel to obtain doses for administering when pharmacy services are unavailable.

(7) Medication storage areas outside of the pharmacy shall have proper conditions of sanitation, temperature, light, moisture, ventilation and segregation. Refrigerated medications shall be stored in a sealed compartment separate from food and laboratory materials. Medication storage areas shall be accessible only to authorized personnel and locked when appropriate.

(8) The evaluation, selection, source of supply and acquisition of medications shall occur according to the hospital's policies and procedures. Medications and supplies needed on an emergency basis and necessary medications not included in the hospital formulary shall be acquired according to the hospital's policies and procedures.

(9) Records shall be maintained of medication transactions, including: acquisition, compounding, repackaging, dispensing or other distribution, administration and controlled substance disposal. Persons involved in compounding, repackaging, dispensing, administration and controlled substance disposal shall be identified and the records shall be retrievable. Retention time for records of bulk compounding, repackaging, administration, and all controlled substance transactions shall be a minimum of two (2) years. Retention time for records of dispensing and extemporaneous compounding, including sterile medications, shall be a minimum of six (6) months.

(10) Security and record keeping procedures in all areas shall ensure the accountability of all controlled substances, shall address accountability for other medications subject to theft and abuse and shall be in compliance with 19 CSR 30-1.030(3). Inventories of Schedule II controlled substances shall be routinely reconciled. Inventories of Schedule III–V controlled substances outside of the pharmacy shall be routinely reconciled. Records shall be maintained so that inventories of Schedule III–V controlled substances in the pharmacy shall be reconcilable.

(11) Controlled substance storage areas in the pharmacy shall be separately locked and accessible only to authorized pharmacy staff. Reserve supplies of all controlled substances in the pharmacy shall be locked. Controlled substance storage areas outside the pharmacy shall be separately locked and accessible only to persons authorized to administer them and to authorized pharmacy staff.

(12) Authorization of access to controlled substance storage areas outside of the pharmacy shall be established by the director of pharmacy services in conjunction with nursing and administration. The distribution and accountability of keys, magnetic cards, electronic codes or other mechanical and electronic devices shall occur according to the hospital's policies and procedures.

(13) All variances involving controlled substances—including inventory, security, record keeping, administration and disposal—shall be reported to the director of pharmacy services for review and investigation. Loss, diversion, abuse or misuse of medications shall be reported to the director of pharmacy services, administration, and local, state and federal authorities as appropriate.

(14) The provision of pharmacy services in the event of a disaster, removal from use of medications subject to product recall and reporting of manufacturer drug problems shall occur according to the hospital's policies and procedures.

(15) Compounding and repackaging of medications in the pharmacy shall be done by pharmacy personnel under the supervision of a pharmacist. Those medications shall be labeled with the medication name, strength, lot number, expiration date and other pertinent information. Record keeping and quality control, including end-product testing when

appropriate, shall occur according to the hospital's policies and procedures.

(16) Compounding, repackaging or relabeling of medications by nonpharmacy personnel shall occur according to the hospital's policies and procedures. Medications shall be administered routinely by the person who prepared them, and preparation shall occur just prior to administration except in circumstances approved by the director of pharmacy, nursing and administration. Compounded sterile medications for parenteral administration prepared by nonpharmacy personnel shall not be administered beyond twenty-four (24) hours of preparation. Labeling shall include the patient's name, where appropriate, medication name, strength, beyond use date, identity of the person preparing and other pertinent information.

(17) Compounded sterile medications shall be routinely prepared in a suitably segregated area in a Class 100 environment by pharmacy personnel. Preparation by nonpharmacy personnel shall occur only in specific areas or in situations when immediate preparation is necessary and pharmacy personnel are unavailable and shall occur according to policies and procedures. All compounded cytotoxic/hazardous medications shall be prepared in a suitably segregated area in a Class II biological safety cabinet or vertical airflow hood. The preparation, handling, administration and disposal of sterile or cytotoxic/hazardous medications shall occur according to policies and procedures including: orientation and training of personnel, aseptic technique, equipment, operating requirements, environmental considerations, attire, preparation of parenteral medications, preparation of cytotoxic/hazardous medications, access to emergency spill supplies, special procedures/products, sterilization, extemporaneous preparations and quality control.

(18) Radiopharmaceuticals shall be acquired, stored, handled, prepared, packaged, labeled, administered and disposed of according to the hospital's policies and procedures and only by or under the supervision of personnel who are certified by the Nuclear Regulatory Commission.

(19) A medication profile for each patient shall be maintained and reviewed by the pharmacist and shall be reviewed by the pharmacist upon receiving a new medication order prior to dispensing the medication. The pharmacist shall review the prescriber's order or a direct copy prior to the administration of the initial dose, except in an emergency or when the pharmacist is unavailable, in which case the order shall be reviewed within seventy-two (72) hours.

(20) Medications shall be dispensed only upon the order of an authorized prescriber with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved policy/protocol after an assessment for contraindications, and only dispensed by or under the supervision of the pharmacist.

(21) All medications dispensed for administration to a specific patient shall be labeled with the patient name, drug name, strength, expiration date and, when applicable, the lot number and other pertinent information.

(22) The medication distribution system shall provide safety and accountability for all medications, include unit of use and ready to administer packaging, and meet current standards of practice.

(23) To prevent unnecessary entry to the pharmacy, a locked supply of routinely used medications shall be available for access by authorized personnel when the pharmacist is unavailable. Removal of medications from the pharmacy by authorized supervisory nursing personnel, documentation of medications removed, restricted and unrestricted medication removal, later review of medication orders by the pharmacist, and documented audits of medications removal shall occur according to the hospital's policies and procedures. The nurse shall remove only amounts necessary for administering until the pharmacist is available.

(24) Floorstock medications shall be limited to emergency and nonemergency medications which are authorized by the director of pharmacy services in conjunction with nursing and administration. The criteria, utilization and monitoring of emergency and non-emergency floorstock medications shall occur according to the hospital's policies and procedures. Supplies of emergency medications shall be available in designated areas.

(25) All medication storage areas in the hospital shall be inspected at least monthly by a pharmacist or designee according to the hospital's policies and procedures.

(26) The pharmacist shall be responsible for the acquisition, inventory control, dispensing, distribution and related documentation requirements of investigational medications according to the hospital's policies and procedures. A copy of the investigational protocol shall be available in the pharmacy to all health care providers who prescribe or administer investigational medications. The identity of all recipients of investigational medications shall be readily retrievable.

(27) Sample medications shall be received and distributed by the pharmacy according to the hospital's policies and procedures.

(28) Dispensing of medications by the pharmacist to patients who are discharged from the hospital or who are outpatients shall be in compliance with 4 CSR 220.

(29) Persons other than the pharmacist may provide medications to patients leaving the hospital only when prescription services from a pharmacy are not reasonably available. Medications shall be provided according to the hospital's policies and procedures, including: circumstances when medications may be provided, practitioners authorized to order, specific medications and limited quantities, prepackaging and labeling by the pharmacist, final labeling to facilitate correct administration, delivery, counseling and a transaction record. Final labeling, delivery and counseling shall be performed by the prescriber or a registered nurse.

(30) Current medication information resources shall be maintained in the pharmacy and patient care areas. The pharmacist shall provide medication information to the hospital staff as requested.

(31) The director of pharmacy services shall be an active member of the pharmacy and therapeutics committee or its equivalent, which shall advise the medical staff on all medication matters. A formulary shall be established which includes medications based on an objective evaluation of their relative therapeutic merits, safety and cost and shall be reviewed and revised on a continual basis. A medication use evaluation program shall be established which evaluates the use of selected medications to ensure that they are used appropriately, safely and effectively. Follow-up educational information shall be provided in response to evaluation findings.

(32) The pharmacist shall be available to participate with medical and nursing staff regarding decisions about medication use for individual patients, including: not to use medication therapy; medication selection, dosages, routes and methods of administration; medication therapy monitoring; provision of medication-related information; and counseling to individual patients. The pharmacist or designee shall personally offer to

provide medication counseling when discharge or outpatient prescriptions are filled. The pharmacist shall provide requested counseling.

(33) Medication orders shall be initiated or modified only by practitioners who have independent statutory authority to prescribe or who are legally given authority to order medications. That authority may be given through an arrangement with a practitioner who has independent statutory authority to prescribe and who is a medical staff member. The authority may include collaborative practice agreements, protocols or standing orders and shall not exceed the practitioner's scope of practice. Practitioners given this authority who are not hospital employees shall be approved through the hospital credentialing process. When hospital-based agreements, protocols or standing orders are used, they shall be approved by the pharmacy and therapeutics or equivalent committee.

(34) All medication orders shall be written in the medical record and signed by the ordering practitioner with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy/protocol after an assessment for contraindications. When medication therapy is based on a protocol or standing order and a specific medication order is not written, a signed copy of the protocol or of an abbreviated protocol containing the medication order parameters or of the standing order shall be placed in the medical record with the exception of physician-approved policies/protocols for the administration of influenza and pneumococcal polysaccharide vaccines after an assessment for contraindications. The assessment for contraindications shall be dated and signed by the registered nurse performing the assessment and placed in the medical record. Telephone or verbal orders shall be accepted only by authorized staff, immediately written and identified as such in the medical record and signed by the ordering practitioner within a time frame defined by the medical staff.

(35) Medication orders shall be written according to policies and procedures and those written by persons who do not have independent statutory authority to prescribe shall be included in the quality improvement program.

(36) Automatic stop orders for all medications shall be established and shall include a procedure to notify the prescriber of an impending stop order. A maximum stop order shall be effective for all medications which do not have a shorter stop order. Automatic stop orders are not required when the pharmacist continuously monitors medications to ensure that they are not inappropriately continued.

(37) Medications shall be administered only by persons who have statutory authority to administer or who have been trained in each pharmacological category of medication they administer, and administration shall be limited to the scope of their practice. Persons who do not have statutory authority to administer shall not administer parenteral medications, controlled substances or medications that require professional assessment at the time of administration. A person who has statutory authority to administer shall be readily available at the time of administration. Training for persons who do not have statutory authority to administer shall be documented and administration by those persons shall be included in the quality improvement program. Medications shall be administrated only upon the order of a person authorized to prescribe or order medications. Administration by all persons shall occur according to the hospital's policies and procedures.

(38) Medications brought to the hospital by patients shall be handled according to policies and procedures. They shall not be administered unless so ordered by the prescriber and identified by the pharmacist or the prescriber.

(39) Medications shall be self-administered or administered by a responsible party only upon the order of the prescriber and according to policies and procedures.

(40) Medication incidents, including medication errors shall be reported to the prescriber and the appropriate manager. Medication incidents shall be reported to the appropriate committee. Adverse medication reactions shall be reported to the prescriber and the director of the pharmacy services. The medication administered and medication reaction shall be recorded in the patient's medical record. Adverse medication reactions shall be reviewed by the pharmacy and therapeutics committee and other medical or administrative committees when appropriate.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(G). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.102 Radiology Services in Hospitals

PURPOSE: This rule establishes the requirements for radiology services in a hospital.

(1) Radiographic and fluoroscopic diagnostic services shall be provided in each hospital.

(2) The director of radiology services shall be a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing the quality and scope of radiology services and safety precautions to protect patients and personnel.

(3) Radiotherapy services shall be administered only under the supervision of a physician appropriately qualified by special training and experience.

(4) Requests for radiology services shall be authenticated in the patient's medical record by the attending physician, licensed house staff or other medical staff member authorized to request radiologic services.

(5) A written interpretation, authenticated by a radiologist or other medical staff member appropriately trained and qualified through the medical staff credentialing process, shall be made for all radiological diagnostic services.

(6) Documentation of each radiotherapy treatment shall be authenticated and become a part of the patient's medical record.

(7) A qualified radiologic technologist shall be on duty or on call at all times. Emergency radiologic services shall be available at all times.

(8) Protection from radiation to patients and personnel shall comply with 19 CSR 20-10.010–19 CSR 20-10.190.

(9) There shall be periodic inspection of equipment by a medical physicist qualified to furnish complete evaluation. Documentation shall be maintained and available for two (2) years.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR*

30-20.021(3)(H). Original rule filed June 27, 2007, effective Feb. 29, 2008.

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.104 Social Work Services in Hospitals

PURPOSE: This rule establishes the requirements for social work services in a hospital.

(1) The program shall include: a method of screening to determine the social service needs of the patient; a method of providing appropriate social work interventions, including discharge planning and counseling; and a mechanism for referrals to community agencies when appropriate.

(2) The social service program shall be identified and integrated in the total hospital organizational plan. Social work services shall be provided under the direction of a qualified social services worker. When the individual is not a qualified social worker, a qualified social worker shall be employed on a part-time or consultant basis.

(3) Social work services including discharge planning shall be integrated with other direct patient-care services of the hospitals. The social work assessment and plan of action shall be implemented for each patient who has need for social services.

(4) Written policies and procedures relating to the quality and scope of social work services shall be kept current.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(3)(I). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.106 Inpatient Care Units in Hospitals

PURPOSE: This rule establishes classifications for hospitals.

(1) A facility to be classified as a general hospital shall provide inpatient care for medical or surgical patients, or both, and may include pediatric, obstetrical and newborn, psychiatric or rehabilitation patients. To be classified a specialized pediatric, psychiatric or rehabilitation hospital, a facility shall provide inpatient care in an exclusive specialty such as pediatrics, psychiatry or rehabilitation and shall have a medical staff and other professional or technical personnel especially qualified in the particular specialty for which the hospital is operated.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(J)1. Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.108 Fire Safety, General Safety and Operating Features for Hospitals

PURPOSE: This rule specifies the requirements for fire safety, general safety and operating features in a hospital.

(1) Each hospital shall comply with the "Operating Features" requirements of Chapter 31 of NFPA 101, 1994. New hospitals or portions of hospitals constructed or remodeled after the effective date of this amendment shall be maintained so that the building and its various operating systems comply with NFPA 99, 1993 and NFPA 101, 1994. Existing hospital facilities constructed prior to the effective date of this amendment shall maintain and operate the building in compliance with the design and safety regulations in effect at the time of their construction.

(2) Each hospital shall be maintained in good repair to facilitate the maintenance of an appropriate health care delivery environment and to minimize hazards.

(3) Each hospital shall develop a mechanism for the identification and abatement of occupant safety hazards in their facilities. Any safety hazard or threat to the general safety of patients, staff or the public shall be corrected.

(4) Each hospital shall develop and maintain current a disaster plan which is specified to its facility for response to man-made or natural disasters. Annex 1 of NFPA 99, 1993 shall be used as a guide in the preparation and revision of the hospital's health care disaster plan.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(3)(K). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.110 Orientation and Continuing Education in Hospitals

PURPOSE: This rule specifies the requirements for orientation and continuing education programs in hospitals.

(1) There shall be an orientation and continuing education program for the development and improvement of necessary skills and knowledge of the facility personnel.

(2) The orientation program shall be of the scope and duration necessary to effectively prepare personnel new to a unit for their assigned duties and responsibilities based on job descriptions. Temporary personnel shall participate in an orientation prior to providing direct patient care.

(3) Educational programs shall be conducted using internal or external resources and shall be planned and documented. Documentation on the topic, presenter, date/time of presentation and the program attendance shall be available.

(4) Teaching material and suitable references shall be identified and supplied as needed for the staff of each department or unit that treats patients.

(5) The orientation and continuing education program shall participate in the performance improvement process and shall provide evaluation opportunities appropriate to its goals and objectives.

(6) The continuing education program shall include, as appropriate for the job, but not be limited to:

(A) Problems and needs of specific age groups, chronically ill, acutely ill and disabled patients;

(B) Prevention and control of infections including universal precautions;

(C) Interpersonal relationships and communication skills;

(D) Fire prevention, safety and accident prevention;

(E) Patient rights, dignity and privacy issues;

(F) Licensed nursing personnel training on basic cardiac life support and choking prevention and intervention; and

(G) Any other educational need identified through the quality improvement activities and those generated by advances made in health care science and technology.

(7) Competency of all employees shall be evaluated annually based on job description and necessary job skills and knowledge.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(3)(L). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

19 CSR 30-20.112 Quality Improvement Programs in Hospitals

PURPOSE: This rule specifies the requirements for quality improvement programs in a hospital.

(1) The governing body shall ensure the development and implementation of an effective, ongoing, systematic hospital-wide, patient-oriented performance improvement plan.

(2) This plan shall be designed to measure, assess and improve the quality of patient care as evidenced by patient health outcomes or improvement in processes, or both.

(3) The performance improvement plan shall be written and shall include:

(A) Description of the plan purpose, objectives, organizations, scope, authority, responsibility, and mechanisms of a planned systematic, organization-wide approach to designing, measuring, assessing and improving performance;

(B) Assurance of collaborative participation from appropriate departments and services, both clinical and nonclinical, including those services provided directly and under contract;

(C) Provision for assessment and coordination of quality improvement activities through an established oversight team that meets on an established periodic basis;

(D) Assurance of ongoing communication, reporting and documentation of patient-care issues and quality improvement activities and their effectiveness to the governing body and medical staff at least quarterly; and

(E) Development of an annual assessment of the effectiveness of the plan.

(4) At a minimum, the plan shall include:

(A) Organization-wide design, measurement, assessment and improvement of patient care and organizational functions;

(B) Review of care that includes outcomes of care provided by the medical and nursing staff and by other health care practitioners employed or contracted by the hospital;

(C) Measurements of quality of care which are outcome- or process-based, specific to the hospital, and to identified needs and expectations of the patients and staff;

(D) Review on a continuing basis of the processes that affect a large percentage of patients, that place patients at risk or that have caused or are likely to cause quality problems; and

(E) Review of all hospital specific data and state normative data provided by the Department of Health (DOH). The CEO or his/her designee shall respond to the DOH with a corrective plan when the hospital is directed to do so by the Bureau of Hospital Licensing and Certification.

(F) The performance improvement plan shall be designed to review activity, actions initiated and reassessments. Documentation shall be maintained on these activities.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(M). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995, 197.080, RSMo 1953, amended 1993, 1995, and 197.154, RSMo 2004.*

19 CSR 30-20.114 Environmental and Support Services in Hospitals

PURPOSE: This rule specifies the requirements for environmental and support services provided by a hospital.

(1) Each hospital shall have an organized service which maintains a clean and safe environment.

(A) Housekeeping Services.

1. The housekeeping services shall have a director who is qualified by education, training and experience in the principles of hospital housekeeping. This individual shall report to a designated administrative officer.

2. Approved written policies and procedures shall define and describe the scope and conduct of housekeeping services. These shall be reviewed in cooperation with the infection control program and kept current.

3. Space for housekeeping services shall provide for office(s), the storage of supplies and equipment and for equipment maintenance.

4. There shall be sufficient trained personnel to meet the needs of housekeeping services. Housekeeping personnel shall be given the opportunity to participate in service training or other relevant continuing educational programs.

5. All noninfectious wastes generated within the hospital shall be collected in appropriate containers for disposal.

6. There shall be a mechanism for the review and evaluation on a regular basis of the quality of housekeeping services provided.

(B) Laundry and Linen Services.

1. The hospital shall have organized services which ensure that adequate supplies of clean linens are available. There shall be specific written procedures for the processing, distribution and storage of linen. These shall be reviewed in cooperation with the infection control committee and kept current.

2. Soiled linen processing functions shall be physically separated from both clean linen storage and soiled linen holding areas. Only commercial laundry equipment shall be used to process hospital linen.

3. Clean linen shall be stored and distributed to the point of use in a way that minimizes microbial contamination from surface contact or airborne particles.

4. Soiled linen shall be collected at the point of use and transported to the soiled linen holding room in a manner that minimizes microbial dissemination into the environment.

5. If a commercial laundry service is used, verification shall be provided to assure the hospital that the processing and handling of linen complies with paragraphs (5)(C)1.–4. of this rule.

6. There shall be a mechanism for the review and evaluation on a regular basis of the quality of laundry and linen services provided.

(C) Infectious Waste Management.

1. Every hospital shall write an infectious waste management plan with an annual review identifying infectious waste generated on-site, the scope of the infectious waste program, and policies and procedures to implement the infectious waste program. The director of this program shall be qualified by education, training and experience in the principles of infectious waste management. The plan shall include at least the following: chief executive officer's endorsement letter; introduction and purpose; objectives; phone number of responsible individuals; organizational chart; schematic(s) of waste disposal routes; definition of those wastes handled by the system; department and individual

responsibilities; procedures for waste identification, segregation, containment, transport, treatment and disposal; emergency and contingency procedures; training and educational procedures; and appendices (rules and other applicable institutional policy statements). Any hospital exempt from infectious waste processing facility permit requirements of 10 CSR 80-7.010 and that accepts infectious waste from off-site shall include in its plan requirements for storage, processing and record keeping of this waste and the cleanup of potential spills in the unloading area. Manufacturers' specifications for temperature, residence time and control devices for any infectious waste processing devices shall be included in the plan. A trained operator shall operate the equipment during any infectious waste treatment procedures.

2. Infectious waste shall be segregated from other wastes at the point of generation and shall be placed in distinctive, clearly marked, leakproof containers or plastic bags appropriate for the characteristics of the infectious waste. Containers for infectious waste shall be identified with the universal biological hazard symbol. All packaging shall maintain its integrity during storage and transport. Infectious waste shall not be placed in a gravity waste disposal chute.

3. Pending disposal, infectious waste shall be stored, separated from other wastes, in a limited-access enclosure posted with the biological hazard symbol. This enclosure shall afford protection from vermin, be a dry area and be provided with an impervious floor with a perimeter curb. The floor shall slope to a drain connected to the sanitary sewage system or collection device. If infectious waste is compacted, the mechanical device shall contain the fluids and aerosols and shall not release aerosols or fluids when opened and the container is removed. Provisions for waste stored seventy-two (72) hours or more shall be separately addressed in the infectious waste management plan.

4. Hospital infectious waste treated on site shall be rendered innocuous, using one (1) of the following methods:

A. Sterilization of the waste in an autoclave is permitted, provided that the unit is operated in accordance with the manufacturer's recommendations and that the autoclave's effectiveness is verified at least weekly with a biological spore assay containing *Bacillus Stearothermophilus*. If the autoclave is used for other functions, the infectious waste management plan will develop specific guidelines for its use;

B. Incineration in a multi-chamber incinerator designed to provide complete combustion of the type of waste introduced into the incinerator is permitted. The incinerator shall be operated in accordance with the manufacturer's recommendations and shall comply with air pollution control laws and regulations. The incinerator shall achieve a minimum temperature of eighteen hundred degrees Fahrenheit (1,800°F) in the secondary chamber with a minimum retention time of one-half (1/2) second in the secondary chamber. The incinerator shall be equipped with continuous temperature recording charts for the secondary chamber and utilized during any infectious waste treatment process. Pathological wastes mixed with or contained in plastic materials shall be incinerated in a multi-chamber incinerator achieving a minimum temperature of eighteen hundred degrees Fahrenheit (1,800°F) in the secondary combustion chamber with one-half (1/2) second retention time;

C. Decontamination of the infectious waste by other technologies in a manner acceptable to the Department of Health shall be permitted;

D. Bulk blood, suctioned fluids, excretions and secretions may be carefully poured down a drain connected to a sanitary sewer; or

E. Infectious waste rendered innocuous by the methods in subparagraphs (1)(C)4.A. or C. of this rule shall be disposed of in accordance with the requirements of 10 CSR 80-7.010.

5. An infectious waste treatment program shall include records of biological spore assay tests if required by treatment methods and the approximate amount of waste disinfected or incinerated per hour measured by weight per load. The program director shall maintain records demonstrating the proper operation of the disinfection or incineration equipment.

6. All infectious waste when transported off the premises of the hospital shall be packaged and transported as provided in sections 260.200–260.207, RSMo.

7. Any hospital which accepts infectious waste from small quantity generators as defined by 10 CSR 80-7.010 or from other Missouri hospitals—in quantities exceeding fifty percent (50%) of the total poundage of infectious waste generated on-site at the hospital—shall notify the Department of Natural Resources and comply with permitting requirements of sections 260.200–260.207, RSMo. The weight of infectious waste generated on-site shall be calculated by multiplying one and five-tenths (1.5) pounds per day times the number of beds complying with Department of Health standards for hospital licensure. Infectious waste generated off-site may be accepted by a hospital only if packaged according to 10 CSR 80-7.010(2)(A)–(D).

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(5)(A), (C) and (D). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.116 Infection Control in Hospitals

PURPOSE: This rule specifies the requirements for infection control practices in a hospital.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) There shall be an active multidisciplinary infection control committee responsible for implementing and monitoring the infection control program. The committee shall include, but not be limited to, the infection control officer, a member of the medical staff, registered professional nursing staff, quality improvement staff and administration. This program shall include measures for preventing, identifying, and investigating healthcare-associated infections and shall establish procedures for: collecting data, conducting root cause analysis, reporting sentinel events, and implementing corrective actions. These measures and procedures shall be applied throughout the hospital, including as a part of the employee health program.

(2) The infection control committee shall conduct an ongoing review and analysis of healthcare-associated infections (HAI) data and risk factors. Priorities and goals related to preventing the acquisition and transmission of potentially infectious agents will be established based on risks identified.

(3) Hospitals shall implement written policies and procedures outlining infection control

measures. These measures shall include, but are not limited to, a hospital-wide hand hygiene program that complies with the October 25, 2002 Centers for Disease Control and Prevention (CDC) *Guideline for Hand Hygiene in Health-Care Settings*, which is incorporated by reference in this rule. A copy of the CDC *Guideline for Hand Hygiene in Health-Care Settings* may be obtained from the Superintendent of Documents, U.S. Government Printing Office (GPO), Washington, DC 20402-9371; telephone: (202) 512-1800. This rule does not incorporate any subsequent amendments or additions. At a minimum, the program shall require every health care worker to properly wash or sanitize his or her hands immediately before and immediately after each and every episode of patient care. Procedures shall include, at a minimum, requirements for the facility's infection control program to conduct surveillance of personnel in accordance with section 197.150, RSMo. Surveillance procedures may also include monitoring the employees' and medical staff's use of hand hygiene products. A mechanism approved by the hospital infection control committee for reporting and monitoring patient and employee infections shall be developed for all patient care and support departments in the hospital.

(4) Orientation and ongoing education shall be provided to all patient care and patient-care support personnel on the cause, effect, transmission, prevention and elimination of infections. Records of employee attendance shall be retained and available for inspection. A mechanism for monitoring compliance with infection control policies and procedures shall be coordinated with administrative staff, personnel staff and the quality improvement program.

(5) Infection control committee meetings shall be held quarterly. Minutes shall be retained.

(6) There shall be an annual review and evaluation of the quality of the infection control program.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.150 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(5)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; 197.150, RSMo 2004; and 197.154, RSMo 2004.*

19 CSR 30-20.118 Ambulatory Care Services in Hospitals

PURPOSE: This rule specifies the requirements for ambulatory care services provided by a hospital.

(1) Ambulatory care services, if provided through an organized department of the hospital, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing rules of the medical staff governing the quality and scope of ambulatory care services provided.

(2) Ambulatory care services shall be integrated with other hospital services as required to meet the needs of the patient.

(3) Nursing personnel assigned to the ambulatory care services shall be under the supervision of a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

(4) Approved written policies and procedures shall describe the scope of ambulatory care provided. Policies and procedures shall be reviewed at least annually and revised as necessary.

(5) Ambulatory care services shall be staffed by personnel qualified by education, training and experience to provide safe patient care.

(6) Patient's medical records shall reflect ambulatory care and treatment provided. These records shall be filed and maintained under supervision of the medical records department.

(7) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of ambulatory care services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(A). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.120 Anesthesia Services in Hospitals

PURPOSE: This rule specifies the requirements for anesthesia services in a hospital.

(1) Anesthesia services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing the quality and scope of anesthesia care provided.

(2) Approved written policies and procedures shall include: patient and employee safety, pre- and post-anesthesia evaluation, care of equipment, storage of anesthesia agents and the administration of anesthesia.

(3) Anesthesia shall be administered only by qualified anesthesiologists, physicians or dentists trained in anesthesia, certified nurse anesthetists or supervised students in an approved educational program.

(4) An anesthesia record documenting the care given shall be a permanent part of the patient's medical record.

(5) The pre-anesthesia patient evaluation shall be accomplished by a physician and documented within forty-eight (48) hours before surgery and shall include the history and physical examination; anesthetic, drug and allergy history; essential laboratory data; and other diagnostic test results to establish potential anesthetic risks. These procedures may be waived in the event of a life threatening emergency, provided the surgeon so certifies on the patient medical record.

(6) A post-anesthesia evaluation shall be documented in the patient's medical record within twenty-four (24) hours after surgery.

(7) The use of flammable anesthetic agents shall be limited to those areas of the hospital which comply with all applicable requirements of the *Standard for Inhalation Anesthetics 1980* published by the National Fire Protection Association.

(8) Prior to surgery, the patient's medical record shall contain evidence that the patient has been advised regarding the surgical procedure(s) contemplated, the type of anesthesia to be administered and the risks involved with each. Evidence that informed consent has been given shall become a part of the patient's medical record.

(9) There shall be a mechanism for the review and evaluation on a regular basis of the quality and scope of anesthesia services.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.122 Home-Care Services in Hospitals

PURPOSE: This rule specifies the requirements for home care services provided by a hospital.

(1) Home-care services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing rules of the medical staff governing the quality and scope of home-care services.

(2) The objectives and description of home-care services shall be related to identifiable needs and shall include those services the hospital provides or those provided through participating community agencies.

(3) There shall be written policies and procedures delineating administrative control, scope of services offered and the manner in which they are provided. These policies and procedures shall be reviewed annually and revised as necessary.

(4) A medical record shall be maintained on every patient receiving home-care services. These records shall contain the overall care plan, physician's orders, services provided, progress notes and disposition of the patient. Records shall be filed under supervision of the medical records department.

(5) There shall be a mechanism for the review and evaluation on a regular basis of the quality and scope of home-care services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(C). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.124 Medical Services in Hospitals

PURPOSE: This rule specifies the requirements for medical services in a hospital.

(1) Medical services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body as chief of the medical services. This director shall be responsible for implementing the rules of the medical staff governing medical privileges and the quality of medical care provided.

(2) Medical services shall be responsible for the medical care of all patients except those under the care of physicians or other services as defined in the medical staff or governing body bylaws.

(3) The activities of medical services shall be integrated with other services in the hospital.

(4) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of medical services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(D). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.125 Unlicensed Assistive Personnel Training Program

PURPOSE: This rule requires hospitals to have a personnel training policy that requires unlicensed health care personnel who provide direct patient care under the delegation and supervision of a registered nurse to complete the Unlicensed Assistive Personnel (UAP) Training Program, which shall be used to prepare individuals for employment in hospitals. This program shall be designed to teach the knowledge and skills that will qualify students to perform uncomplicated nursing procedures and assist in direct patient care.

(1) Definitions Relating to this Rule.

(A) Acute care unit—an area of a hospital that provides care primarily for patients with acute diseases or conditions. This does not include care provided in a long-term care unit such as a skilled nursing, intermediate care and residential care units.

(B) Unlicensed Assistive Personnel (UAP)—unlicensed health care personnel who provide direct patient care twenty-five percent (25%) or more of the time, under the delegation and supervision of a registered nurse. Individuals who provide a specific job function such as, but not limited to, phlebotomist, radiology technician or patient transporter are not included in this definition.

(2) The hospital training policy for UAPs shall include the following minimum standards:

(A) The curriculum of the UAP Program shall consist of a standard plan of instruction to include:

1. A minimum of seventy-five (75) hours of classroom instruction.

2. Computer or paper-based learning modules that provide documentation of completion may be substituted for up to sixty (60) hours of classroom time.

3. A minimum of one hundred (100) hours of clinical practicum.

4. Curriculum content of the program shall include procedures and instructions on basic nursing skills including but not limited to the areas of:

A. The Role of the UAP (ethics, law, team member communication, observation, reporting, documentation, medical terminology);

B. Patient/Client Rights (Health Insurance Portability and Accountability Act (HIPAA), privacy, confidentiality, advanced directives, abuse and neglect, age specific care, cultural diversity, pain management, restraint-free care, end-of-life care, death and dying, do not resuscitate (DNR) orders, postmortem care);

C. Vital Signs;

D. Basic Human Needs (age specific cognitive/psychological/social needs, activities of daily living, ambulation, positioning, personal care, elimination and toileting, nutrition, hydration, feeding, bed making);

E. Infection Control (universal precautions, blood-borne pathogens, safe needle devices, aseptic technique, hand washing, gloving, isolation);

F. Skin Care (wound care, pressure ulcers and prevention); and

G. Safety (cardiopulmonary resuscitation (CPR), allergies, fall prevention, environmental safety issues, fire/electrical, hazardous materials transportation safety information (HAZMAT), emergency procedures, body mechanics).

5. The clinical practicum of one hundred (100) hours shall start after the student has enrolled and started the course curriculum.

6. Skill validation and knowledge verification is to be used to determine student competence.

7. Annual in-service training also shall occur as required under 19 CSR 30-20.021(3)(L)6. and 7. and (5)(B)4.

(3) The hospital training policy for UAPs shall begin three (3) months after the effective date of this rule. UAP training shall be completed within ninety (90) days of employment for any individual who is hired as a UAP. UAPs from staffing agencies shall comply with this regulation. A UAP shall not work in direct patient care, except as part of their supervised practicum, until the entire UAP training requirements have been met. Hospitals shall not be required to meet the UAP training requirements if an employee demonstrates competency in the content areas required by this rule; in the duties specific to their job and the patient population assigned and:

(A) Is enrolled in a professional or practical nursing education program and has or will complete within ninety (90) days a fundamentals of nursing course; or

(B) Was a professional nursing or practical nursing licensure candidate who failed to pass the state licensure examinations in the past three (3) years; or

(C) Is certified as a nursing assistant as defined in section 198.082, RSMo; or

(D) Has documented experience as a nurse assistant, emergency medical technician or surgical technician in the past three (3) years; or

(E) Has proof of completion of UAP training program in Missouri or another state which meets the requirements of this rule within the last three (3) years; or

(F) Has completed a professional or licensed practical nursing program outside the United States and is awaiting the licensure examination in this country.

(4) The hospital training policy for UAPs shall meet the following faculty qualifications and responsibilities:

(A) A registered nurse shall be designated as the course coordinator and shall be responsible for all aspects of the course, and must supervise all classroom and clinical instruction;

(B) Instructors shall hold a current license or temporary permit to practice as a registered nurse in Missouri and have a minimum of two (2) years of nursing experience in an acute care, long-term care or ambulatory surgery facility within the prior five (5) years, or an experience as a clinical faculty member in a nursing program within the prior five (5) years. An instructor's nursing license shall not be under current disciplinary action;

(C) A clinical supervisor's or preceptor's nursing license shall not be under current disciplinary action or investigation; and

(D) UAPs who have satisfied the training requirements of this rule and Licensed Practical Nurses may assist with the clinical practicum under the direction of the course coordinator.

(5) A hospital or ambulatory surgical center that provides training for UAPs shall meet the following training site requirements:

(A) Provide designated space sufficient to accommodate the classroom teaching portion of the course or have a written agreement with another acute care hospital, an area vocational-technical school, a high school offering a health service occupation program, a community college or a provider agency to provide the classroom portion of the course;

(B) Provide on-the-job clinical practicum or have a written agreement with one (1) or more hospitals or ambulatory surgical centers in their vicinity to do so;

(C) Assess and review the program and outcomes of any training provided by another facility to ensure that all of the requirements of this rule have been met;

(D) Maintain, either electronically or on paper in the employee's personnel file, records of course completion and competency for a minimum of three (3) years. Records shall be signed and dated by the course coordinator and each of the instructors and clinical supervisors verifying classroom time, clinical time and competency for each student; and

(E) Provide a signed copy of the course completion and competency record to the student, that includes the elements in subsection (5)(D) of this rule.

AUTHORITY: section 197.287, RSMo 2000. Original rule filed Jan. 31, 2008, effective Sept. 30, 2008.*

**Original authority: 197.287, RSMo 2000.*

19 CSR 30-20.126 Obstetrical and Newborn Services in Hospitals

PURPOSE: This rule specifies the requirements for obstetrical and newborn services in a hospital.

(1) Obstetrical services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing obstetrical privileges, quality of obstetrical care and patient safety.

(2) Obstetrical services shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

(3) The obstetrical nursing supervisor shall have the authority to implement and enforce hospital policies and procedures governing obstetrical services and shall have the responsibility for evaluating the competency of nursing personnel assigned to obstetrical services.

(4) Facilities for obstetrical services shall be designed to prevent unauthorized traffic.

(5) Undelivered patients receiving intravenous oxytocin shall be under continuous observation by trained personnel. Induction or augmentation of labor with oxytocin may be initiated only after a qualified physician has evaluated the patient, determined that induction or augmentation is beneficial to the mother, fetus, or both, recorded the indication and established the plan of management. The physician initiating these procedures shall be readily accessible to manage complications that arise during infusion and a physician who has privileges to perform Caesarean deliveries shall be in consultation and readily accessible in order to manage any complications that require surgical intervention.

(6) There shall be provision for isolation of infants with known or suspected infections or communicable diseases. Policies and procedures regarding isolation shall be integrated with the hospital infection control program.

(7) Each newborn shall be identified by an acceptable method which includes the name, date and time of birth, the infant's sex and the mother's hospital number.

(8) A delivery room record shall be maintained.

(9) A nursery shall be provided for care of the newborn.

(10) Hospitals with an obstetrical service shall have at least one (1) premature-care incubator by an independent testing laboratory.

(11) All cases of acute infectious conjunctivitis *(Ophthalmia neonatorum)* shall be reported immediately to the individual(s) responsible for the infection control program and to

the local or district health department in accordance with section 210.080, RSMo.

(12) All cases of epidemic diarrhea of the newborn shall be reported immediately to the individual(s) responsible for the infection control program and the local or district health department.

(13) Resuscitation, suction, oxygen, monitoring and newborn temperature control equipment shall be available for the care of newborn. Supplies for the proper care of newborn shall be available.

(14) An incubator or bassinet with controlled temperature shall be available for each delivery room and for transport to the nursery.

(15) Space shall be provided for the preparation or the handling and storage of formula. Separate refrigeration shall be provided for formula.

(16) Eye care of newborn shall be in accordance with section 210.070, RSMo.

(17) Written policies and procedures shall be established to provide safe transport of infants within the hospital or to another health-care facility.

(18) Written policies and procedures governing special care programs shall be approved by the medical staff and governing body.

(19) There shall be a mechanism for the review and evaluation on a regular basis of the quality of obstetrical and newborn services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(E). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.128 Pediatric Services in Hospitals

PURPOSE: This rule specifies the requirements for pediatric services in a hospital.

(1) The pediatric unit, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing the quality and scope of pediatric services.

(2) The pediatric unit shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

(3) The pediatric supervisor shall have the authority to implement and enforce hospital policies and procedures governing pediatric services and shall have the responsibility for evaluating the competency of nursing personnel assigned to pediatric services.

(4) The pediatric unit shall be designed for specific needs of children and located apart from adult patients and the newborn.

(5) The pediatric unit shall have at least one (1) room suitable for isolation.

(6) Supplies and equipment required for emergencies shall be readily available in the pediatric unit.

(7) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of pediatric services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(F). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.130 Post-Anesthesia Recovery Services in Hospitals

PURPOSE: This rule specifies the requirements for post-anesthesia recovery services in a hospital.

(1) Post-anesthesia recovery services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This director shall be responsible for implementing the rules of the medical staff governing post-anesthesia recovery services.

(2) A qualified registered professional nurse shall direct and evaluate the nursing care provided by post-anesthesia recovery services.

(3) A post-anesthesia recovery record documenting patient care shall be a permanent part of the patient's medical record.

(4) Patients receiving post-anesthesia recovery care shall be closely observed by qualified personnel until each patient is stabilized for safe transfer. Written procedures for discharge from the post-anesthesia recovery service shall be approved by the medical staff.

(5) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of post-anesthesia recovery services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule was previously filed as 19 CSR 30-20.021(4)(G). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.132 Psychiatric Services in Hospitals

PURPOSE: This rule specifies the requirements for psychiatric services in a hospital.

(1) Emergency psychiatric care.

(A) If the hospital does not have a psychiatric unit, written policies and procedures shall be developed to provide for the safe management of patients requiring psychiatric services until they can be safely transferred to an appropriate facility.

(B) Written policies shall be established regarding the use of restraints or seclusion. These restraints or seclusion shall be used only on the order of a physician. In the absence of a physician, a registered professional nurse shall make the decision that the use of a physical restraint or seclusion is the least restrictive procedure appropriate at the time of the emergency situation. The physician shall be notified immediately and a physician's order obtained as soon as possible after the occurrence of an emergency. Physicians' orders for use of physical restraints or seclusion shall be rewritten every twenty-four (24) hours. A full record of any restriction of activity for any patient shall be recorded on the nurses' notes and shall include the reason for restriction, the type of restriction used, the time of starting and ending the restriction and regular observations of the patient while restricted.

(2) Acute psychiatric services. If a psychiatric unit is designed within the hospital, it shall comply with the following requirements as a minimum:

(A) Psychiatric services shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. The director shall be responsible for implementing rules of the medical staff governing psychiatric privileges, quality and scope of care and patient safety;

(B) Psychiatric services shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency;

(C) The psychiatric nursing supervisor shall have the authority to implement and enforce hospital policies and procedures governing psychiatric care and shall have the responsibility for evaluating the competency of all nursing personnel assigned to psychiatric services;

(D) Appropriate registered nurse staffing patterns shall be developed to meet the care needs and activity demands of each patient in the psychiatric unit;

(E) New employees shall attend appropriate orientation, in-service and staff development programs prior to being considered part of the staff required to meet the minimum standards of patient care;

(F) Written policies shall be established regarding the use of restraints or seclusion. These restraints or seclusion shall be used only on the order of a physician. In the absence of a physician, a registered professional nurse shall make the decision that the use of a physical restraint or seclusion is the least restrictive procedure appropriate at the time of the emergency situation. The physician shall be notified immediately and a physician's order obtained as soon as possible after the occurrence of an emergency. Physician's orders for use of physical restraints or seclusion shall be rewritten every twenty-four (24) hours. A full record of any restriction of activity for any patient shall be recorded on the nurses' notes and shall include the reason for restriction, the type of restriction used, the time of starting and ending the restriction and regular observations of the patient while restricted;

(G) The social work services staff shall be available to participate as members of the treatment team, exchanging information and evaluations with the attending physician and other professional disciplines in order to insure a comprehensive treatment program for patients;

(H) Activity therapy services shall be available with the services provided under the direction of a qualified therapist. All therapy shall be given on the written order of a physician and documented in the patients' clinical records; and

(I) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of psychiatric services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(H). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.134 Rehabilitation Services in Hospitals

PURPOSE: This rule specifies the requirements for rehabilitation services in a hospital.

(1) The rehabilitation services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. The director shall be responsible for implementing rules of the medical staff governing the quality and scope of rehabilitation services.

(2) Rehabilitation services shall be supervised by a qualified physician or a qualified therapist with relevant education and experience.

(3) Rehabilitation services shall be integrated within the total organizational plan and the director shall assist in the formulation of policies and development of long-range planning affecting patient care.

(4) Therapy shall be administered in accordance with a physician's written orders and shall be documented in the patient's medical record.

(5) Rehabilitation services shall be provided by qualified personnel. In-service shall be ongoing and documented.

(6) Approved written policies and procedures which define and describe the scope and conduct of rehabilitative care shall be reviewed annually and revised as necessary.

(7) The qualified therapist shall evaluate and reevaluate the therapy administered and this shall be documented in the patient's medical record.

(8) Space and equipment shall be provided to meet the needs of rehabilitation services. Space, supplies and equipment shall be maintained to ensure patient safety.

(9) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of rehabilitation services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(I). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.136 Respiratory Care Services in Hospitals

PURPOSE: This rule specifies the requirements for respiratory care services in a hospital.

(1) Respiratory care services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. The director shall be responsible for implementing rules of the medical staff governing the quality and scope of respiratory care services.

(2) Respiratory care services shall be integrated within the total hospital organizational plan.

(3) Respiratory care services shall be administered under the direction of a qualified registered or certified respiratory therapist or a registered professional nurse with relevant education and experience.

(4) Therapy shall be administered in accordance with a physician's written orders and shall be documented in the patient's medical record.

(5) Respiratory care services shall be provided by qualified personnel. In-service shall be ongoing and documented.

(6) Approved written policies and procedures which define and describe the scope and conduct of respiratory care shall be reviewed annually and revised as necessary.

(7) A qualified registered or certified respiratory therapist or a registered professional nurse shall evaluate and reevaluate the therapy administered and this shall be documented in the patient's medical record.

(8) Space and equipment shall be provided to meet the needs of respiratory care services. Space, supplies and equipment shall be maintained to ensure patient safety.

(9) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of respiratory care services provided.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(J). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.138 Special Patient Care Services in Hospitals

PURPOSE: This rule specifies the requirements for special patient care services in a hospital.

(1) Special care units, if provided, shall be under the medical direction of a qualified physician, member of the medical staff and appointed by the governing body.

(2) Patient care in each special care unit shall be integrated with the other nursing services and supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

(3) Approved written policies and procedures shall define and describe the scope and conduct of each special patient-care service. These shall be reviewed annually and revised as necessary.

(4) Qualifications of personnel for assignment to each special care unit shall be delineated in writing. Orientation, in-service training and continuing education shall be provided and documented.

(5) Registered nurse staffing patterns shall be developed to meet the needs of each patient in special care units.

(6) A multi-disciplinary committee, chaired by the director, shall develop protocols for the conduct of patient care in each special care unit. This committee shall meet at least quarterly and minutes shall be kept and filed on a confidential basis.

(7) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of care provided in each special care area.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(K). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.140 Surgical Services in Hospitals

PURPOSE: This rule specifies the requirements for surgical services in a hospital.

(1) Surgical services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing rules of the medical staff governing the quality and scope of surgical services.

(2) Approved written policies and procedures shall define and describe the scope and conduct of surgical services. These shall be reviewed annually and revised as necessary.

(3) The surgical suite shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency. This supervisor shall have the authority to implement hospital policies and procedures for the surgical suite and shall have the responsibility for evaluating all nursing personnel assigned to the surgical suite.

(4) A qualified registered professional nurse shall be assigned circulating duties for surgical procedures performed.

(5) Accepted standards of patient care, sterility and aseptic techniques shall be maintained.

(6) Prior to surgery, the patient's medical record shall contain evidence that the patient has been advised as to the surgical procedure(s) contemplated, the type of anesthesia to be administered and the risks involved with each. Evidence that informed consent has been given shall become a part of the patient's medical record.

(7) An operating room record documenting the patient care provided shall become a part of the patient's medical record. The record shall contain at least the name of the patient, the patient's hospital number, the name of the surgeon, name of surgical procedure(s), the date, time surgery began and ended, names and titles of persons assisting with the procedure and the verification of countable materials.

(8) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of surgical services.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(L). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

19 CSR 30-20.142 Variance Requests by Hospitals

PURPOSE: This rule specifies the manner through which hospitals may request a variance from 19 CSR 30-20.001 through 19 CSR 30-20.140.

(1) Requests for variance from the requirements of 19 CSR 30-20.001 through 19 CSR 30-20.140 shall be in writing to the Department of Health. Approvals for variance shall be in writing and both requests and approvals shall be made a part of the permanent Department of Health records for the facility. Licensed hospitals participating in innovative demonstration projects may be granted a variance from certain requirements.

(A) This request shall contain—

1. The section number and text of the rule in question;

2. Specific reasons why compliance with the rule would impose an undo hardship on the operator, including an estimate of any additional cost which might be involved;

3. An explanation of the relevant extenuating factors which may be relevant; and

4. A complete description of the individual characteristics of the facility or patients or any other factors which would fulfill the intent of the rule in question to safeguard the health, safety and the welfare of the

patient, staff or public if the variance from the requirement is granted.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(1) and (1)(A). Original rule filed on June 27, 2007, effective Feb. 29, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*