Protective Health Services
Oklahoma State Department of Health

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# CHAPTER 667

# HOSPITAL STANDARDS

**AVAILABLE ONLINE AT:** http://mfs.health.ok.gov

**UNOFFICIAL COPY**

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## Important Reminder

Please remember that laws and rules are subject to change throughout the calendar year. The Oklahoma State Department of Health attempts to provide the most current unofficial laws and rules in this booklet, but changes may occur within months or even weeks of the printing date. Several sites on the Internet make up-to-date laws and rules available free of charge.

The official rules are published in *The Oklahoma Administrative Code* and *The Oklahoma Register,* as required by 75 O.S., Section 250 et seq. To order an official copy of these rules, contact the Office of Administrative Rules at (405) 521-4911.

Oklahoma laws, including pending legislation, are available through the Oklahoma Legislative Information Service at: www.lsb.state.ok.us

The Oklahoma State Department of Health makes detailed information available by facility types at www.health.ok.gov. Select the "Program" icon and then look for the listing of regulated entities under "Protective Health Services."

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# TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
# CHAPTER 667. HOSPITAL STANDARDS

"Unofficial Version"


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[**Authority:** Oklahoma State Board of Health; 63 O.S. Sections 1-104, 1-705, and 1-707]

[**Source:** Codified June 26, 1995]

## SUBCHAPTER 1. GENERAL PROVISIONS

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### 310:667-1-1. Purpose

The purpose of this Chapter is to provide rules for hospitals as required by 63 O.S. 1991, §§ 1-705.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 2992, eff 7-13-00]

### 310:667-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.

**"Addition"** means an extension or increase in floor area or height of a building structure.

**"Administrator"** means the chief executive officer for the hospital.

**"Advanced practice nurse"** means a licensed registered nurse recognized by the Oklahoma Board of Nursing as an advanced practice nurse. Advanced practice nurses shall include advanced registered nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.

**"Automatic"** means providing a function without the necessity of human intervention.

**"Building"** means a structure used or intended for supporting or sheltering any use or occupancy. The term "building" shall be construed as if followed by the words "or portions thereof."

**"Chemical restraint"** means the use of a medication for the purpose of discipline, convenience, or in an emergency situation to control mood or behavior and not required to treat a patient's condition.

**"Combustible"** means capable of undergoing combustion.

**"Critical Access Hospital"** means *a hospital determined by the State Department of Health to be a necessary provider of health care services to residents of a rural community* [63 O.S. Supp. 1999, *§ 1-701(a)(4)].*

**"Department"** means the Oklahoma State Department of Health.

**"Emergency hospital"** means *a hospital that provides emergency treatment and stabilization services on a 24-hour basis that has the ability to admit and treat patients for short periods of time* [63 O.S., § 1-701(a)(5)].

**"Existing facility"** means licensed hospitals that are in existence or have had final drawings for construction approved by the Department at the date this Chapter become effective. A general medical surgical hospital that converts to a critical access hospital shall be considered an existing facility.

***"General hospital"*** *means a hospital maintained for the purpose of*

*providing hospital care in a broad category of illness and injury {63 O.S. 1991, § 1-701(a)(1)}.*

**"General medical surgical hospital"** means a general hospital that provides medical and surgical procedures.

**"Governing body"** means the person(s) having ultimate responsibility, including fiscal and legal authority for the hospital.

***"Hospital"*** *means any institution, place, building, or agency, public or private, whether organized for profit or not, devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care of patients admitted for overnight stay or longer in order to obtain medical care, surgical care, obstetrical care, or nursing care for illness, disease, injury, infirmity, or deformity. All places where pregnant females are admitted and receive care incident to pregnancy or delivery shall be considered to be a "hospital" within the meaning of this publication regardless of the number of patients received or the duration of their stay. The term "hospital" includes general medical surgical hospitals, specialized hospitals, critical access and emergency hospitals, and birthing centers [63 O.S. Supp. 1999, § 1-701(a)].*

**"Hospital campus"** means inpatient and/or outpatient facilities located at different addresses operated under a common hospital license issued by the Department.

**"Licensed independent practitioner"** means any individual permitted by law and by the licensed hospital to provide care and services, without direct supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include advanced practice nurses with prescriptive authority, physician assistants, dentists, podiatrists, optometrists, chiropractors, and psychologists.

**"Licensed practical nurse"** means a person currently licensed to practice practical nursing in Oklahoma.

**"Licensed/registered dietitian"** means a person who is registered as a dietitian by the American Dietetic Association and is currently licensed as a dietitian in Oklahoma.

**"Licensure"** means the process by which the Department grants to persons or entities the right to establish, operate, or maintain any facility.

**"Occupancy"** means the purpose for which a building or portion thereof is used or intended to be used.

**"Pharmacist"** means a person who is currently registered by the Oklahoma State Board of Pharmacy to engage in the practice of pharmacy.

**"Physical restraint"** means any manual method or physical or mechanical device, material or equipment attached or adjacent to a patient's body that the patient cannot remove easily, that is not used for the purpose of therapeutic intervention or body alignment as determined by the patient's physician or licensed independent practitioner, and which restricts the patient's desired freedom of movement and access to his or her body.

**"Physician"** means a doctor of medicine (M.D.) or osteopathy (D.O.) currently licensed to practice medicine and surgery in Oklahoma.

**"Physician assistant"** means an individual licensed as a physician assistant in Oklahoma.

**"Practitioner"** means a dentist, podiatrist, chiropractor, optometrist, physician assistant, psychologist, certified nurse mid-wife, advanced registered nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, physical therapist, occupational therapist, pharmacist, social worker or other individual currently licensed or authorized to practice as a medical professional in Oklahoma.

**"Psychiatric hospital"** means a specialized hospital maintained for the purpose of providing psychiatric care.

**"Registered nurse"** means a person currently licensed to practice registered nursing in Oklahoma.

**"Rehabilitation hospital"** means a specialized hospital maintained for the purpose of providing rehabilitation.

***"Respiratory care practitioner"*** *means a person licensed by this state and employed in the practice of respiratory care {59 O.S. Supp. 1995, § 2027}.*

***"Specialized hospital"*** *means a hospital maintained for the purpose of providing hospital care in a certain category, or categories, of illness and injury {63 O.S. 1991, § 1-701(a)(2)}.*

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-1-3. Licensure**

(a) **Application for licensure.**

(1) No person or entity shall operate a hospital without first obtaining a license from the Department. The license is not transferable or assignable.

(2) The applicant shall file a licensure application in a timely manner. The application shall be on forms provided by the Department, with a check of $10.00 for each census bed, crib and bassinet, payable to the Oklahoma State Department of Health.

(3) The entity responsible for operation of the hospital and appointment of the medical staff shall be considered the applicant for the license. This entity may be a lessee if the hospital is leased and the lessee is the operating entity. For the purposes of licensure, a company providing administrative management of a hospital, which functions by contract with the governing body of the hospital, shall not be considered the entity responsible for operation.

(4) An application is not considered to be filed unless it is accompanied by the application fee.

(b) **Application filing.** An initial license application or renewal application shall be filed as follows:

(1) The application for an initial license for a new hospital shall be filed prior to or at the time final drawings for construction are submitted to the Department for review which shall be at least thirty (30) days before a hospital begins operation.

(2) The application for an initial license for a change of ownership

or operation, shall be filed at least thirty (30) days before the transfer. The sale of stock of a corporate licensee, where a majority of the governing body does not change, is not considered a change of ownership or operation. The sale or merger of a corporation that owns an operating corporation that is the licensed entity shall not be considered a change of ownership unless a majority of the governing body is replaced.

(3) The application for renewal of a license of an existing hospital shall be filed at least thirty (30) days before the expiration date of the current license.

(c) **Where to file.** The application and the license fee shall be delivered or sent to the Department. The effective date shall be the date the application and fee are received.

(d) **Forms.** The applicant for a license shall file application forms as follows:

(1) For an initial license of a new hospital, or for an existing hospital following a change in ownership or operation, the applicant shall file these forms: Application for License to Operate a Hospital or Related Institution; Board of Directors Information Sheet; and Designation of Licensed Beds Form.

(2) For renewal of a current license, the applicant shall file the Application for License to Operate a Hospital or Related Institution; Board of Directors Information Sheet; Designation of Licensed Beds Form; and a Fire Inspection Report For Hospitals.

(e) **Description of forms.** The forms used to apply for a hospital license are the following:

(1) The Application For License to Operate Hospital or Related Institution (Form 920) requests: identification of the type of license requested; the name and address of the hospital; the name and address of the operating entity; the number of beds and bassinets; the ownership of the building and grounds; the applicant's name; the chief executive officer/administrator's name; attachment for credentialed staff; and an affidavit attesting the signature of the applicant.

(2) The Board of Directors Information Form (Form AGH-2) requests: The names and addresses of the Board of Directors for the hospital.

(3) The Designation of Licensed Beds Form (Form 920-A) requests: A listing of the types of beds operated by the hospital and a total of the beds.

(4) The Fire Inspection Report for Hospitals (Form 928) requests: a check list of the annual inspection conducted by the local fire marshall.

(f) **Eligibility for license.**

(1) Hospitals making appropriate application that have been determined to be compliant with these standards are eligible for a license.

(2) A hospital may operate inpatient and outpatient facilities under one (1) license as a hospital campus as long as the following requirements are met:

(A) The facilities shall be separated by no more than fifty (50) miles. This requirement may be waived if the services of the facilities are totally integrated through telecommunication or by

other means.

(B) The facilities are operated by the same governing body with one administrator.

(C) The medical staff for all facilities is totally integrated so that any practitioner's privileges extend to all facilities operated under the common license.

(3) An outpatient facility located at a different address from a hospital is eligible to be licensed as part of the hospital but is not required to be licensed.

(4) Each hospital shall participate in a functioning regional system of providing twenty-four (24) hour emergency hospital care approved by the Commissioner of Health in consultation with the Oklahoma Trauma Systems Improvement and Development Advisory Council. Participation in a regional system may include active participation of the hospital in the provision of emergency services based upon the system plan, participation of the hospital’s medical staff in the provision of emergency services at other hospitals in the system based on the system plan, or payment into a fund to reimburse hospitals providing emergency services in the system.

(5) If an area of the state fails to develop a functioning regional system of providing twenty-four (24) hour emergency hospital care necessary to meet the state’s needs for trauma and emergency care as established by the state-wide trauma and emergency services plan, the Commissioner of Health, in consultation with the Oklahoma Emergency Response Systems Development Advisory Council, shall develop a system for the area. Each hospital located in the area shall participate as specified by the system plan for that region.

(g) **Regional system of emergency hospital care.**

(1) In counties and their contiguous communities with populations of 300,000 or more, a functioning regional system of providing twenty-four (24) hour emergency hospital care shall include definitive emergency care for all clinical categories specified in OAC 310:667-59-7. In these regions, a functioning system shall only transfer emergent patients out of the system when treatment or diagnostic services are at capacity unless the patient has a special treatment need not normally provided by the system. Transfers out of the system may occur based upon the patient or the patient's legal representative's request or based upon a special circumstance for the transfer.

(2) In counties and communities with populations of less than 300,000, a functioning regional system of providing twenty-four (24) hour emergency hospital care shall include definitive care based upon the classification of hospital’s emergency services in the region as specified in OAC 310:667-59-7. Transfers out of the regional system may be based upon lack of diagnostic or treatment capability or capacity. A functioning system shall not permit emergent patient transfers out of the system if the system has the capability and capacity to provide care unless the patient or patient's legal representative requests the transfer.

(3) A functioning regional system of providing twenty-four (24) hour emergency hospital care shall demonstrate compliance with OAC 310:667-1-3(g)(1) or (2) through system continuous quality

improvement activities. Activities shall include monitoring of patient transfers and corrective actions when inappropriate transfers are identified. Special circumstance patient transfers shall be identified and reviewed through continuous quality improvement activities.

(h) **Quality indicators.** The Department, with the recommendation and approval of the Hospital Advisory Council, shall establish quality indicators to monitor and evaluate the quality of care provided by licensed hospitals in the state.

(1) The quality indicators shall focus on the following measurement areas:

(A) Acute myocardial infarction (including coronary artery disease);

(B) Heart failure;

(C) Community acquired pneumonia;

(D) Pregnancy and related conditions (including newborn and maternal care);

(E) Surgical procedures and complications;

(F) Patient perception measures such as satisfaction surveys; and

(G) Ventilator-associated pneumonia and device-related blood stream infections for certain intensive care unit patients in acute care hospital settings.

(2) The quality indicators in use shall be periodically evaluated and revised as health care quality issues are identified and others are resolved.

(i) **Data submission requirements.**

(1) The Department shall define the parameters and scope of each quality indicator, the beginning and ending dates of the period when each indicator will be in effect, how the indicator will be measured, any inclusionary or exclusionary criteria, and the frequency and format of how the data shall be reported.

(2) Each hospital shall report applicable data related to these indicators to the Department in the specified format and within required time frames.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 21 Ok Reg 573, eff 1-12-2004 (emergency); Amended at 21 Ok Reg 2785, eff 7-12-2004; Amended at 22 Ok Reg 2437, eff 7-11-2005; Amended at 24 Ok Reg 2018, eff 6-25-2007]

**310:667-1-4. Enforcement**

(a) **Inspections.** All hospitals required to have a license are subject to inspection by Department staff. This includes hospitals under construction that have submitted final drawings and made application for a license. These inspections may be routine or conducted as a result of a complaint investigation.

(b) **Adverse actions.** The State Commissioner of Health may suspend or revoke any hospital license based on any of the following:

(1) Violation of any provisions of 63 O.S. 1991, § 1-701 et seq. or this Chapter.

(2) Permitting, aiding or abetting the commission of any illegal act

in the licensed hospital.

(3) Conduct of practices deemed by the Commissioner to be detrimental to the welfare of patients of the hospital.

(c) **Hearings.** Hearings shall be conducted according to the Administrative Procedures Act and Chapter 2 of this Title 310:002.

(d) **Appeals.** A final order of the Commissioner of Health may be appealed to the District Court by any party affected or aggrieved by the order.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-1-5. Purpose, authority and indoor tobacco smoke**

(a) The purpose of this section is to establish a prevention program for several non-communicable diseases, which will improve the health of Oklahomans by eliminating exposure to secondhand tobacco smoke and its deadly effects. This section abates the public health nuisance of secondhand smoke under the authority of the Commissioner of Health as specified under Section 1-106(b)(1) of Title 63 of the Oklahoma Statutes. This section also further specifies how compliance with the Smoking in Public Places Act will be accomplished. [63 O.S. §§ 1-1521 *et seq.*]

(b) The Commissioner of Health has conducted a study and is recommending these measures to the Board of Health under his authority as stated in section 1-106 of the Public Health Code. [63 O.S. § 1-106] The Board has the authority to establish prevention programs for non-communicable disease and to promulgate rules for the control of causative or toxic substances, which can cause disease under section 1-502b of the Public Health Code. [63 O.S. § 1-502b] The Board is adopting this rule under its authority in sections 1-104 and 1-1526 of Title 63 of the Oklahoma Statutes. [63 O.S. §§ 1-104 & 1-1526]

(c) Smoking or possessing a lighted tobacco product is prohibited in a hospital and within fifteen (15) feet of each entrance to a facility and of any air intakes; provided however, the hospital may provide a smoking room not available to the public for use by addicted patients with a physician’s or licensed independent practitioner’s order.

(d) An indoor smoking room may be provided if:

(1) It is completely enclosed;

(2) It is exhausted directly to the outside and maintained under negative pressure sufficient to prevent any tobacco smoke from entering non-smoking areas of the building;

(3) It allows for visual observation of the patients from outside of the smoking room; and

(4) The plans are reviewed and approved by the Department.

(e) The walkway to the main entrance shall also be smoke free.

(f) No ashtray shall be located closer than fifteen (15) feet to an entrance, except in an indoor smoking room.

(g) Should construction requirements not be in agreement with this rule, the stricter rule shall apply.

[**Source:** Added at 19 Ok Reg 2097, eff 7-01-2002]

## SUBCHAPTER 3. PATIENT RIGHTS

310:667-3-1. General
310:667-3-2. Advance directives
310:667-3-3. Medical therapies
310:667-3-4. Itemized patient bill
310:667-3-5. Patient restraint
310:667-3-6. Seclusion

### 310:667-3-1. General

(a) Policies describing mechanisms by which patient rights are protected shall be formulated by the medical staff, with input from administration, and approved by the governing body.
(b) Patients have a right to considerate and respectful care from all personnel involved.
(c) Policies regarding care of the patients shall consider differences in culture and religion which may result in differences in how illness is perceived.
(d) Patients have the right, upon request, regardless of reimbursement mechanisms, to be informed of customary charges, in advance, for the type of hospital stay anticipated.
(e) The hospital shall inform each patient, or when appropriate the patient's representative, of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-3-2. Advance directives

Written policies and procedures relating to advance directives with respect to all adult individuals receiving care shall be maintained by the facility. These policies and procedures shall comply with existing state and federal laws.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-3-3. Medical therapies

The policies and procedures concerning medical therapies shall include:

(1) Consideration of a patient's right to be involved in health care decisions, in collaboration with a physician or licensed independent practitioner.
(2) Consideration of a patient's right to accept or reject medical care to the extent permitted by law.
(3) A patient's right to information necessary to enable the patient to make informed treatment decisions. This information shall be presented in plain language and in a format which the patient can understand; e.g., in their language if they do not speak English, sign language for the deaf, or other appropriate methods.

(4) Policies for patients who are diagnosed as terminal and the therapies which are aimed at optimizing comfort and alleviating pain.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-3-4. Itemized patient bill**

After receiving a written request from a patient, survivor, or legal representative as may be appropriate, facilities shall provide an itemized statement of the specific nature of charges or expenses incurred by the patient. The facility shall have a written policy, such as chart audits, to resolve differences of opinion concerning hospital charges.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-3-5. Patient restraint**

Patients have the right to be free from physical or chemical restraint unless such restraint is required to prevent injury to the patient or others or prevent serious disruption in the therapeutic environment. The responsibility for restraining any patient shall be limited to the patient's attending physician or licensed independent practitioner although physical restraint may be temporarily applied in emergency situations in accordance with established written policies at the direction of a registered nurse. Each facility shall have policies regarding the use of physical and chemical restraints and these policies shall comply with all requirements specified in these rules and other appropriate state and federal requirements. Each patient or their legal representative shall have access to these policies upon request.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-3-6. Seclusion**

Patients have the right to be free from seclusion unless seclusion is required to prevent injury to the patient or others or prevent serious disruption to the therapeutic environment. The responsibility for ordering seclusion of any patient shall be limited to the patient's attending physician or licensed independent practitioner although seclusion may be temporarily employed in emergency situations in accordance with established written policies at the direction of a registered nurse who immediately obtains verbal consent from a physician or licensed independent practitioner. Each facility shall have policies regarding the use of seclusion and these policies shall comply with all requirements specified in these rules and other appropriate state and federal requirements. Each patient or their legal representative shall have access to these policies upon request.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 5. COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS

310:667-5-1. Licensure or registration of personnel
310:667-5-2. Non-physician practitioners
310:667-5-3. Conformity with other laws
310:667-5-4. Employee health examinations
310:667-5-5. Health care information system

### 310:667-5-1. Licensure or registration of personnel

(a) Staff of the hospital shall be licensed or registered in accordance with applicable state laws and shall provide care according to the requirements of their respective practice Acts.

(b) Each student who is participating in a recognized training program to become a physician or a non-physician practitioner may be allowed to carry out patient care responsibilities under the supervision of their instructor as a part of their training. Physicians and other practitioners serving as instructors shall be appropriately licensed or registered and shall have been granted appropriate clinical privileges if required by the medical staff bylaws. Each hospital that allows student training shall authorize and limit student patient care activities through approved policies and procedures.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-5-2. Non-physician practitioners

Those hospitals using non-physician practitioners, such as physician assistants, advanced registered nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, psychologists, or other practitioners, shall clearly define the role, limitation and mechanism of supervision in their job description, contract, or bylaws, as appropriate, to insure compliance with state law and good-practice standards for each practitioner.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-5-3. Conformity with other laws

The hospital shall be in conformity with federal, state, and local laws relating to fire and safety, to communicable and reportable diseases, to occupational safety and health, and to other relevant matters.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-5-4. Employee and/or worker health examinations

(a) **Pre-employment.** Each employee and/or worker (with or without patient care responsibilities, paid or volunteer, full-time or part-

time: physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory and pharmacy workers, hospital volunteers, and administrative staff, including food service workers) in the hospital shall have a pre-employment health examination, which shall include (but not be limited to):

(1) An immunization history shall be part of each pre-employment examination or application for hospital privileges. The immunization history shall include documentation of immunity to measles, mumps, rubella and varicella.

(A) Birth before 1957 is considered acceptable evidence of immunity to measles, mumps, and rubella, with the exception that birth before 1957 is not acceptable evidence of immunity to rubella for female employees and/or workers born before 1957 who can become pregnant.

(B) Persons born in 1957 or later can be considered immune to measles, mumps or rubella only if they have documentation of one of the following:

(i) measles or mumps disease diagnosed by a physician or licensed independent practitioner;

(ii) laboratory evidence of measles, mumps, or rubella immunity; or

(iii) vaccination on or after the first birthday with two doses of live measles vaccine separated by at least 28 days, at least one dose of live mumps vaccine, and at least one dose of live rubella vaccine.

(C) Persons can be considered immune to varicella if they have a reliable history of having had varicella or if they have received one dose of varicella vaccine on or after the first birthday prior to the 13th birthday, or two doses of varicella vaccine separated by at least 28 days on or after the 13th birthday.

(D) Serologic screening need not be done before vaccinating against measles, mumps, rubella and varicella unless the facility considers it cost-effective.

(E) Serologic screening is not necessary for persons who have documentation of appropriate vaccination or other acceptable evidence of immunity to measles, mumps, rubella, and varicella.

(F) Contraindications to MMR or varicella vaccines should be followed.

(2) A tuberculin skin test utilizing the Mantoux technique shall be included as part of the pre-employment health examination or application for hospital privileges. Only a previous reactive tuberculin skin test or documented evidence of tuberculin skin testing within the previous twelve (12) months as a part of another licensed health care facility’s tuberculosis control program would negate this requirement. If PPD (Purified Protein Derivative) is less than 10 mm., repeat PPD in one to two (1-2) weeks, if it has been more than a year since the employee's and/or worker’s last non-reactive tuberculin test (Booster Effect). A history of vaccination with BCG (Bacillus of Calmette and Guerin) does not preclude initial tuberculin skin testing, and a reaction of ten (10) mm. or more should be managed in the same manner as it would be in a patient with

no history of BCG vaccination.

(3) Hepatitis B vaccine shall be offered consistent with 29 CFR Section 1910.1030 (Occupational Exposure to Bloodborne Pathogens).

(4) Each hospital shall meet Occupational Safety and Health Act standards applicable to the facility.

(b) **Periodic health examinations.** A tuberculin skin test utilizing the Mantoux technique shall be repeated at regular intervals on those employees and/or workers who have potential for exposure to *Mycobacterium tuberculosis* unless the employee and/or worker has a previous documented reactive skin test on file. Such periodic tuberculin skin testing shall be part of a documented tuberculosis control program that is based on a facility-specific risk assessment that considers at a minimum: the type and size of the facility, the prevalence of tuberculosis in the community, the patient population served by the facility, the occupational group the person represents, the area of the facility where the person works, and the effectiveness of the facility's tuberculosis control program. The following guidelines shall be used for the information and education of facilities with regard to their tuberculosis control program: "Centers for Disease Control and Prevention. Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health care facilities, 1994. MMWR 1994;43(No. RR-13)".

(1) Follow-up examinations for employees and/or workers who react significantly to a tuberculin skin test shall be conducted.

(2) Employees and/or workers with an initial negative chest x-ray, whether they take appropriate preventive therapy (treatment of latent tuberculosis infection) or not, shall be exempt from yearly, routine chest x-rays unless signs or symptoms suggestive of tuberculosis develop.

(3) Employees and/or workers with a documented reactive skin test and a proven negative chest x-ray, whether they have taken appropriate preventive therapy (treatment of latent tuberculosis infection) or not, shall be exempt from yearly, routine chest x-rays unless signs or symptoms suggestive of tuberculosis develop.

(4) Employees and/or workers with documented prior reactive tuberculin skin tests shall be seen yearly by medical personnel to determine if signs or symptoms are present. The results of such examinations shall be recorded on the individual employee's and/or worker’s health record.

(c) **Interim health examinations.** Employees and/or workers, when found to be likely to transmit a communicable disease as determined by a physician or licensed independent practitioner, shall be removed from patient contact duties, consistent with state and federal laws, until such time as a physician or licensed independent practitioner certifies that the risk of transmission of communicable disease is within acceptable limits as defined by the infection control program in its written policies and procedures.

(d) **Follow-up examinations.** Follow-up of an employee and/or workers, who, while employed at the facility, is a contact to active tuberculosis:

(1) An employee and/or worker who is a known tuberculosis contact shall have a tuberculin skin test. If this test is reactive for the first time, the individual shall have a chest x-ray. If the

individual with a reactive skin test does not take preventive medication (treatment of latent tuberculosis infection), the employee and/or worker shall be monitored.

(2) If an employee and/or worker is a known, recent tuberculosis contact, he or she shall have a tuberculin skin test and, if non-reactive, and if the individual is asymptomatic for tuberculosis, then a repeat tuberculin skin test shall be done in three (3) months. If the employee and/or worker is symptomatic, an x-ray shall be done immediately.

(3) If an employee and/or worker is a contact to active tuberculosis and has a documented previous reactive skin test, he or she shall be exempt from yearly, routine x-rays unless signs or symptoms develop suggestive of tuberculosis.

(e) **Annual influenza vaccination program.** Each hospital shall have an annual influenza vaccination program consistent with the recommendations of the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices that shall include at least the following:

(1) The offer of influenza vaccination onsite, at no charge to all employees and/or workers in the hospital or acceptance of documented evidence of current season vaccination from another vaccine source or hospital;

(2) Documentation of vaccination for each employee and/or worker or a signed declination statement on record from each individual who refuses the influenza vaccination for other than medical contraindications; and

(3) Education of all employees and/or workers about the following:

(A) Influenza vaccination;

(B) Non-vaccine influenza control measures; and

(C) The symptoms, transmission, and potential impact of influenza.

(4) Each hospital influenza vaccination program shall conduct an annual evaluation of the program including the reasons for non-participation.

(5) The requirements to complete vaccinations or declination statements for each employee and/or worker may be suspended by the hospital's medical staff executive in the event of a shortage of vaccine as recognized by the Commissioner of Health.

(f) **Health examination records**. A file shall be maintained for each employee and/or worker, containing the results of the evaluations and examinations specified at OAC 310:667-5-4 (a) through (d) and the dates of illnesses as relate to employment.

(g) **Credentialing records.** For credentialed non-employee workers, including physicians, hospitals may meet these requirements if as part of the credentialing process such workers provide evidence of an immunization history and tuberculin skin test, consistent with the tuberculosis control program required at 310:667-5-4(b), in the form of a signed attestation statement from the non-employee worker that documents the worker’s immunization history and the date and results of the latest tuberculin skin test.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003;

Amended at 22 Ok Reg 2437, eff 7-11-2005; Amended at 26 Ok Reg 2054, eff 6-25-2009]

**310:667-5-5. Health care information system**

Each hospital shall be in compliance with the Oklahoma Health Care Information System Act [63 O.S., Section 1-115 et seq.] and the rules promulgated thereto.

**[Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 7. GOVERNING BODY

310:667-7-1. General
310:667-7-2. Bylaws
310:667-7-3. Meetings
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310:667-7-9. Risk management

### 310:667-7-1. General

The hospital shall have an effective governing body legally responsible for the hospital and the quality of patient care provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-7-2. Bylaws

The governing body shall have adopted bylaws in accordance with legal requirements.

(1) The bylaws shall be in writing and available to all members of the governing body.

(2) The bylaws shall:

(A) Stipulate the basis upon which members shall be selected, their term of office, and their duties and requirements.

(B) Specify to whom responsibilities for operation and maintenance of the hospital, including evaluation of hospital practices, may be delegated; and the methods established by the governing body for such individuals responsible.

(C) Provide for the designation of necessary officers, their terms of office and their duties, and for the organization of the governing body into essential committees.

(D) Specify the frequency with which meetings shall be held.

(E) Provide for the appointment of members of the medical staff.

(F) Provide mechanisms for the formal approval of the organization, bylaws, rules and regulations of the medical staff and its departments in the hospital.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-7-3. Meetings

(a) The governing body shall meet at regular, stated intervals.

(b) Meetings shall be held frequently enough for the governing body to carry on necessary planning for growth and development and to evaluate the conduct of the hospital, including the care and treatment of

patients, the control, conservation, and utilization of physical and financial assets, and the procurement and direction of personnel.
(c) Minutes of meetings shall be maintained and approved by the governing body.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-7-4. Medical staff**
(a) The governing body shall appoint members of the medical staff.
(b) A formal procedure shall be established, governed by written rules and regulations, covering the application for medical staff membership and the method of processing applications.
(c) The procedure related to the submission and processing of applications shall involve the administrator, credentials committee of the medical staff or its counterpart, and the governing body, all functioning on a regular basis.
(d) Selection of physicians and licensed independent practitioners and definition of their medical privileges, both for new appointments and reappointments, shall be based on written, defined criteria.
(e) Actions taken on applications for medical staff appointments by the governing body shall be put in writing and retained.
(f) Written notification of applicants shall be made by either the governing body or its designated representative
(g) Applicants, approved for medical staff appointment, shall sign an agreement to abide by the medical staff bylaws, rules and regulations. In instances where physician or licensed independent practitioner services are provided by a corporation, the corporation and/or individual physicians and licensed independent practitioners shall agree to comply with medical staff bylaws.
(h) There shall be a procedure for appeal and hearing by the governing body or other designated committee if the applicant or medical staff feels the appointment or privileging decision is unfair or wrong.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-7-5. Administrator duties**
(a) The administrator, as appointed by the governing body, shall act as the executive officer of the hospital, be responsible for the management of the hospital, and provide liaison for the governing body to the medical staff, nursing staff, and other departments of the hospital.
(b) In discharging his or her duties, the administrator shall keep the governing body fully informed of the conduct of the hospital through written reports and by attendance at meetings of the governing body and meetings of the medical staff.
(c) The administrator shall organize the day-to-day functions of the hospital through appropriate departmentalization and delegation of duties.

(d) The administrator shall establish formal means of accountability on the part of the subordinates to whom he or she has assigned duties.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-7-6. All patients under physician's or licensed independent practitioner's care**

(a) The governing body shall be responsible for establishing a policy which requires that every patient shall be under the care of a physician or licensed independent practitioner.

(b) Patients shall be admitted to the hospital only upon the recommendation of a physician or licensed independent practitioner.

(c) A physician or licensed independent practitioner shall be on duty or on call at all times, and physically available if needed within twenty (20) minutes at the most.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-7-7. Physical plant**

(a) The governing body shall assure that the hospital is constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

(b) The governing body shall receive periodic reports from appropriate sources about the adequacy of the physical plant, equipment, and personnel, as well as any deficiencies.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-7-8. Institutional planning**

The administrator, under the direction of the governing body, shall be responsible for an over-all plan and budget which provides for an annual operating budget and a capital-expenditure plan.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-7-9. Risk management**

The facility shall have a risk-management program. A risk management program includes, but is not limited to, a system for identifying, evaluating, and minimizing risk exposures and a qualified person, defined in governing body bylaws, assigned to coordinate and/or perform indicated functions. The program shall include both clinical and non-clinical, including safety, functions. The governing body shall provide support for the program and receive periodic reports.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 9. MEDICAL STAFF

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### 310:667-9-1. General

The hospital shall have a medical staff, organized under bylaws approved by the governing body and responsible to the governing body of the hospital for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members. The medical staff includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services in the hospital.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-9-2. Responsibilities toward policies

(a) The medical staff shall be responsible for support of medical staff and hospital policies.

(b) Medical staff members shall participate on various staff committees. Attendance requirements for committee members shall be established in the medical staff bylaws. Committee records shall verify that committee meetings are attended by members as required by approved bylaws.

(c) There shall be prescribed, enforced disciplinary procedures for infraction of hospital and medical policies.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-9-3. Consultations

(a) The medical staff shall have established policies concerning the

holding of consultations.
(b) The status of consultants shall be determined by the medical staff on the basis of an individual's training, experience, and competence. A consultant shall be qualified to give an opinion in the field in which his or her opinion is sought.
(c) A consultation shall include a written opinion, signed by the consultant; the written opinion shall be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to operation.
(d) The patient's physician or licensed independent practitioner is responsible for requesting consultations when indicated. It is the duty of the medical staff, through its chief of service and executive committee, to make certain that members of the staff do not fail in the matter of contacting consultants as needed and in a timely manner. The medical staff shall establish and enforce policies on appropriate methods to be used when contacting consultants.
(e) Routine procedures, such as diagnostic imaging and electrocardiogram determination, are not normally considered to be consultations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-4. Staff appointments**
(a) Staff appointments shall be made by the governing body, taking into account recommendations made by the active staff.
(b) The governing body has the legal right to appoint the medical staff and the obligation to appoint only those physicians and practitioners who are judged by their peers to be qualified and competent in their respective fields.
(c) Reappointments shall be made periodically, and recorded in the minutes of the governing body. Reappointment policies provide for a periodic appraisal of each member of the staff, including consideration of his or her physical and mental capabilities. Recommendations for reappointments shall be noted either in the credential committee or medical staff meetings minutes.
(d) Temporary staff privileges, for example locum tenens, shall be granted as specified in the medical staff bylaws for a limited time if the person is otherwise properly qualified for such.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-5. Staff qualifications**
(a) Members of the staff shall be qualified legally, professionally, and ethically for the positions to which they are appointed.
(b) To select its members and delineate privileges, the hospital medical staff shall have a system, based upon definite workable standards, to evaluate each applicant and make recommendations to the medical staff and to the governing body regarding appointments.

(c) Privileges may be extended to duly licensed qualified persons to practice in their appropriate specialty fields only if appropriate to the services provided by the facility.
(d) Criteria for selection shall be individual character, competence, training, experience, judgement, and comity.
(e) Under no circumstances shall the accordance of staff membership or professional privileges in the hospital be based solely upon certification, fellowship, or membership in a specialty body or society. All qualified candidates shall be considered by the credentials committee.
(f) The scope of privileges for each member shall be specifically delineated or the medical staff shall define a classification system. If a system involving classification is used, the scope of the divisions shall be well defined, and the standards which shall be met by the applicant are clearly stated for each category.
(g) Patient admission quotas or revenue generation minimums shall not be a condition for medical staff appointments or reappointments.
**[Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-9-6. Active staff**

Regardless of any other categories having privileges in the hospital, there shall be an active staff, properly organized, which performs all of the organizational duties pertaining to the medical staff. These include:

(1) Maintenance of the proper quality of all medical care and treatment in the hospital.
(2) Organization of the medical staff, including adoption of rules and regulations for its government (which require the approval of the governing body), election of its officers, and recommendations to the governing body for appointments to the staff and delineation of hospital privileges.
(3) Making other recommendations to the governing body for matters within the purview of the medical staff.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-7. Other staff**

(a) In larger hospitals, and in some smaller hospitals, the medical staff may include one (1) or more of the categories in addition to the active staff. This in no way modifies the duties and responsibilities of the active staff.
(b) The categories of staff other than active may include the following:

(1) **Honorary staff.** The honorary staff shall be composed of former active staff, retired or emeritus, and other physicians and practitioners of reputation whom the hospital desires to honor.
(2) **Consulting staff.** The consulting staff shall be composed of recognized specialists willing to serve in such capacity. A member of

the consulting staff may become a member of the active staff, but only if another appointment is made.

(3) **Associate staff.** The associate staff shall be composed of those members who use the hospital infrequently or those less-experienced members undergoing a period of probation before being considered for appointment to the active staff.

(4) **Courtesy staff.** The courtesy staff shall be composed of those who desire to attend patients in the hospital but who, for some reason not disqualifying, are ineligible for appointment in another category of the staff.

(5) **Non-physician practitioners.** The medical staff may designate a category of staff membership for non-physician practitioners who are approved to provide services in an allied health profession. The roles of those persons approved by the medical staff for this category of membership shall be clearly defined in accordance with OAC 310:667-5-2.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-8. Medical staff officers**

(a) There shall be such officers as may be necessary for the governance of the staff. These officers shall be members of the active staff and shall be elected by the active staff, unless this is precluded by medical staff policy.

(b) The officers shall be elected from and by the active staff or appointed in accordance with medical staff policy on the basis of ability and willingness to assume responsibility and devote time to the office.

(c) Where officers are elected, the process for election shall be delineated in the bylaws.

(d) The chief of staff shall:

(1) Have direct responsibility for the organization and administration of the medical staff, in accordance with the terms of the medical staff constitution, bylaws, rules and regulations.

(2) In all medico-administrative matters, act in coordination and cooperation with the hospital administrator in implementing the policies adopted by the governing body.

(3) Be responsible for the function of the clinical organization of the medical staff and keeps or causes to be kept careful supervision over the clinical work in all departments.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-9. Medical staff bylaws**

(a) Bylaws shall be adopted to govern and enable the medical staff to carry out its responsibilities.

(b) The bylaws of the medical staff shall be a precise and clear statement of the policies under which the medical staff regulates

itself.

(c) Medical staff bylaws, rules and regulations shall include the following:

(1) A descriptive outline of medical staff organization.

(2) A statement of the necessary qualifications which physicians and licensed independent practitioners shall possess to be eligible for medical staff privileges to work in the hospital, and/or the duties and privileges of each category of medical staff.

(3) A procedure for granting and withdrawing privileges to physicians and licensed independent practitioners.

(4) A mechanism for appeal of decisions regarding medical staff membership and privileges.

(5) A definite and specific statement forbidding the practice of the division of fees under any guise whatsoever.

(6) Provision for regular meetings of the medical staff.

(7) Provision for keeping accurate and complete medical records.

(8) A provision that all patient tissue removed in the hospital, except tissue specifically excluded by medical staff policy, shall be examined by a pathologist and a report made of this examination.

(9) Provision for performing and documenting a routine examination of all patients upon admission and recording of pre-operative diagnosis prior to surgery.

(10) A rule permitting a surgical operation only on consent of the patient or his or her legal representative, except in emergencies.

(11) A rule providing that, except in emergency, consultation is required as outlined above.

(12) A regulation requiring physicians' and licensed independent practitioners' orders be recorded and signed.

(13) If dentists and oral surgeons, podiatrists, psychologists, or other allied health professionals are to be admitted to staff membership, the necessary qualifications, status, privileges, and rights of this group shall be stated in the bylaws.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-10. Committees-general**

The structure of committee organization is a decision to be made by the medical staff as long as the required committee functions are carried out. A small staff may function as a committee-of-the-whole.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-9-11. Executive committee**

(a) The executive committee (or its equivalent) shall coordinate the activities and general policies of the various departments, act for the staff as a whole under such limitations as may be imposed by the staff, and receive and act upon the reports of the medical records, tissue, and such other committees as the medical staff may designate.

(b) The committee shall meet at least nine (9) months out of each calendar year and maintain a permanent record of its proceedings and actions.
(c) Committee membership shall be made up of the officers of the medical staff, chiefs of major departments or services, and one (1) or more members elected at large from the active medical staff.
(d) The committee's functions and responsibilities shall include but not be limited to the following:
(1) Consider and recommend action to the administrator on all matters which are of a medico-administrative nature.
(2) Investigate any reports of breach of ethics by members of the medical staff, as referred to this committee by the credentials committee.
(3) Act as the program committee for staff meetings, unless this responsibility is delegated to a specific committee.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-9-12. Credentials committee**
(a) The credentials committee (or its equivalent) shall review applications for appointment and reappointment to all categories of the staff as often as needed and at least biennially. It shall delineate the privileges to be extended to the applicant and make appropriate recommendations to the governing body according to the procedure outlined in the hospital's medical staff bylaws.
(b) The committee shall recommend individuals for initial appointment, hospital privileges, promotions, demotions, and reappointments.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-9-13. Medical records committee**
(a) The medical records committee (or its equivalent) shall supervise the maintenance of medical records at the required standard of completeness. Routine review and monitoring of records may be performed by hospital medical records staff or through the quality improvement program. On the basis of documented evidence, the committee shall review and evaluate the completeness of the record.
(b) The committee shall be available to meet as often as necessary and shall submit a written report of meetings to the executive committee.
(c) The committee's members shall represent a cross section of the clinical services. In large hospitals, each major clinical department may have its own committee.
(d) Membership shall be staggered so that experienced committee physicians shall always be included. Senior residents may serve on this committee.
(e) Review of the record for completeness may be performed for the most part by medical record staff. In addition, on-the-spot scanning of current inpatient records for completeness shall be performed.

(f) The committee shall:
(1) Recommend to the medical staff the approval of, use of, and any changes in form or format of the medical record.
(2) Advise and recommend policies for medical record maintenance and supervise the medical records to insure that details shall be recorded in the proper manner and that sufficient data shall be present to evaluate the care of the patient.
(3) Insure proper filing, indexing, storage, and availability of all patient records.
(4) Advise and develop policies to guide the medical record administrators or medical record staff, medical staff, and administration so far as matters of privileged communication and legal release of information are concerned.

**[Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-14. Tissue committee**

(a) The tissue committee (or its equivalent) shall review and evaluate all surgery performed in the hospital on the basis of agreement or disagreement among the pre-operative, post-operative, and pathological diagnoses, and on the acceptability of the procedure undertaken. Reviews may be conducted by hospital staff or conducted as a part of the quality improvement program. All reviews shall be conducted based on criteria established by the committee.
(b) The committee shall be available to meet as often as necessary and shall submit a written report to the executive committee.
(c) This committee's work shall include continuing education through such mechanisms as utilization of its findings in the form of hypothetical cases or review of cases by category at staff meetings or publishing in coded form physicians' standings in the hospital regarding percentage of cases in which normal tissue is removed.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-9-15. Pharmacy and therapeutics committee**

(a) A pharmacy and therapeutics committee (or its equivalent), composed of physicians, licensed independent practitioners, pharmacists, and registered nurses, shall assist in the formulation of broad procurement, storage, distribution, use, and safety procedures, and all other matters relating to drugs in hospitals and shall advise the medical staff and the pharmacist.
(b) The committee shall meet at least quarterly and shall:
(1) Serve as an advisory group on matters pertaining to the choice of drugs.
(2) Monitor and enforce stop-order policies.
(3) Monitor and control the use of preventive antibiotics and the use of antibiotics in the presence of infection.
(4) Develop and review periodically a formulary or drug list for use

in the hospital.
(5) Establish standards concerning the use and control of investigational drugs in research and the use of recognized drugs.
(6) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.
(7) Make recommendations concerning drugs to be stocked on the nursing-unit floors and by other services.
(8) Provide information to the medical staff on the relative cost of equivalent or generic medicines.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-16. Meetings of the medical staff**

(a) Meetings that include the medical staff shall be held at least monthly to review, analyze, and evaluate the clinical work of its members.
(1) The number and frequency of these meetings shall be determined by the active staff and clearly stated in the bylaws of the staff.
(2) Attendance requirements for each individual member of the staff and for the total attendance at each meeting shall be clearly stated in the bylaws of the staff, and attendance records shall be kept.
(3) Adequate minutes of all meetings shall be kept.
(4) The method adopted to insure adequate evaluation of clinical practice in the hospital shall be determined by the medical staff, e.g. quality improvement meetings, meetings of medical records and tissue committees in which clinical practice is discussed and evaluated and reports made to the active staff, active staff meetings, etc., and shall be clearly stated in the bylaws.
(b) Minutes of such meetings shall provide evidence of the following:
(1) A review of the clinical work done by the staff on at least a monthly basis according to policies established by the medical staff to monitor clinical activities.
(2) Discussion of agenda items, such as committee reports received.
(3) Names of members and staff present.
(4) Duration of meeting.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-17. Departments**

(a) Division of staff into services or departments to fulfill medical staff responsibilities promotes efficiency and is recommended in general hospitals with seventy-five (75) or more beds. Each autonomous service or department shall be organized and function as a unit.
(b) Medical staff members of each service or department shall be qualified by training and demonstrated competence and be granted privileges based on their individual training and competence.
(c) In those hospitals where the review and evaluation of clinical

practice are done by committees of the medical staff or by monthly meetings of the entire staff, departmental meetings shall be optional. In those hospitals where the clinical review is done by the departments, each service or department shall meet at least once a month. Records of these meetings shall be kept and shall become part of the records of the medical staff.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-9-18. Chief of service or departments**

(a) The chief of service or department shall be a member of the service or department, qualified by training and by definition in the medical staff bylaws. The chief of service or department shall be responsible to the medical staff as to the qualifications of service or department members. He or she shall make recommendations to the department for the professional care of patients and make recommendations to the medical staff as to the planning of hospital facilities, equipment, routine procedures, and any other matters concerning patient care.

(b) Each chief of service shall be selected as required by medical staff bylaws or hospital policies based on recommendations of the medical staff.

(c) Duties and responsibilities of the chief shall include, in addition to those cited above:

(1) Responsibility for arranging and expediting inpatient and outpatient departmental programs embracing organization, educational activities, supervision, and evaluation of the clinical work.

(2) Responsibility for enforcement of the hospital medical staff bylaws, rules and regulations, with special attention to those pertaining to the chief's department.

(3) Maintaining the integrity of the medical records in the department.

(4) Representing the department, in a medical advisory capacity, to the administration and governing body.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 11. QUALITY IMPROVEMENT

310:667-11-1. General
310:667-11-2. Quality improvement plan
310:667-11-3. Quality improvement committee
310:667-11-4. Quality improvement implementation
310:667-11-5. Communication

### 310:667-11-1. General

There shall be an ongoing, comprehensive quality improvement program, approved by the governing body, which shall identify problems in the facility, suggest solutions, and monitor results.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-11-2. Quality improvement plan

(a) A written quality improvement plan shall be developed, approved, and implemented by the governing body with advice from the medical staff. The plan shall include but not be limited to the following:

(1) Methods of evaluating all patient services to assure quality of care, including those provided under contract.

(2) Methods of evaluating off-site health care organizations for appropriateness of use and the degree to which the services aid in the provision of quality patient care.

(3) Evaluation of all surgeries, inpatient and outpatient.

(b) The evaluation of nosocomial infections and accompanying medication therapy shall be linked to the hospital-wide quality improvement program through regular reporting by appropriate hospital committees and functions such as pharmacy and therapeutics, infection control, pharmaceutical services, etc.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-11-3. Quality improvement committee

A quality improvement committee (or its equivalent) shall meet at least quarterly to evaluate the quality of patient care and address problems identified by the various services. All organized hospital services shall report findings to the committee on at least a quarterly basis or more frequently if findings require immediate action by the committee.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-11-4. Quality improvement implementation

There shall be documentation that the hospital has taken action to address problems identified by hospital services. There shall be documentation that the hospital is monitoring the effectiveness of the

proposed solutions.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-11-5. Communication**

The facility shall establish mechanisms to communicate quarterly quality improvement summaries to the governing body and to the medical staff.

**[Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 13. INFECTION CONTROL

310:667-13-1. Infection control program
310:667-13-2. Infection control committee
310:667-13-3. Policies and procedures review
310:667-13-4. Policies and procedures content

### 310:667-13-1. Infection control program

Each hospital shall establish an infection control program to provide a sanitary environment and avoid sources and transmission of infections. The program shall include written policies and procedures for identifying, reporting, evaluating and maintaining records of infections among patients and personnel, for ongoing review and evaluation of all aseptic, isolation and sanitation techniques employed in the hospital, and development and coordination of training programs in infection control for all hospital personnel.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-13-2. Infection control committee

The infection control committee (or its equivalent) shall meet at least quarterly. If central services are discussed such as the dietary service, employee health, engineering or maintenance, housekeeping, laundry, material management, surgical services, pharmacy, or laboratory, at least one individual with appropriate background who can speak for the relevant department(s) attends the meeting or is consulted.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-13-3. Policies and procedures review

(a) The infection control committee shall evaluate, revise as necessary, and approve the type and scope of surveillance activities utilized at least annually.

(b) Infection control policies and procedures shall be reviewed periodically and revised as necessary, based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-13-4. Policies and procedures content

The policies and procedures outlined by the infection control program shall be approved by the infection control committee and contain at least the following:

(1) A requirement that a record of all reported infections generated by surveillance activities include the identification and location of the patient, the date of admission, onset of infection, the type of

infection, the cultures taken, the results when known, any antibiotics administered and the physicians and practitioners responsible for care of the patient.
(2) Specific policies related to the handling and disposal of biomedical waste.
(3) Specific policies and procedures related to admixture and drug reconstitution, and to the manufacture of intravenous and irrigating fluids.
(4) Specific policies regarding the indications for and types of isolation to be used for each infectious disease. These policies shall incorporate the concepts of Standard Precautions and utilize the recommended transmission-based categories of Contact, Airborne, and Droplet isolation procedures where deemed appropriate by the medical staff.
(5) A definition of nosocomial infection.
(6) Designation of an infection control officer, who coordinates the infection control program.
(7) A program of orientation of new employees and other workers, including physicians, and a program of continuing education for previously employed personnel concerning infection control. Written documentation shall be maintained indicating new employees have completed the program and that previously employed have attended continuing education.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-13-5. Universal birth dose hepatitis B vaccination**

All Oklahoma birthing hospitals shall implement a procedure to ensure that the hepatitis B vaccination is administered to all live infants within twelve hours of birth and recorded in the Oklahoma State Immunization Information System. A parent or guardian may refuse hepatitis B vaccination of their newborn on the grounds of medical reasons or that such vaccination conflicts with their religious tenets or personal beliefs. A refusal based on medical reasons shall include a statement in the medical record by a physician stating that the physical condition of the newborn is such that the vaccination would endanger the life or health of the child and that the child should be exempt from the vaccination requirement. A refusal based on the parent’s or guardian’s religious tenets or personal beliefs shall be documented in the newborn’s medical record.

[**Source:** Added at 29 Ok Reg 1603, eff 7-12-2012]

## SUBCHAPTER 15. NURSING SERVICE

310:667-15-1. General
310:667-15-2. Organization
310:667-15-3. Registered nurse
310:667-15-4. Other nursing personnel
310:667-15-5. Qualifications
310:667-15-6. Evaluation and review of nursing care
310:667-15-7. Special-care units
310:667-15-8. Patient physical restraint
310:667-15-9. Patient chemical restraint

### 310:667-15-1. General

The hospital shall have an organized nursing department. A registered nurse shall be on duty at all times, and registered nursing services shall be available for all patients at all times.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-15-2. Organization

There shall be an organized departmental plan of administrative authority with the delineation of responsibilities and duties of each category of nursing personnel.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-15-3. Registered nurse

(a) There shall be an adequate number of registered nurses to meet the following minimum staff requirements: director of the department; assistants to the director for evening and night services; supervisory and staff personnel for each department or nursing unit to insure the immediate availability of a registered nurse for bedside care of any patient when needed; and registered nurse on duty at all times and available on-site for all patients on a twenty-four (24) hour basis.
(b) The staffing pattern shall insure the availability of registered nursing care for all patients on a twenty-four (24) hour basis every day.
(c) If a licensed practical nurse or nurse aide is assigned care of patients who do not generally need skilled nursing care, there shall be a registered nurse supervisor who makes frequent rounds and is immediately available to give skilled nursing care when needed. This registered nurse shall be free to render bedside care and not be occupied in the operating room, delivery room, or emergency room for long periods of time.
(d) The ratio of registered nurses to patients and the ratio of registered nurses to other nursing personnel shall be adequate to provide proper supervision of patient care and staff performance, based on patient acuity.
(e) A registered nurse shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's acuity and

the nursing staff available.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-15-4. Other nursing personnel**

There shall be other ancillary nursing personnel in sufficient numbers to provide nursing support as needed under the supervision of a registered nurse. The training and supervision of these personnel shall be appropriate for the duties assigned.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-15-5. Qualifications**

(a) Individuals selected for the nursing staff shall be qualified by education and experience for the positions they are assigned.
(b) The director of nursing shall make recommendations regarding the selection and promotion of nursing personnel based on their qualifications and capabilities and recommend the termination of employment when necessary.
(c) The qualifications required for each category of nursing staff shall be in written policy and job descriptions and shall be available for review.
(d) The functions of nursing personnel shall be clearly defined in written policies and procedures.
(e) Verification of current licensure and credentials shall be maintained in the personnel files or department of nursing.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-15-6. Evaluation and review of nursing care**

(a) There shall be a continuous review and evaluation of the nursing care provided for patients. There shall be written nursing care procedures and nursing care plans for patients.
(b) Nursing care policies and procedures shall be written and be consistent with current standards of practice and be reviewed and revised as necessary.
(c) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.
(d) Nursing care plans shall include assessment, planning, intervention, and evaluation. Nursing care plans shall be established for each inpatient and be revised as necessary.
(e) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.
(f) Only the following shall be permitted to administer medications, and in all instances, in accordance with state and federal law:
    (1) A licensed physician or licensed independent practitioner;
    (2) A registered nurse;
    (3) A licensed practical nurse; or
    (4) Other practitioners, if designated by the medical staff and

authorized by law.

(5) Facilities participating in a program for training nursing students may permit nursing students to administer medications to patients provided the facility has on file an agreement between the nursing school and the facility, outlining protocols for participation, scope of involvement, education levels of students, level of supervision, and a current roster of nursing students in the program. Specific details relating to the operation of the program shall be included in the facility's policies and procedures manual.

(g) All medical orders shall be signed by the prescribing physician or practitioner. Telephone or verbal orders for medications, treatments and tests shall be given only to the practitioner authorized by administration to receive these orders and be signed by the prescribing physician or practitioner. Other orders may be accepted by staff as designated by medical staff policy, consistent with state and federal laws. The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(h) Telephone or verbal orders may be authenticated as described at OAC 310:667-19-2(c)(4).

(i) Blood product transfusions and intravenous medications shall be administered as required by written hospital policy in accordance with state and federal law. Hospital staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(j) An effective hospital procedure shall be established for reporting transfusion reactions and adverse drug reactions.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-1995 (emergency); Added at 12 Ok Reg 2429, eff 6-26-1995; Amended at 18 Ok Reg 2032, eff 6/11/2001; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008; Amended at 30 Ok Reg 1966, eff 7-25-2013]

**310:667-15-7. Special-care units**

(a) Areas providing specialized nursing care shall be well defined by policies and procedures specific to the nursing services such as intensive care, coronary care, obstetrics, nursery, emergency services, and renal units.

(b) Specific policies and procedures shall supplement basic hospital nursing policies and procedures for special-care units. Nursing policies and procedures of special-care units shall be in accordance with current standards of practice and shall include but not be limited to:

(1) Protocol for resuscitation and disaster situations.

(2) Immediate availability of emergency equipment and drugs.

(3) Appropriate and safe storage of pharmaceuticals and biologicals.

(4) Programs for maintenance and safe operation of all equipment.
(5) Appropriate infection-control measures.
(6) Control of visitors and nonessential personnel.
(7) Documentation of quality improvement.

(c) Special-care unit nursing services shall be integrated with other hospital departments and services.

(d) Supervision of nursing care in the unit shall be provided by a registered nurse with relevant education, training, experience, and demonstrated current competence.

(e) All nursing personnel shall be prepared for their responsibilities in the special-care unit through orientation, ongoing inservice training, and continuing education programs. A planned, formal training program shall be required for registered nurses and licensed practical nurses and shall be of sufficient duration and substance to cover applicable patient care responsibilities in the special-care unit.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-15-8. Patient physical restraint**

(a) Patients may be physically restrained only by order of a physician or licensed independent practitioner who has determined such restraint is required to prevent injury to the patient or others or prevent serious disruption in the therapeutic environment. Orders for physical restraint shall include a statement of reason for the restraint and specify which approved facility methods and devices shall be used. Alternative measures to the use of physical restraints shall be evaluated prior to their use. Physical restraints shall not be imposed for discipline or convenience purposes.

(b) Emergency physical restraint to ensure the physical safety of the patient, staff, or other patients may be initiated by a registered nurse who obtains written or verbal consent from a physician or licensed independent practitioner within a time-frame specified by written facility policy. Verbal physical restraint orders shall be signed by the physician or licensed independent practitioner as soon as possible within twenty-four (24) hours. Physical restraint orders shall automatically terminate as specified by facility policy, or sooner as warranted by the patient's condition. If physical restraint is to continue past the time-frame specified by facility policy, a new order shall be obtained from a physician or licensed independent practitioner.

(c) Patients may be restrained only in accordance with documented specific policies established by the medical staff and the governing body. These policies shall include circumstances in which restraint is appropriate and specific techniques and devices that shall be used for restraint.

(d) Physically restrained patients shall be monitored as required by facility policy and justification for continued restraint shall be documented. A physically restrained patient shall have restraint devices released at time-frames specified by facility policy; and the patient shall be repositioned, exercised, or provided range of motion and toileted as necessary.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-15-9. Patient chemical restraint**

(a) Patients may be chemically restrained only by order of a physician or licensed independent practitioner who has determined that the chemical restraint is required to prevent injury to the patient or others or prevent serious disruption in the therapeutic environment. Alternative measures to the use of the chemical restraint shall be evaluated prior to their use. Chemical restraint shall not be imposed for discipline or convenience purposes.

(b) Orders for medications used in chemical restraint shall specify the duration and frequency of administration and shall comply with specific stop order policies established by the medical staff for medications used for these purposes.

(c) Patients who are chemically restrained shall be continuously monitored to ensure that side effects are observed and reported to the attending physician or licensed independent practitioner. Monitoring observations and reports to physicians and licensed independent practitioners shall be documented.

**[Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 17. FOOD AND NUTRITIONAL SERVICES

310:667-17-1. Organization
310:667-17-2. Services and facilities
310:667-17-3. Diets and menus
310:667-17-4. Food preparation and storage
310:667-17-5. Sanitation

### 310:667-17-1. Organization

(a) The clinical nutritional services shall be under the supervision and direction of a licensed/registered dietitian on a full-time or consultant basis. The number of dietitians shall be adequate to supervise or direct the nutritional aspects of patient care and services, considering the size, scope, and complexity of the needs of the patient.

(1) The licensed/registered dietitian shall be responsible for approval of menus, including modified diets, review of clinical policies and procedures, evaluation of the nutritional services and staff education in continuing education programs.

(2) The licensed/registered dietitian shall provide for patient/family counseling on modified diets as needed, any required nutritional assessments, and development of clinical policies and procedures.

(3) If the licensed/registered dietitian is employed on a part-time or consultant basis, a designee for clinical aspects of patient care shall be a certified dietary manager or a registered dietary technician.

(4) The licensed/registered dietitian or designee shall enter nutritional status information into the medical record.

(5) Part-time and consultant licensed/registered dietitians shall prepare written reports concerning all services rendered.

(b) The food and nutrition services manager may or may not be a licensed/registered dietitian. If the manager is not a licensed/registered dietitian, the manager is only responsible for administrative management and does not direct clinical nutritional activities.

(c) Personnel shall be adequate in number and training to carry out the preparation and serving of foods and other related functions with the proper and necessary sanitary procedures. The food service staff shall complete a basic orientation program before working in the food service area. This orientation shall include, but not be limited to, basic dietary guidelines, infection control including food safety, and fire and safety precautions.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-17-2. Services and facilities

(a) **Equipment.** Equipment used in the preparation and handling of food in hospitals shall bear the seal of the National Sanitation Foundation

(NSF) or comply with the requirements of the NSF (Rules and Regulations Pertaining to Food Establishments).
(b) **Nourishment room.** A room accessible to nursing staff shall be provided for the preparation and serving of light refreshments, equipped with equipment for warming food, refrigerator, and lavatory. This room may serve as the location for an ice machine.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-17-3. Diets and menus**
(a) At least three (3) palatable meals or their equivalent shall be served daily, at regular times with not more than fifteen (15) hours between a substantial evening meal and breakfast. Menus shall be planned and followed to meet nutritional needs of patients, in accordance with physicians' or licensed independent practitioners' orders and to the extent medically possible, in accordance with the Dietary Reference Intakes (DRIs) of the Food and Nutrition Board of the Institute of Medicine, National Academy of Sciences.
(b) Diets shall be prescribed by the physician or licensed independent practitioner responsible for the care of the patient. All modified diets shall be prescribed by the patient's physician or licensed independent practitioner according to the latest edition of the Oklahoma Diet Manual or other equivalent approved diet manual. The Oklahoma Diet Manual or other equivalent manual shall be approved by the licensed/registered dietitian and medical staff and shall be available to all medical, nursing, and food service personnel.
(c) Nourishments shall be available and may be offered at anytime in accordance with approved diet orders.
(d) Menus covering all prescribed diets shall be approved, dated, and periodically reviewed by a licensed/registered dietitian.
(1) Modified diet orders not covered with an approved menu shall be planned in writing, reviewed, and approved by the licensed/registered dietitian or designee with consultation by the licensed/registered dietitian.
(2) All modified diets shall be efficiently served under the general supervision of a licensed/registered dietitian, a certified dietary manager, or a registered dietary technician.
(e) The portioning of menu servings shall be accomplished with the use of portion-control serving utensils.
(f) All modified diets shall be prepared separately, as necessary, from regular diets.
(g) An identification system shall be established to assure that each patient receives their prescribed diet as ordered.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-17-4. Food preparation and storage**
(a) Potentially hazardous food, as defined in Chapter 257 of this

Title, shall be maintained at one hundred-forty (140) °F (approximately 60°C) or above or at an internal temperature of forty-one (41) °F (approximately 5°C) or below. A product thermometer shall be available (metal stem-type numerically scaled indicating temperature, accurate to plus or minus two (2) °F and used to check internal food temperatures).
(b) Milk and milk products shall be served, handled and stored in accordance with the requirements of Chapter 257 of this Title.
(c) All ice which is in contact with food or drink shall come from a source approved by the Department, including storage, transportation, handling, and dispensing, which shall be in a sanitary manner, approved by the Department in accordance with Chapter 257 of this Title.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, Eff 6-12-2003; Amended at 24 Ok Reg 2018, eff 6-25-2007]

**310:667-17-5. Sanitation**
(a) The food and nutritional services shall be inspected and approved by state or local health agencies and licensed as a Food Service Establishment. Written reports of the inspection; e.g., Food Establishments Inspection Report Forms, shall be on file at the hospital with notations made by the hospital of action taken to correct violations.
(b) Storage, preparation, and serving of food shall be in compliance with the requirements of Chapter 257 of this Title, including adequate and proper space for each activity.
(c) The system to be used for dishwashing shall be approved by the Department and operated in accordance with approved procedures and requirements of Chapter 257 of this Title.
(d) Garbage and refuse shall be kept in durable, easily cleanable, insect-proof and rodent-proof containers that do not leak and do not absorb liquids. Adequate carriers and containers shall be provided for the collection and transportation, in a sanitary manner, of garbage and refuse from food service areas of the hospital to the place of disposal in accordance with the requirements of Chapter 257 of this Title.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 2018, eff 6-25-2007]

## SUBCHAPTER 19. MEDICAL RECORDS DEPARTMENT

310:667-19-1. General
310:667-19-2. Reports and records
310:667-19-3. Maintenance
310:667-19-4. Personnel
310:667-19-5. Identification and filing
310:667-19-6. Centralization of reports
310:667-19-7. Indices
310:667-19-8. Content
310:667-19-9. Authorship
310:667-19-10. Signature
310:667-19-11. Emergency medical records
310:667-19-12. Outpatient medical records
310:667-19-13. Promptness of record completion
310:667-19-14. Retention and preservation of records

### 310:667-19-1. General

The hospital shall have a medical records department with administrative responsibility for medical records. A medical record shall be maintained, in accordance with accepted professional principles, for every patient receiving care in the facility.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-19-2. Reports and records

(a) Reports shall be made by each hospital to the appropriate agency, including but not limited to the following:

(1) Communicable disease.

(2) Births and deaths.

(3) Periodic reports to the Department on forms supplied for this purpose.

(4) Newborn hearing screening report.

(A) All hospital nurseries shall complete a newborn hearing screening report form on all live newborns discharged from their facility. For facilities with a two-year average annual birth census of 15 or greater, physiologic hearing screening results as well as "at risk" indicators must be recorded on the report form; for facilities with a two-year average annual birth census of fewer than 15, "at risk" indicators must be recorded and if physiologic hearing screening is conducted, those results also must be recorded on the report form. It shall be the responsibility of the hospital administrator to assure that the Newborn Hearing Screening Report Form is correctly completed and subsequently submitted to the Department. The hospital administrator may designate one individual, who shall then be responsible for review of all newborn discharge summaries to insure that a report form has been completed for each infant and that the report form is a permanent part of that infant's record.

A copy of the hearing screening report form must be given to the infant's caregiver at discharge.

(B) If an infant is transferred from one hospital to another, the second hospital shall be responsible for providing physiologic hearing screening, "risk indicator" screening, and for completion of the report form.

(C) It shall be the responsibility of the hospital administrator to insure that all completed report forms are mailed to the Department within seven (7) days of an infant's birth.

(D) It shall be the responsibility of the attending physician or licensed independent practitioner to inform parents if their infant passed or was referred on the physiologic hearing screening and/or if the infant is to be considered "at risk" for hearing impairment. Prior to discharge, the attending physician or licensed independent practitioner shall review the completed report form and shall inform the parents of their infant's status. Infants who do not pass the physiologic screening shall be referred for a diagnostic audiological evaluation as soon as possible.

(E) It shall be the responsibility of the coordinator of the Newborn Hearing Screening Program at the Department to arrange for hospital in-service training for all hospital personnel involved in the process of completion of report forms. A manual of procedures shall be available in regard to processing of screening forms. The literature for distribution to parents shall be available from the Department.

(5) Newborn metabolic disorder screening.

(A) **Testing of newborns.** All newborns in Oklahoma shall be tested for phenylketonuria, hypothyroidism, galactosemia and sickle cell diseases by a Certified Newborn Metabolic Disorder Screening Laboratory as defined in Chapter 550 of this Title; a parent or guardian may refuse metabolic disorder screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices. A parent or guardian who refuses metabolic disorder screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices shall also indicate in writing this refusal in the newborn's medical record with a copy sent to the Newborn Metabolic Disorder Screening Program, Maternal and Child Health Service, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299.

(B) **Specimen collection for hospital births.** For all live hospital births, the physician or licensed independent practitioner shall order the collection of a newborn metabolic disorder screening specimen on all newborns prior to transfusion, at three to five days of age or immediately prior to discharge, whichever comes first. Specimens shall be collected on the Newborn Metabolic Disorder Form Kit using capillary or venous blood. Cord blood is unacceptable. The hospital is responsible for collecting specimens on all infants.

(i) If the initial specimen for any infant is collected prior to 24 hours of age, the hospital and the physician or licensed

independent practitioner are responsible for notifying the infant's parents that a repeat specimen is necessary at three to five days of age. The infant's physician or licensed independent practitioner is responsible for insuring that the repeat specimen is collected.

(ii) The hospital is responsible for submitting a satisfactory specimen and for documenting all requested information on the form kit including the parent/guardian's name, address, phone or contact phone number and the planned health care provider who will be providing well care for the infant after discharge, or if the infant is to be hospitalized for an extended period of time, the name of the infant's physician or licensed independent practitioner.

(iii) The hospital is responsible for documenting specimen collection and results in the infant's hospital record.

(iv) Infants transferred from one hospital to another during the newborn period shall have specimen collection documented in the infant's hospital record. It is the responsibility of the physician or licensed independent practitioner and the receiving hospital to insure a specimen is collected.

(v) It is the responsibility of the hospital and physician or licensed independent practitioner to insure that all infants are screened prior to discharge. If an infant is discharged prior to specimen collection, the Newborn Metabolic Disorder Screening Program Coordinator shall be notified by contacting Maternal and Child Health Service, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299, (405) 271-6617, FAX (405) 271-4892, 1-800-766-2223, ext. 6617. The physician or licensed independent practitioner is responsible for insuring the specimen is collected at three to five days of age.

(C) **Screening for premature/sick infants.** For all premature/sick infants, the physician or licensed independent practitioner shall order the collection of a newborn metabolic disorder screening specimen prior to red blood cell transfusion, at three to seven days of age, or immediately prior to discharge, whichever comes first. It is recommended that a repeat newborn metabolic disorder screening specimen be collected at 14 days of age. Specimens shall be collected on the Newborn Metabolic Disorder Form Kit using capillary or venous blood. The hospital is responsible for collecting specimens on all premature/sick infants.

(i) Premature/sick infants screened prior to 24 hours of age must be re-screened between 7-14 days of age.

(ii) Premature/sick infants who could not be screened prior to a red blood cell transfusion should be re-screened by the 7th day of life and a repeat specimen collected when plasma and/or red cells will again reflect the infant's own metabolic processes or phenotype. The accepted time period to determine hemoglobin type is 90 to 120 days after transfusion.

(iii) The recommended follow-up study for an abnormal thyroid screen in a premature infant is a serum free T4 (measured by direct dialysis or an equivalent method) at 7-14 days of age.

(D) **Hospital recording.** The hospital shall implement a procedure to assure that a newborn screening specimen has been collected on every newborn and mailed to the Newborn Metabolic Disorder Screening Laboratory within 24 - 48 hours of collection.

(i) The hospital shall immediately notify the infant's physician or licensed independent practitioner, and parents or guardians if an infant is discharged without a sample having been collected. This notification shall be documented in the infant's hospital record.

(ii) If no test results are received within fifteen (15) days after the date of collection, the hospital shall contact the Newborn Metabolic Disorder Screening Laboratory to verify that a specimen had been received. If no specimen has been received, the hospital shall notify the physician or licensed independent practitioner.

(iii) Any hospital or any other laboratory which collects, handles or forwards newborn metabolic disorder screening samples shall keep a log containing name and date of birth of the infant, name of the attending physician or licensed independent practitioner, name of the health care provider who will be providing well care for the infant after discharge, medical record number, serial number of the form kit used, date the specimen was drawn, date the specimen was forwarded, date the test results were received and the test results.

(iv) The hospital is responsible for assuring that employees who collect, handle or perform newborn metabolic screening tests are informed of their responsibilities with respect to screening procedures.

(E) **Parent and health care provider education.** The hospital will be responsible or designate a responsible party to distribute the Newborn Metabolic Disorder Screening Program's written educational materials on newborn metabolic disorder screening provided by the Department to at least one of each newborn's parent or legal guardian.

(F) **Training.** Hospitals shall provide ongoing training programs for their employees involved with newborn screening procedures. These training programs shall include methods of collecting a Satisfactory Newborn Metabolic Disorder Screening Specimen.

(6) Birth defects. Each hospital shall maintain a list of patients up to six (6) years of age who have been diagnosed with birth defects, and all women discharged with a diagnosis of stillbirth or miscarriage. On request, each hospital shall make the medical records of these individuals available to the State Department of Health.

(7) Abortions. Attending physicians shall complete and submit to the Department a report form for each abortion performed or induced as required by 63 O.S. 1999, Section 1-738.

(b) **Record of patient admission.**

(1) All persons admitted to any institution covered by these standards shall be under the care of a doctor of medicine (M.D.) or osteopathy (D.O.) duly licensed to practice medicine and surgery in the State of Oklahoma or a licensed independent practitioner, whose

name shall be shown on the admitting record.

(2) The hospital admitting record also shall show the following for each patient.

(A) Full name of patient with age, sex, address, marital status, birth date, home phone number, date of admission, and admitting diagnosis.

(B) Next of kin, with address, phone number, and relationship.

(C) Date and time of admission, the admission and final diagnoses, and the name of physician or licensed independent practitioner.

(D) Any advanced directive for health care as defined in the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act.

(3) Special clinical reports shall be kept, including the following:

(A) Obstetrical patients throughout labor, delivery, and post-partum.

(B) Newborn, giving the infant's weight, length, and other notes relative to physical examination.

(C) Surgical and operative procedures, including pathological reports.

(D) Record of anesthesia administration.

(c) **Orders for medications, treatments, and tests.**

(1) All medication orders shall be written in ink and signed by the ordering physician or practitioner authorized by law to order the medication, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. The order shall be preserved on the patient's chart.

(2) All orders shall be written in ink and signed by the ordering physician or practitioner. Orders received by resident physicians shall be co-signed if required by medical staff bylaws. The order shall be preserved on the patient's chart.

(3) All orders taken from the physician or practitioner, for entry by persons other than the physician or practitioner, shall be countersigned.

(4) Telephone or verbal orders may be authenticated by an authorized physician or practitioner other than the ordering physician or practitioner when this practice is defined and approved in the medical staff bylaws. If allowed, medical staff bylaws must identify the physicians or practitioners who may authenticate another physician's or practitioner's telephone or verbal order, e.g. physician partners or attending physicians or practitioners, and define the circumstances under which this practice is allowed. The bylaws must also specify that when a covering or attending physician or practitioner authenticates the ordering physician's or practitioner's telephone or verbal order, such an authentication indicates that the covering or attending physician or practitioner assumes responsibility for his or her colleague's order and verifies the order is complete, accurate, appropriate, and final. The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each

facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-1995 (emergency); Added at 12 Ok Reg 2429, eff 6-26-1995; Amended at 18 Ok Reg 2032, eff 6/11/2001; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008; Amended at 30 Ok Reg 1966, eff 7-25-2013]

**310:667-19-3. Maintenance**

(a) A medical record shall be maintained for every patient admitted for care in the hospital. Such records shall be kept confidential.

(b) Only authorized personnel shall have access to the record.

(c) Written consent of the patient shall be presented as authority for release for medical information unless this release is otherwise authorized by law.

(d) Medical records generally shall not be removed from the control of the hospital except upon court order or as authorized by law. Department staff shall be authorized to obtain copies or review any medical record to assure compliance with these rules or other parts of this Title. Information from medical records used by the Department for regulatory purposes shall not disclose individual patient names.

(e) Any person who is or has been a patient of a physician or licensed independent practitioner, hospital, or other medical facility shall be entitled to obtain access to the information contained in all his or her medical records upon request. This request for medical information shall include minors when such request is made by the parent or legal guardian. Copies of all medical records shall be furnished pertaining to his or her case upon the tender of the expense of such copy or copies. There is an exception to the general rule that a patient has an absolute right to the information in or a copy of his or her medical record. Oklahoma law provides *...that this entitlement to medical records shall not apply to psychiatric records* {76 O.S. 1991, §19}.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-4. Personnel**

Qualified personnel adequate to supervise and conduct the activities of the medical records department shall be provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-19-5. Identification and filing**

(a) A system of identification and filing to insure the prompt location of a patient's medical record shall be maintained.

(b) A system of retrieval bearing at least the full name of the

patient, the address, the birth date, and the medical record number shall be available.
(c) Filing equipment and space shall be adequate to house the records and facilitate retrieval and ensure an environment secure from unauthorized individuals.
(d) A unit record shall be maintained so that both inpatient and outpatient treatments are in one folder. Records maintained in an electronic format will be considered a unit record if they are retrievable by a single patient identifier and immediately available for review by physicians, practitioners and patient care staff.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-6. Centralization of reports**
(a) All clinical information pertaining to a patient's stay shall be centralized in the patient's record.
(b) The original of all reports shall be filed in the medical record.
(c) All reports or records shall be completed and filed within a period consistent with good medical practice and not longer than thirty (30) days following discharge.
(d) A report or record requiring a physician or licensed independent practitioner signature is not considered complete until signed by the physician or licensed independent practitioner.

**[Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-7. Indices**
(a) Records shall be indexed according to disease, operation, and physician or licensed independent practitioner and kept up-to-date. For indexing, any recognized system may be used. The factors explaining the standard are as follows:
(1) As additional indices become appropriate due to advances in medicine, their use shall be adopted.
(2) The index list for a specific disease or operation, according to a recognized nomenclature, shall include all essential data on each patient having that particular condition. "Essential data" shall include at least the medical record number of the patient so that the record may be located. All conditions for which the patient is treated during the hospitalization shall be so indexed.
(3) Diagnoses and operations shall be expressed in terminology which describes the morbid condition as to site and etiological factors or the method of procedure.
(b) Indexing shall be current within sixty (60) days following discharge of the patient.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-8. Content**

(a) The medical record shall contain sufficient information to justify the diagnosis and warrant the treatment provided. The medical record shall contain the following information:

(1) Identification data. Identification data shall include at least the patient's name, address, age and date of birth, sex, and marital status.

(2) Date of admission.

(3) Date of discharge.

(4) Chief complaint. The chief complaint shall consist of a concise statement describing the reason the patient is seeking medical attention.

(5) History of present illness. The history of the present illness shall include a detailed description of the patient's symptoms including:

(A) Location of pain;

(B) Quality of pain and symptoms;

(C) Severity;

(D) Timing;

(E) Duration;

(F) Modifying factors, i.e., things that worsen or alleviate symptoms; and

(G) Associated signs and symptoms.

(6) Past history. The past history shall include all previous illnesses and previous surgical procedures.

(7) Medication history. The medication history shall list all current medications and all know drug reactions/allergies.

(8) Social history. The social history shall include a description of the patient's social setting and use of tobacco and/or alcohol, illicit drugs, and work history.

(9) Family history. The family history shall include a description of the state of health of living first-degree relatives, and causes of death of first-degree relatives.

(10) Review of systems. Elements of the review of systems shall include:

(A) General overall condition (fever, weight loss, stamina, etc.);

(B) Head, eyes, ears, nose, throat;

(C) Cardiovascular;

(D) Respiratory;

(E) Breasts;

(F) Gastrointestinal;

(G) Genitourinary;

(H) Musculoskeletal;

(I) Skin and lymphatics;

(J) Neurological;

(K) Psychiatric;

(L) Hematologic;

(M) Allergic; and

(N) Immunologic.

(11) Physical examination. The physical examination shall include a

record of the patient’s vital signs at the time of the examination including height, weight, blood pressure, temperature, pulse rate, and respiratory rate. Negative findings for a system may be indicated in the record of the physical examination by the lack of an entry for that system. If the hospital allows negative findings for a system on physical examination to be documented by omission of an entry for that system, medical records policies and procedures shall specify whether the omission of an entry signifies the system was examined and no significant findings were noted or that no examination of that system was performed. Specific abnormal or pertinent negative findings of the examination of the affected or symptomatic body area(s) must be documented in regards to the following areas:

(A) Head, eyes, ears, nose, and throat;
(B) Neck;
(C) Chest, including lungs, breasts, and axilla;
(D) Cardiovascular, including peripheral pulses, and examination of abdominal aorta;
(E) Abdomen;
(F) Genitourinary;
(G) Hematologic and Immunologic;
(H) Musculoskeletal;
(I) Neurological;
(J) Psychiatric; and
(K) Skin and lymphatics.

(12) Provisional diagnosis which shall be an impression (diagnosis) reflecting the examining physician's or licensed independent practitioner’s evaluation of the patient's condition and shall be based mainly upon physical findings and history.

(13) Special examinations, if any, such as clinical laboratory reports, diagnostic imaging studies, consultation reports, etc. Consultation reports shall be a written opinion and shall be signed by the consultant, including his or her findings from the history and physical examination of the patient.

(14) Treatment and medication orders.

(15) Diagnostic and medical procedure reports.

(16) Surgical records including anesthesia record, preoperative diagnosis, operative procedure and findings, postoperative diagnosis, and tissue diagnosis on all specimens examined. Tissue reports shall include a report of microscopic findings if hospital regulations require that microscopic examination be done. If only gross examination is warranted, a statement that the tissue has been received and a gross description shall be made by the laboratory and filed in the medical record.

(17) Progress and nursing notes shall give a chronological picture of the patient's progress and shall be sufficient to delineate the course and results of treatment. The condition of the patient shall determine the frequency with which they are made.

(18) Record of temperature, pulse, respiration, and blood pressure.

(19) Definitive final diagnosis expressed in terminology of a recognized system of disease nomenclature.

(20) Discharge Summary that shall be a recapitulation of the

significant findings and events of the patient's hospitalization and condition upon discharge, including prescribed medications at time of discharge.

(21) Autopsy findings in a complete protocol shall be filed in the record when an autopsy is performed.

(b) Facsimile copies shall be acceptable as any portion of the medical record. If the facsimile is transmitted on thermal paper, that paper shall be photocopied to preserve its integrity in the record. Facsimile copies shall be considered the same as original copies.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-9. Authorship**

Only physician and licensed independent practitioner members of the medical staff and supervised resident physicians in training shall be authorized to write or dictate medical histories and physical examinations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-10. Signature**

(a) Records shall be authenticated and signed by a physician or licensed independent practitioner.

(b) Every physician or practitioner shall authenticate the entries which he or she makes except as allowed at OAC 310:667-19-2(c)(4) and OAC 310:667-19-10(e).

(c) A single signature on the face sheet of the record shall not suffice to authenticate the entire record.

(d) Rubber stamp signatures may be used in any place in the medical record that requires a signature, provided signature identification can be verified. Authentication of reports by physicians or practitioners shall not take place prior to review of the final report by the physician or practitioner. Facilities allowing physicians and practitioners to use signature stamps to authenticate entries in the medical record shall have on file a signed statement from each such physician or practitioner that they have jurisdiction over the stamp. The use of signature stamps shall be approved in writing by the hospital administrator and medical records committee (or equivalent).

(e) Reports of history and physical examinations and discharge summaries may be authenticated by an authorized physician or practitioner other than the physician or practitioner who performed the examination or produced the summary when this practice is defined and approved in the medical staff bylaws or rules and regulations. If allowed, medical staff bylaws or rules and regulations must identify the physicians or practitioners who may authenticate another physician’s or practitioner’s report of history and physical examination or discharge summary, e.g. physician partners or attending physicians or practitioners, and define the circumstances under which this practice is

allowed. The bylaws or rules and regulations must also specify that when a covering or attending physician or practitioner authenticates another physician's or practitioner's report of history and physical examination or discharge summary, such an authentication indicates that the covering or attending physician or practitioner assumes responsibility for his or her colleague's report or summary and verifies the document is complete, accurate, and final.

(f) Electronic or computerized signatures may be used any place in the medical record that requires a signature, provided signature identification can be verified. Computerized authorization shall be limited to a unique identifier (confidential code) used only by the individual making the entry. Authentication of reports by physicians or practitioners shall not take place prior to review of the final report by the physician or practitioner. Electronic or computerized signature shall be the full, legal name of physician or practitioner and include the professional title. The use of computerized or electronic signatures shall be approved in writing by the hospital administrator and medical records committee (or equivalent). Each physician or practitioner using an electronic or computerized signature shall sign and file a statement in the hospital administrator's office which states that:

(1) The physician or practitioner shall use an electronic or computer generated signature to authenticate his entries in the medical record;

(2) The signature shall be generated by a confidential code which only the physician or practitioner possesses;

(3) No person other that the physician or practitioner shall be permitted to use the signature.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 21 Ok Reg 2785, eff 7-12-2004]

**310:667-19-11. Emergency medical records**

(a) Complete medical records shall be kept on every patient seen and/or treated in the emergency room and shall contain as a minimum the following:

(1) Patient identification.

(2) Time and means of arrival.

(3) History of disease or injury.

(4) Physical findings.

(5) Laboratory and x-ray reports, if any.

(6) Diagnosis and therapeutic orders.

(7) Record of treatment, including vital signs.

(8) Disposition of the case.

(9) Signature of the registered nurse.

(10) Signature of the licensed independent practitioner, if applicable.

(11) Signature of the physician, if applicable.

(12) Documentation if patient left against medical advice.

(b) Medical records for patients seen and/or treated in the emergency room shall be organized and filed by the medical records department.

(c) Where appropriate, medical records of emergency services shall be integrated with those of the inpatient and outpatient services.
(d) Emergency medical records shall be kept, as a minimum, as required by state and federal statutes.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-12. Outpatient medical records**
(a) Outpatient medical records shall be maintained and correlated with other hospital medical records.
(b) The outpatient medical record shall be filed in a location which ensures accessibility to the physicians and licensed independent practitioners, nurses, and other personnel of the department.
(c) The outpatient medical record shall be integrated with the patient's overall hospital record.
(d) Information contained in the medical record shall be complete and sufficiently detailed relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis, and treatment to facilitate continuity of care.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-19-13. Promptness of record completion**
(a) Current records and those on discharged patients shall be completed promptly.
(b) All dictated reports shall include the date of dictation and the date of transcription.
(c) Medical record transcription shall be timely. Current records; e.g. progress notes, consultation reports, operative notes, radiology reports, shall be transcribed and available for review in the medical record within forty-eight (48) hours of dictation.
(d) History and physical examinations shall be completed, signed, and placed in the medical record within forty-eight (48) hours following admission or not more than thirty (30) days prior to admission.
(e) When the medical history and physical examination are completed within thirty (30) days before admission, the hospital must ensure that an updated medical record entry documenting an examination for any changes in the patient's condition is completed. A timely review of the prior history and physical examination or an updated examination must be completed and documented in the patient's medical record within forty-eight (48) hours.
(f) Records of patients discharged shall be completed within thirty (30) days following discharge.
(g) If a patient is readmitted within thirty (30) days for the same condition, reference to the previous history and physical examination with an interval note shall suffice.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12

Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008]

**310:667-19-14. Retention and preservation of records**

(a) **State retention requirements.** Medical records shall be retained a minimum of five (5) years beyond the date the patient was last seen or a minimum of three (3) years beyond the date of the patient's death. Records of newborns or minors shall be retained three (3) years past the age of majority.

(b) **Preservation of records.**

(1) Hospitals may microfilm, put on optical disk, or adopt similar recording technology to record the medical records and destroy the original record in order to conserve space.

(2) Records reconstituted from the technology employed to conserve space shall be considered the same as the original and the retention of the technically retained record constitutes compliance with preservation laws.

(3) The minimum contents of a medical record to be recorded shall be as required by OAC 310:667-19-8.

(4) In the event of closure of a hospital, the hospital shall inform the Department of the disposition of the records. Disposition shall be in a manner to protect the integrity of the information contained in the medical record. These records shall be retained and disposed of in a manner consistent with the statute of limitations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 21. DRUG DISTRIBUTION

310:667-21-1. General
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### 310:667-21-1. General

(a) **Distribution of Drugs.** Every hospital shall provide routine and emergency drugs and biologicals in a safe and accurate manner to meet the needs of its patients, through an organized pharmacy directed by a pharmacist or a drug room under the supervision of a consultant pharmacist. Hospitals not having a licensed pharmacy shall have a drug room supervisor under the direction of a consultant pharmacist.

(b) **Scope of services.** Each hospital shall have drug and medication services commensurate with the size of the hospital and scope of services offered.

(c) **Organization.** An organizational chart shall be provided to display the distinct function of the pharmacy department in the hospital.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-21-2. Personnel

(a) **Pharmacist director or consultant.** The pharmacist director or consultant shall be responsible for all drugs that come into the hospital. The pharmacist shall be trained in the specialized functions of hospital pharmacy and be responsible to the administrator for developing, supervising, and coordinating all activities of the pharmacy or drug room, whether on a full-time or consultant basis. The consultant pharmacist shall visit the hospital a minimum of fifty-two (52) times per year, with no more than five (5) visits in any one month counted toward this total, and shall submit a report outlining issues encountered and decisions made during the visit. The responsibility and authority of the pharmacist shall be clearly defined in a written job description. The responsibilities include but are not limited to:

(1) Establishes and implements intradepartmental and interdepartmental written policies and procedures regarding methods of reconciliation and control of drugs, including audit trails governing all areas of pharmaceutical services. These policies and procedures shall be in compliance with local, state, and federal laws and current professional principles and practices.

(2) Establishes liaison with the administrator and the chief of the medical staff regarding written policies and procedures and their interaction and interdependency with the requirements of the medical staff bylaws and rules and regulations, the governing body rules and

regulations, and administrative interdepartmental policies.

(3) Employs an adequate number of pharmacists and other personnel, as required by department activities and services to implement pharmaceutical services.

(4) Provides drug information services to physicians and licensed independent practitioners, dentists, nurses, and other health care staff.

(5) Provides poison information services to physicians and licensed independent practitioners, dentists, nurses, and other health care staff.

(6) Provides inservice training to physicians and licensed independent practitioners, nurses, pharmacy staff, and other personnel as applicable.

(7) Provides documentation that orientation and staff-development training are provided to pharmacy personnel. Documentation shall include but not be limited to:

(A) Formal orientation of new personnel to written policies of the department.

(B) Inservice education and staff development.

(C) Specialized training in admixture service.

(D) Outline of program content.

(E) Signatures of staff attending with title.

(8) Provides records of tax-free alcohol, investigational drugs, and controlled dangerous drug substances, as required by local, state, and federal laws, rules and regulations.

(9) Provides reviews of patient drug orders and requisitions to avoid possible errors in medication administration.

(10) Maintains a stock of drugs, as agreed in the formulary or drug list, for daily and emergency use.

(11) Develops quality assurance methods to determine that the activities of the department are within the interdepartmental and intradepartmental policies and procedures.

(12) Reports all deficiencies identified through quality assurance methods and the methods of correction of deficiencies to the chief executive officer, the departmental chief, and/or the pharmacy and therapeutics committee.

(13) Provides reports of all visits by the consulting pharmacist. The reports include documentation of consultation with the administrator or the administrator's designee. A copy of the consultant's visit reports shall be retained in the drug room.

(14) Make copies of current policies and procedures available to all appropriate personnel.

(15) Provides an agreement with other licensed pharmacists for provision of outside pharmacy services in case of emergency.

(b) **Pharmacist.** The pharmacist shall provide drugs in conformance with ordering physicians' or practitioners' orders, departmental policy, medical staff bylaws, and local, state, and federal rules and regulations and in accordance with current professional principles and practices. Proof of current licensure shall be available for all pharmacists. Pharmacists who serve as preceptors shall provide the approved preceptorship permit.

(c) **Drug room supervisor.** The drug room supervisor shall be a

registered pharmacist, registered nurse, or a licensed practical nurse, who shall assist the pharmacist in procuring, receiving, storage, distribution, record keeping, and disposition of drug products and medications. The drug room supervisor shall be designated in writing by the consultant pharmacist and the administrator. All dispensing, compounding, labeling, and repackaging of drugs products shall be under the direct supervision of the pharmacist. The qualifications and duties of the drug room supervisor shall be provided in a written job description.
(d) **Other pharmacy staff.** Written job descriptions shall be available and a staff orientation, development, and inservice training program shall be provided to acquaint the staff of the requirements and limitation of their functions in the pharmacy.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-21-3. Supervision of pharmacy services**
(a) At least one (1) pharmacist or drug room supervisor shall be assigned to the pharmacy or drug room during standard operating hours.
(b) Consultant pharmacist services shall be used when a staff pharmacist is not available.
(c) Consultant pharmacist services shall be provided in accordance with a written job description and a written agreement, which shall discuss the duties and responsibilities of the pharmacist, the terms of the agreement, be signed by both parties, and be dated.
(d) If the hospital maintains a drug room, only the functions of storage and distribution of properly packaged and labeled drugs may be performed by the drug room supervisor within the hospital. Drug products requiring repackaging and labeling shall be dispensed by a qualified pharmacist.
(e) The prescriber's original order or a copy shall be made available to the pharmacy or drug room prior to distributing or dispensing drugs and medications.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-21-4. Delivery of service**
(a) Records shall be maintained of the transactions of the pharmacy (or drug room) to account for the receipt, distribution, disposition, and destruction of drugs and biologicals.
(b) A record of the stock of controlled dangerous drug substances on hand shall be maintained and the record shall be maintained in such a manner that the disposition of any particular item may be readily traced.
(c) Methods shall be provided of reconciliation of drugs distributed to the nurses station for administration to a patient.
(d) Floor stock shall be controlled. Distribution shall be in accordance with the floor stock drug list. A method shall be provided

of reconciliation of floor stock drugs distributed for use in a procedure or for a particular patient.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-21-5. Physical facilities of pharmacy**

(a) Facilities shall be provided for the storage, safeguarding, preparation and dispensing of drugs.
(b) The drug preparation area shall be clean, well lighted, and of sufficient size to ensure the safe preparation of drugs for administration.
(c) The drug preparation areas shall be located so that the person preparing the drugs shall not be disturbed.
(d) All drug storage areas shall be properly ventilated with appropriate humidity and temperature to eliminate drug deterioration.
(e) Suitable sinks with hot and cold water, toileting, and handwashing facilities shall be available to the pharmacy/drug room.
(f) Equipment and supplies shall be provided to adequately protect the personnel from toxic substances, including antineoplastic medications, and disposal of waste products in conjunction with local, federal and state laws.
(g) Equipment, facilities, and floor space shall be provided for the preparation, storage, safeguarding, compounding, record keeping, packaging, distribution, dispensing, and methods of administration of drugs and biologicals.
(h) Space, equipment, and facilities shall be available for the operation, record keeping, planning, training, administrative management, and facilitation of pharmacy services.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-21-6. Drug-information services**

(a) The hospital shall assure that current information on drugs and drug interactions is available to physicians, practitioners, nurses, and other health-care staff. The system for communicating drug information shall be appropriate for the size, scope, and complexity of the hospital.
(b) Suitable, current, library of drug reference materials, books, journals, and teaching aids in hard copy or electronic format shall be available for drug information reference by pharmacy services and physicians and practitioners.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-21-7. Access to pharmacy or drug room**

(a) All drugs and biologicals shall be kept in a secure area. Drugs

listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse and Control Act of 1970 must be kept locked within a secure area.
(b) Provisions shall be made for obtaining drugs after the pharmacy or drug room is closed. The procedure shall specify the personnel permitted access to the drug storage area, method of maintaining drug control, and inventory and methods of record keeping of drugs and biologicals removed. Access to the drug room/pharmacy shall be restricted to authorized individuals.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008]

**310:667-21-8. Drug handling**
(a) Drugs shall be given to hospital patients only upon written order of a physician or practitioner legally authorized to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. No change in an order shall be made without the approval of the prescriber. Telephone or verbal orders are discouraged but, when necessary, shall be written by an authorized employee and signed by the person legally authorized to write a prescription or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.
(b) Single use units of controlled substances shall be used in the hospital except in the pharmacy where multiple dose vials may be used for IV admixtures.
(c) All Schedule drugs in the hospital, except those in the pharmacy, shall be verified by actual count at the change of shift by two (2) licensed nurses and documented. Schedule drugs outside the pharmacy which are contained in, and controlled by, an automated dispensing device may be verified by actual count at the time of each access and documented. Adequate day-to-day accountability-of-use records shall be maintained and shall include the date and time of each check of a schedule drug substance supply, the balance on hand, the names of patients receiving drugs, the physician's or prescribing practitioner's name, quantity of medication used and wasted, and the signatures of the two persons making the check. Wastage of schedule drugs shall be witnessed by at least two (2) persons, one (1) of which shall be a licensed health professional. Witnesses shall document wastage by signature.
(d) The medical staff shall establish a written policy that all toxic or dangerous drugs not specifically prescribed as to time or number of doses shall be automatically stopped after a reasonable time limit set by the staff. Examples of drugs ordinarily thought of as toxic or

dangerous drugs include: controlled substances, sedatives, anticoagulants, antibiotics, oxytocics, and steroids.
(e) The administrator, or his or her authorized representative, shall inventory pharmacy controlled substances and alcohol at least annually.
(f) Drugs past the date of expiration shall be removed from stock and shall not be available for patient use.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-1995 (emergency); Added at 12 Ok Reg 2429, eff 6-26-1995; Amended at 18 Ok Reg 2032, eff 6/11/2001; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008; Amended at 30 Ok Reg 1966, eff 7-25-2013]

## SUBCHAPTER 23. DIAGNOSTIC AND TREATMENT SERVICES

310:667-23-1. General
310:667-23-2. Radiological, computerized tomography, magnetic resonance imaging services
310:667-23-3. Nuclear medicine
310:667-23-4. Laboratory
310:667-23-5. Rehabilitation, physical therapy, and occupational therapy departments
310:667-23-6. Respiratory therapy
310:667-23-7. Pet Therapy

### 310:667-23-1. General

The hospital shall have diagnostic and treatment services available to patients, either on site or by arrangement. Each service shall have written policies and procedures including, but not limited to, the following:

(1) A job description for every type of employee in the service.

(2) A written list of procedures performed by the service that is available to the active staff physicians and practitioners.

(3) Procedure for orientation of each new employee into the service.

(4) Infection control procedures specific to the service.

(5) Hospital safety plan.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-23-2. Radiological, computerized tomography, magnetic resonance imaging services

(a) **Radiology.** The hospital shall maintain or have available radiological services according to needs of the hospital.

(1) **Hazards for patients and personnel.**

(A) The radiological department shall be free of health and safety hazards for patients and personnel.

(B) Proper safety precautions shall be maintained against fire and explosion hazards, electrical hazards, and radiation hazards.

(C) Inspection of x-ray equipment shall be made once every two (2) years by a certified health physicist or members of the Diagnostic x-ray section of the Department, and hazards so identified shall be promptly corrected.

(D) The hospital shall identify those employees who are subject to significant occupational exposure to radiation while performing their job duties. All such workers shall be checked periodically for amounts of radiation exposure by the use of exposure meters or badge tests.

(E) With fluoroscopes, attention shall be paid to modern safety design and good operating procedures; records shall be maintained for the output of all fluoroscopes.

(F) Regulations based upon medical staff recommendations shall be established as to the administration of the application and

removal of radium element, its disintegration products, and other radioactive isotopes.

(G) If mammography is performed at the facility, the facility shall have a current certificate from the Food and Drug Administration as required by the Mammography Quality Standards Act.

(2) **Personnel.**

(A) Personnel adequate to supervise and conduct the services shall be provided, and the interpretation of radiological examinations shall be made by physicians or licensed independent practitioners competent in the field according to individually granted clinical privileges.

(B) The hospital shall have a qualified radiologist, either full-time, part-time or on a consulting basis, both to supervise the department and to interpret films and studies that require specialized knowledge for accurate reading.

(C) If the activities of the radiology department extend to radiotherapy, the physician in charge shall be appropriately qualified.

(D) The amount of qualified radiologist and technologist time shall be sufficient to meet the hospital's requirements. A technologist shall be on duty or on call at all times.

(E) The use of all x-ray apparatus shall be limited to personnel designated as qualified by the radiologist or by an appropriately constituted committee of the medical staff. The same limitation shall apply to personnel applying and removing radium element, its disintegration products, and radioactive isotopes. Radiology technologists shall not independently perform fluoroscopic procedures. Fluoroscopic procedures may be performed by radiology technologists only upon the written authorization of a qualified radiologist, and in the presence of a physician or licensed independent practitioner or by real time visualization through electronic means.

(3) **Signed reports.**

(A) Signed reports shall be filed with the patient's medical record and exact duplicates of the signed reports shall be kept in the department.

(B) Requests by the attending physician or licensed independent practitioner for x-ray examination shall contain a concise statement of reason for the examination.

(C) Reports of interpretations shall be written or dictated and signed by the radiologist, physician, or licensed independent practitioner making the interpretation.

(D) X-ray reports shall be preserved or microfilmed in accordance with the statute of limitations and OAC 310:667-19.

(E) X-rays and other images shall be maintained at least five (5) years. These images may be maintained in a digital or electronic format as long as a duplicate can be reproduced.

(b) **Ultrasound imaging.**

(1) Ultrasound imaging shall be performed only upon order of a physician or licensed independent practitioner.

(2) Ultrasound imaging shall be performed by a physician or licensed

independent practitioner or by a technologist that has specific training in ultrasound imaging and designated as qualified by the radiologist.

(3) Reports of findings of ultrasound imaging shall be included in the patient's medical record.

(c) **Computerized tomography and magnetic resonance imaging.**

(1) Computerized tomography and magnetic resonance imaging may be provided.

(2) If used by the facility, all computerized tomography (CT) and magnetic resonance imaging (MRI) examinations shall be authorized by a written and signed order from a physician or licensed independent practitioner.

(3) CT and MRI examinations shall be performed under the direction of and interpreted by a qualified radiologist who is a member of the hospital active or consulting medical staff.

(4) CT and MRI examinations shall be performed by a radiology technologist with documented CT or MRI training and experience and designated as qualified by the radiologist.

(5) A qualified physician or licensed independent practitioner shall be available during the administration of intravenous contrast media.

(6) Oxygen and emergency medical supplies shall be maintained within the CT/MRI suite or be readily available. If the CT/MRI suite is a mobile unit, the mobile unit shall contain oxygen and emergency medical supplies.

(7) CT/MRI films and reports shall be maintained at the hospital in the same manner as x-ray films and reports.

(8) If the CT/MRI is a mobile unit, written infection control policy and procedures and safety plans shall be maintained as part of the overall hospital plans.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 21 Ok Reg 2785, eff 7-12-2004]

**310:667-23-3. Nuclear medicine**

Nuclear medicine services may be provided. If provided, the entity providing nuclear medicine services shall be licensed by the Nuclear Regulatory Commission.

(1) Nuclear medicine procedures shall be under the supervision of a physician who is a member of the medical staff.

(2) Nuclear medicine services shall be supervised by a qualified and trained nuclear medicine technologist.

(3) There shall be a sufficient number of qualified technical and supportive staff to perform the procedures provided by nuclear medicine.

(4) Personnel that provide nuclear medicine services shall have written authorization by the physician director to provide these services.

(5) All radioactive materials shall be purchased, stored, and administered in accordance with the standards approved by the medical staff and shall be in compliance with local, state, and federal laws.

A record of the receipt and disposition of all radiopharmaceuticals shall be maintained for a minimum of five (5) years. The dose of radiopharmaceuticals shall be reverified prior to patient administration.

(6) Equipment shall be appropriate for the types of services offered and shall be maintained, tested, and calibrated as required by the manufacturer.

(7) There shall be written policies and procedures for all services offered which shall additionally include the following:

(A) Safety rules.

(B) Steps to take in the event of an adverse reaction.

(C) Clean up of spills.

(8) The policy and procedure manual shall be reviewed annually and revised as necessary.

(9) If diagnostic in-vitro laboratory testing is performed in this department, such testing shall conform to all conditions in 42 CFR part 493 (CLIA '88).

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-23-4. Laboratory**

(a) The hospital shall have a well-organized, adequately supervised clinical laboratory with the necessary staff, space, facilities, and equipment to perform those services commensurate with the hospital's needs for its patients. All or part of these services may be provided by arrangements with certified reference laboratories.

(b) If a hospital directly provides laboratory services, it shall meet all conditions as set forth in 42 CFR part 493 and be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). The hospital shall possess a current, unrevoked or unsuspended certificate appropriate for the extent of testing performed issued by the Department of Health and Human Services applicable to the category of examinations or procedures performed by the facility.

(c) If a hospital provides laboratory services under arrangement, the referral laboratory shall also meet the requirements of this section.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-23-5. Rehabilitation, physical therapy, and occupational therapy departments**

(a) The rehabilitation, physical therapy, and occupational therapy departments, if offered, shall have effective policies and procedures relating to the organization and functions of the service(s) and shall be staffed by qualified therapists.

(b) Policies and procedures shall include, in addition to the above named items, the following:

(1) Standards of care.

(2) Criteria for assuring communication of the patient's therapy and progress to the physician or licensed independent practitioner.
(3) Assembly and operation of the equipment.
(4) Each procedure performed by each employee shall be designated in writing by the department head and shall include the amount of supervision required when performing the procedure.
(5) Cleaning, disinfecting, and sterilizing procedures.

(c) There may be a rehabilitation department, including both physical and occupational therapy and which may also include other rehabilitation services, such as speech therapy, vocational counseling, and other appropriate services, or there may be separate physical and/or occupational therapy departments.

(d) The department head shall have the necessary knowledge, experience, and capabilities to properly supervise and administer the department. A rehabilitation department head shall be a physiatrist or other physician or practitioner with pertinent experience. If separate physical or occupational therapy departments are maintained, the department head shall be a qualified and licensed physical or occupational therapist (as appropriate) or a physician or practitioner with pertinent experience.

(e) Facilities and equipment for physical and occupational therapy shall be adequate to meet the needs of the services and maintained in good condition.

(f) Physical therapy or occupational therapy shall be given in accordance with the physician's or licensed independent practitioner's orders, and such orders shall be incorporated in the patient's record. These orders shall include:
(1) Identification of the patient.
(2) Date.
(3) Physician's or licensed independent practitioner's name.
(4) Type, frequency, and duration of treatment.
(5) Physician or licensed independent practitioner signature.

(g) Complete records shall be maintained for each patient provided such services and shall be part of the patient's record. Physical therapy records shall include:
(1) Current written plan of care.
(2) Statement of treatment objectives.
(3) Statement of patient's long-term and short-term rehabilitation potential.
(4) Functional limitations.
(5) Individual treatments shall be documented.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-23-6. Respiratory therapy**

(a) The respiratory therapy service shall be under the supervision of a qualified physician or physicians. Respiratory therapy services, including equipment, shall be supervised by a licensed respiratory therapist.

(b) Services may be performed by other respiratory care practitioners

as long as a licensed respiratory therapist is readily available for consultation.

(c) Respiratory care practitioners shall be on the premises whenever continuous ventilatory support is provided to patients.

(d) All respiratory therapy personnel shall be trained in the following:

(1) CPR techniques.

(2) Patient isolation techniques.

(3) Safety rules and regulations for oxygen and oxygen equipment.

(e) There shall be written policies and procedures, approved by the physician director and/or medical staff, which shall include, in addition to the above named items, the following:

(1) Each procedure performed by each employee shall be designated in writing by the department head and shall include the amount of supervision required when performing the procedure.

(2) Fire safety and other safety procedures for the use of oxygen in a facility.

(3) Handling, storage and dispensing of therapeutic gasses.

(4) Infection control measures that address frequency of changing disposable equipment and frequency of cleaning reusable equipment.

(5) Assembly, operation, and maintenance of equipment.

(6) Steps to take in the event of an adverse reaction.

(7) Cleaning, disinfecting, and sterilizing procedures.

(f) If arterial blood gasses are performed, the respiratory therapy department shall meet the provisions of 42 CFR part 493 (CLIA '88).

(g) All respiratory therapy orders shall:

(1) Originate from a physician or licensed independent practitioner.

(2) Specify the type, frequency, duration of treatment, and, if needed, the dose of medication.

(h) Respiratory therapy reports of pulmonary function studies shall be prepared in duplicate and signed by the respiratory care practitioner responsible for the test or procedure. The original shall be placed in the patient's medical record and the duplicate shall be retained in the department.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-23-7. Pet therapy**

If pet therapy is to be incorporated into therapeutic regimens, procedures shall require the animals to be utilized in this modality to be restricted to dogs (canis familiarus), cats (felis domesticatis), birds, and fish. Mammals shall be vaccinated annually for rabies and leptospirosis by a licensed veterinarian. Animals shall be evaluated for the presence of internal parasites semi-annually by a licensed veterinarian and shall be evaluated for the presence of external parasites as needed. Birds obtained for use in pet therapy shall be from breeding establishments free from avian chlamydiosis (psittacosis). Animals shall be humanely housed in designated areas under staff control. The infection control committee and the medical staff shall approve any program prior to initiation. The facility shall evaluate the

temperament of animals before they are considered appropriate for pet therapy.

**[Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 25. SURGICAL SERVICES

310:667-25-1. Department of surgery
310:667-25-2. Anesthesia services

### 310:667-25-1. Department of surgery

The department of surgery shall have effective policies and procedures regarding surgical privileges, maintenance of the operating rooms, and evaluation of the surgical patient.

(1) Surgical privileges shall be delineated for all physicians and practitioners doing surgery in accordance with the competencies of each physician or practitioner. A roster of physicians and practitioners, specifying the surgical privileges of each, shall be kept in the confidential files of the operating room supervisor and in medical staff credential records.

(2) In any procedure with unusual hazard to life, as defined by the medical staff, there shall be present and scrubbed as first assistant a physician designated by the credentials committee as being qualified to assist in major surgery.

(3) Second and third assistants at major operations, and first assistants at lesser operations, may be nurses, technicians, or other practitioners if designated by the medical staff as having sufficient training to properly and adequately assist at such procedures.

(4) The operating room log shall be complete and up to date and include the following information:

(A) Patient's name.
(B) Medical record number.
(C) Name of surgeon.
(D) Name of assistant(s).
(E) Type of anesthetic and person administering.
(F) Circulating nurse.
(G) Scrub nurse.
(H) Procedures performed.
(I) Time surgery began and ended.
(J) Other people present.

(5) There shall be an appropriate history and physical examination in the chart of every patient prior to surgery (whether the surgery is major or minor). If such has been transcribed, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note by the physician or licensed independent practitioner in the chart.

(6) A properly executed consent form for the operation shall be in the patient's chart prior to surgery.

(7) There shall be adequate provisions for immediate post-operative care.

(8) An operative report describing techniques and findings shall be written or dictated immediately following surgery and signed by the surgeon.

(9) The surgical service shall cooperate with the infection control program in the investigation and correction of problems identified

through infection control surveillance activities.

(10) The operating rooms shall be supervised by an experienced registered nurse.

(11) Surgical technicians and licensed practical nurses may be permitted to serve as "scrub nurses" under the direct supervision of a registered nurse; they shall not be permitted to function as circulating nurses in the operating room.

(12) The following equipment shall be available to the operating suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, thoracotomy set, and tracheotomy set. Thoracotomy set and tracheotomy set shall be defined by the medical staff and include instruments and supplies deemed necessary.

(13) The operating room suite and accessory services shall be so located that traffic in and out can be and is controlled, and there shall be no through traffic.

(14) Rules and regulations and/or policies related to the operating rooms shall be available and posted.

(15) The service shall be responsible for central sterile supply and shall adhere to the following:

(A) Sterilization equipment shall be provided which is adequate to properly sterilize the instruments and other supplies.

(B) Chemical, biological, and mechanical process indicators appropriate to the type of sterilizer shall be used to indicate items have been subjected to sterilization conditions. A sterilization process indicator shall be placed within each package to be sterilized. If the internal process indicator is not visible from the outside of the package, a separate indicator should be used on the outside of the package.

(C) Equipment for all sterilization methods shall be used, maintained, and monitored according to the manufacturer's written instructions. Sterilized items and packages shall be cooled, aerated, rinsed, dried, or otherwise handled according to the method of sterilization and manufacturer's instructions after sterilization.

(D) Each facility shall establish policies and procedures which describe the interval(s) during which sterile items are considered to remain sterile. Such policies may be event-related or time-related. Policies for event-related shelf life labeling shall take into consideration environmental sources of contamination, barrier properties of packaging materials, storage and distribution practices, inventory control, and frequency of handling between distributor and the user. Inventory control practices shall include a requirement that stock be rotated on a first in, first out basis and a lot control system shall be established to allow for traceability of the contents of each sterilized load in the event of a sterilizer failure or malfunction.

(E) Written or graphic records shall be maintained for each operation of the sterilizer, showing mechanical monitoring of temperature, exposure time, pressure, humidity, chemical concentrations, and/or air removal as appropriate. Records shall also include the date and time for each operation, with other

pertinent data, and the signature of the operator of the sterilizer.

(F) Periodic bacteriological testing of sterilizer performance shall be conducted at least weekly using a biologic indicator appropriate to the type of sterilizer and as recommended by the manufacturer. The results of all biological indicator tests shall be interpreted by qualified individuals in accordance with the manufacturer's instructions. Records of biological indicator testing shall include at least the date and time of the test, the identity of the sterilizer used, the test result, the identity of the individual interpreting the test, and a description of any corrective actions taken as a result of the test.

(G) Written policies and procedures shall be established and followed for the recall of reprocessed items in the event of a sterilization failure.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-25-2. Anesthesia services**

(a) Anesthesia services may be provided through a separately organized department or as a service of the department of surgery. The service shall have effective policies and procedures regarding staff privileges, the administration of anesthetics, and the maintenance of strict safety controls.

(b) Each anesthesia service shall have written policies and procedures. These policies and procedures shall include, but not be limited to:

(1) Pre-anesthesia evaluation.

(2) Intraoperative anesthesia report.

(3) Post-anesthesia follow-up report.

(4) Approved anesthesia agents.

(5) Drug accountability procedures in accordance with hospital policies.

(6) Infection control in anesthesia procedures.

(7) Safety procedures for oxygen and gas anesthetics.

(c) There shall be required for every patient:

(1) Pre-anesthetic evaluation by a physician or other practitioner authorized to perform pre-anesthesia evaluations with findings recorded not more than forty-eight (48) hours before surgery.

(2) Anesthetic record on a special form.

(3) Post-anesthetic follow-up conducted during the post anesthesia recovery period by a person authorized to administer anesthesia to the patient, with findings recorded not more than forty-eight (48) hours after surgery.

(d) The anesthesia service shall be responsible for all anesthetics administered in the hospital.

(e) In hospitals where there is no department of anesthesia, the department of surgery shall be responsible for establishing general policies and supervision for the administration of anesthetics.

(f) If anesthetics are not administered by a qualified

anesthesiologist, they shall be administered by a physician anesthetist, dentist, oral surgeon, podiatrist, or a certified registered nurse anesthetist under the supervision of the operating surgeon. The hospital medical staff shall designate in writing those persons qualified to administer anesthetics and delineate what the person is qualified to do.

(g) During all general anesthetics, regional anesthetics, and monitored anesthesia care, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

(h) Safety precautions shall include where appropriate:

(1) Shockproof and spark-proof equipment.

(2) Humidity control.

(3) Proper grounding.

(4) Safety regulations posted.

(5) Storage of oxidizing gases shall meet the standards of the National Fire Protection Association Code. The use of flammable anesthetics as anesthetic agents is forbidden.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008]

## SUBCHAPTER 27. OUTPATIENT DEPARTMENT

310:667-27-1. Outpatient department

### 310:667-27-1. Outpatient department

(a) **Organization.** The outpatient department, if utilized, shall be organized into sections (clinics), the number of which depends upon the size and the degree of departmentalization of the medical staff, available facilities, and the needs of the patients for whom it accepts responsibility.

(1) The outpatient department shall have appropriate cooperative arrangements and communications with community agencies, such as other outpatient departments, public health nursing agencies, the department of health, and welfare agencies.

(2) Clinics shall be integrated with corresponding inpatient services.

(3) Clinics shall be maintained for the following purposes:

(A) Care of ambulatory patients unrelated to admission or discharge.

(B) Study of pre-admission patients.

(C) Follow-up of discharged hospital patients.

(4) Patients, on their initial visit to the department, shall receive a general medical evaluation, and patients under continuous care shall receive an adequate periodic reevaluation.

(5) Established medical screening procedures shall be employed routinely.

(b) **Personnel.** There shall be such professional and nonprofessional personnel as are required for efficient operation.

(1) A physician shall be responsible for the professional services of the department. Either this physician or a qualified administrator shall be responsible for administrative services.

(2) A registered nurse shall be responsible for the nursing services of the department.

(3) The number and type of other personnel employed shall be determined by the volume and type of work carried out and the type of patient served in the outpatient department.

(c) **Facilities.** Facilities shall be provided to assure the efficient operation of the department.

(1) The number of examination and treatment rooms shall be adequate in relation to the volume and nature of work performed.

(2) Suitable facilities for necessary laboratory tests shall be available, either through the hospital or some other facility approved to provide these services under 42 CFR part 493 (CLIA '88).

(d) **Medical records.** Medical records shall be maintained and correlated with other hospital medical records.

(1) The outpatient medical record shall be filed in a location which insures ready accessibility to the physicians, licensed independent practitioners, nurses, and other personnel of the department.

(2) The outpatient medical record shall be integrated with the patient's over-all hospital record.

(3) Information contained in the medical record shall be complete

and sufficiently detailed relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis, and treatment to facilitate continuity of care.

(e) **Liaison conferences.** Conferences, both departmental and interdepartmental, shall be conducted to maintain close liaison between the various sections with the department and with other hospital services.

(1) Minutes of staff and/or departmental meetings shall indicate that a review of selected outpatient cases takes place and that there is integration of hospital inpatient and outpatient services.

(2) The outpatient department shall have close working relationships with the social work services.

(f) **Location.** The outpatient department shall be located in the hospital facility or at a campus licensed as part of the hospital.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 29. EMERGENCY SERVICES

310:667-29-1. Emergency service or department
310:667-29-2. Patient transfers

### 310:667-29-1. Emergency service or department

(a) **General.** The hospital shall have procedures for the treatment of emergency cases. The hospital may meet this requirement through an organized emergency service department or by establishing emergency protocols. Appropriate emergency signage shall be displayed when the hospital has an organized service or department.

(b) **Organization and direction.** The department or service shall be directed by qualified personnel and integrated with other departments of the hospital.

(1) There shall be written policies which shall be enforced to control emergency room procedures. Hospitals that do not offer maternity service shall have policies and procedures for treatment of this type of patient.

(2) The policies and procedures governing medical care provided in the emergency service or department shall be established. This shall be a continuing responsibility of the medical staff.

(3) The emergency service shall be supervised by a qualified member of the medical staff. Nursing functions shall be the responsibility of a registered nurse.

(4) The administrative functions shall be a responsibility of a member of the hospital administration.

(c) **Facilities.** Facilities shall be provided to assure prompt diagnosis and emergency treatment.

(1) Facilities shall be separate and independent of the operating rooms.

(2) The location of the emergency service shall be in close proximity of an exterior entrance of the hospital.

(3) Diagnostic and treatment equipment, drugs, supplies, and space, including a sufficient number of treatment rooms, shall be adequate in terms of the size and scope of services provided. An obstetrics pack and supplies shall be available at all times in the emergency room. A cardiac defibrillator and monitoring equipment shall be available to the emergency services.

(4) The emergency room shall be equipped with a base station radio using medical frequencies VHF 155.340 or UHF Medical Channels 1 through 10 and/or compatible frequencies with ambulance services operating in the area. The emergency room staff shall use this equipment to communicate with all emergency medical vehicles and relay the information from emergency medical personnel to the emergency room physician and/or nurse.

(d) **Medical and nursing personnel.** There shall be adequate medical and nursing personnel available at all times.

(1) The hospital shall be responsible for insuring adequate medical coverage for emergency services.

(2) Qualified physicians or licensed independent practitioners shall be regularly available at all times for the emergency service, either

on duty or on call. If a physician or licensed independent practitioner is on call, he or she shall be able to present at the emergency room within twenty (20) minutes.

(3) A physician or licensed independent practitioner shall be responsible for all patients who arrive for treatment in the emergency service.

(4) Registered nurses shall be available on site at all times and in sufficient number to deal with the number and extent of emergency services.

(e) **Medical records.** Adequate medical records on every patient shall be kept.

(1) The emergency room record contains:

(A) Patient identification.
(B) Time and means of injury.
(C) History of disease or injury.
(D) Medication history and drug allergies.
(E) Physical findings.
(F) Laboratory and x-ray reports, if any.
(G) Diagnosis and therapeutic orders.
(H) Record of treatment including vital signs.
(I) Disposition of the case.
(J) Signature of the registered nurse.
(K) Signature of the non-physician practitioner, if applicable.
(L) Signature of the physician.
(M) Documentation if the patient left against medical advice.

(2) Medical records for patients treated in the emergency service shall be organized by personnel from medical records department in accordance with facility policy.

(3) Where appropriate, medical records of emergency services shall be integrated with those of the inpatient and outpatient services.

(4) A proper method of filing records shall be maintained.

(f) **Drug and medication distribution and control**. Drugs in the emergency department shall be securely maintained and controlled by staff at all times. If the department does not have staff present at all times, all drugs shall be secured in sealed storage with devices placed to denote tampering. All Schedule II drugs shall be stored as specified in OAC 310:667-21-8(c). All drugs shall be administered and dispensed as required by state law.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-29-2. Patient transfers**

Patient transfers shall be conducted in accordance with 42 U.S.C. (1395dd) and 42 U.S.C. (1395cc) and with the regulations at 42 CFR part 489.20 and 489.24.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 31. SOCIAL WORK SERVICES

310:667-31-1. Social work services
310:667-31-2. Review and evaluation

### 310:667-31-1. Social work services

(a) **Availability of service.** Social work services shall be available to the patient, the patient's family, and other persons significant to the patient, in order to facilitate adjustment of the individuals to the impact of illness and to promote maximum benefits from the health-care services provided. Services may be provided as follows:

(1) An organized social work department or service within the hospital that has a full-time, qualified social work director.

(2) A qualified social worker employed on a part-time basis.

(3) An outside social work service that is obtained through a written agreement, defining the role and responsibility of the outside services (consultant social workers).

(b) **Policies and procedures.** The method for providing social services shall be clearly defined and shall provide for supervision of the delivery of such services by a qualified social worker. Social work services shall be guided by written policies and procedures.

(c) **Adequate records.** Adequate documentation of social work services provided shall be part of the patient's medical record and shall include:

(1) Observation and social assessment of the patient.

(2) Plan of treatment and social work services provided.

(3) Social work summary, including any recommendation for follow-up.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-31-2. Review and evaluation

The quality and appropriateness of social work services provided to patients shall be regularly reviewed, evaluated, and assured through the establishment of quality improvement mechanisms regardless of the mechanisms used to provide social services. This shall be accomplished and coordinated through the hospital quality improvement program.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 33. SPECIALIZED REQUIREMENTS - PSYCHIATRIC

310:667-33-1. General
310:667-33-2. Specialized requirements - personnel and policy

### 310:667-33-1. General

(a) In addition to meeting requirements listed for general medical surgical hospitals in Subchapters 1 through 31 of this Chapter, psychiatric hospitals and psychiatric units of general medical surgical hospitals shall meet the additional requirements listed in this Subchapter.

(b) The psychiatric facility may be a distinct unit of a general medical surgical hospital or a free-standing psychiatric hospital which shall be licensed as a specialized hospital. If the facility is a unit of a general medical surgical hospital, this unit shall be distinctly identified. Beds shall not be commingled with acute care beds.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-33-2. Specialized requirements - personnel and policy

(a) **Personnel.**

(1) A physician with training and experience in psychiatry shall be appointed as medical director of the hospital or unit by the governing body based upon a recommendation from the medical staff. The medical director shall coordinate with other services provided by the hospital, and shall be responsible for developing policies concerning treatment and staffing.

(2) The diagnosis and treatment rendered to each patient in psychiatric hospitals or units shall be under the direction of a physician or licensed independent practitioner with training and experience in psychiatry.

(3) A registered nurse with experience in psychiatric nursing shall be responsible for nursing administration. At least one (1) registered nurse shall be assigned to care and provide active treatment for every fifteen (15) patients on each shift, except that if the unit census exceeds fifteen (15) patients but does not exceed twenty (20) patients during the shift, a licensed practical nurse may be substituted for the second required registered nurse. Licensed practical nurses and/or psychiatric nurse support staff shall be assigned by the registered nurse to support the care provided by the registered nurse and provide necessary active treatment.

(4) All personnel working within an area of psychiatric patients shall be trained in psychiatric patient care.

(b) Polices and procedures shall be developed and implemented that include at least the following:

(1) **Seclusion.** Patients shall be placed in seclusion only on the written order of the attending physician or licensed independent practitioner. Secluded patients shall be constantly monitored by facility staff while in seclusion. Patient seclusion shall terminate

after four (4) hours unless the patient is reevaluated by the attending physician or licensed independent practitioner and a renewal order is received for the seclusion. Patients shall not be continuously secluded for longer than twenty-four (24) hours unless the attending physician or licensed independent practitioner attests in the patient's medical record that seclusion is necessary for the continued treatment of the patient.

(2) **Restraint.** Physical and chemical restraints shall be used in accordance with guidance outlined at OAC 310:667-3-5 and OAC 310:667-15-8 & 9. All staff providing active treatment or monitoring patients shall be trained in facility methods approved to physically hold or restrain patients before patient care responsibilities are assigned. These staff members shall be reoriented regarding these policies annually or when policies are revised.

(3) **Accommodations.**

(A) Patients shall be grouped for accommodations by gender, age, and treatment needs except as provided for at 310:667-33-2(b)(3)(B). As a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each. Nursing staff and support staff shall be assigned to each program and unit to appropriately monitor patients and provide active treatment. Children, adolescents, and adult patient groups shall not be allowed to commingle at anytime.

(B) Patients being primarily treated with diagnosis of anorexia nervosa, bulimia nervosa or other unspecified eating disorder diagnosis, who are separated by gender, and from other non-eating disorder patients, may be grouped for accommodations and treatment with adolescent and adult patients. Such programs shall ensure appropriate monitoring of commingled populations at all times, and shall provide sleeping arrangements with all private rooms, or separate semi-private rooms for adolescent patient(s) and adult patient(s).

(4) **Procedures.** General procedures for the unit shall include at least the following:

(A) A description of the scope of each therapeutic service provided and the qualifications of staff providing these services.

(B) A description of the process for the appointment of a medical director, who shall be a physician with qualifications as specified in section (a). The medical director shall be appointed by the governing body based upon recommendations made by the medical staff.

(C) A description of how staffing for monitoring and active treatment is provided on a twenty-four (24) hour basis.

(D) A description of how comprehensive treatment plans for each patient are developed and time-frames allowed for the development of an initial plan. Procedures shall also state how often comprehensive treatment plans are reviewed for possible revisions.

(E) If the patient is school age, the policies shall include arrangements to initiate appropriate educational exposure if the patient is to be hospitalized over five (5) days.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12

Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 2018, eff 6-25-2007]

## SUBCHAPTER 35. SPECIALIZED REQUIREMENTS REHABILITATION

310:667-35-1. General
310:667-35-2. Services
310:667-35-3. Specialized requirements - policy and personnel
310:667-35-4. Special requirements - medical records

### 310:667-35-1. General

(a) In addition to meeting requirements listed for general medical surgical hospitals in Subchapters 1 through 31 of this Chapter, rehabilitation hospitals and rehabilitation units of general medical surgical hospitals shall meet the following additional requirements listed in this Subchapter.

(b) The rehabilitation facility may be a distinct unit of a general medical surgical hospital or a free-standing rehabilitation hospital which shall be licensed as a specialized hospital. If the facility is a distinct unit, the unit shall be at least ten (10) beds. The unit shall be distinctly identified. Beds shall not be commingled with acute care beds.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-35-2. Services

(a) Each rehabilitation facility shall have written admission criteria that relate to the facility's program capabilities which are applied uniformly to all potential patients.

(b) Services shall be provided by qualified professionals in accordance with a written plan of treatment. All services except rehabilitative medicine and nursing may be provided on a contractual basis as long as patients' needs are met. All rehabilitation facilities shall provide at a minimum, the following clinical services.

(1) Rehabilitative medicine.
(2) Rehabilitative nursing.
(3) Physical therapy.
(4) Occupational therapy.
(5) Speech therapy.
(6) Social services.
(7) Psychological services.
(8) Orthotic and prosthetic services.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-20-2003]

### 310:667-35-3. Specialized requirements - policy and personnel

(a) **Personnel.**

(1) A physician with training and experience in rehabilitative medicine shall be appointed as medical director of the hospital or unit by the governing body based upon a recommendation from the

medical staff. The medical director shall coordinate with other services provided by the hospital, and shall be responsible for developing policies concerning treatment and staffing.

(2) The diagnosis and treatment rendered to each patient in rehabilitation hospitals or units shall be under the direction of a physician or licensed independent practitioner with training and experience in rehabilitative medicine. Every patient, upon admission, shall have written orders from a physician or licensed independent practitioner for the immediate care of the patient.

(3) A registered nurse with experience in rehabilitation medicine shall be responsible for nursing administration. The number of registered nurses, licensed practical nurses and nursing support staff required on each shift to formulate and carry out the nursing components of the individual treatment plan for each patient shall be determined based upon acuity and the rehabilitative nursing needs of the patients.

(4) All other required services shall be supported by adequate qualified staff who may be employed or under contract to provide services. All professional staff whether employed or under contract shall be licensed or certified as required by state law.

(b) **Policies and procedures.** Polices and procedures shall be developed implemented that include at least the following:

(1) The scope of each clinical service.

(2) The appointment of a medical director, who shall be a physician qualified by training, experience, and knowledge of rehabilitative medicine.

(3) A description of how staffing is arranged for twenty-four (24) hour services.

(4) Admission procedures and criteria.

(5) Patient evaluation procedures, including a policy which requires a treatment plan for each patient based on a functional assessment and evaluation. This policy shall require the initial treatment plan to be developed within seventy-two (72) hours of admission, and a comprehensive individualized plan developed no later than one (1) week after admission. The plan shall state the rehabilitative problems, goals, required therapeutic services, prognosis, anticipated length of stay, and planned discharge disposition. This comprehensive plan shall be developed by a multidisciplinary team of professionals treating the patient and shall be approved by the attending physician or licensed independent practitioner.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-35-4. Special requirements - medical records**

In addition to the basic medical record requirements for general medical surgical records, medical records for rehabilitative patients shall include the following:

(1) The reason for referral or admission to the rehabilitation facility.

(2) A summary of the patient's clinical condition, functional

strengths and limitations, indications and contraindications for specific physical rehabilitation services, and prognosis.

(3) Initial and comprehensive treatment plans as specified in 310:667-35-3(a)(5). The goals of treatment, any problems that may affect the outcome of rehabilitation, and criteria leading to the discontinuation of services shall be documented.

(4) Treatment and progress records, with appropriate ongoing assessments as required by the patient's condition. A description of the perception of the patient and family toward, and their involvement in, physical rehabilitation services.

(5) Assessment of physical rehabilitation achievement and estimates of further rehabilitation potential, entered on a timely basis, which shall be made at least monthly and included in the individualized comprehensive treatment plan.

(6) A discharge summary that includes the physical rehabilitation achieved, the medications and therapy prescribed at discharge, and recommendations for further rehabilitation.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 37. SKILLED NURSING UNITS

310:667-37-1. General
310:667-37-2. Administration
310:667-37-3. Skilled nursing
310:667-37-4. Rehabilitation provisions
310:667-37-5. Patient restraint

### 310:667-37-1. General

(a) Skilled nursing units may be established as distinct units of general medical surgical hospitals. These units shall be licensed as part of the hospital and be included in the licensed bed capacity. If a hospital provides a skilled nursing unit, this unit shall be separate and distinctly identified. Beds shall not be commingled.

(b) In addition to requirements listed for general medical surgical hospitals in Subchapters 1 through 31 of this Chapter, skilled nursing units shall comply with the requirements listed in this Subchapter.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-37-2. Administration

The skilled nursing unit shall be considered a department of the hospital and therefore shall be administered by the governing body and the administrator. The unit shall also have a full-time manager who may be the nursing director of the unit. This manager shall have the administrative authority and responsibility for the day to day operation of the unit.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-37-3. Skilled Nursing

All requirements of nursing service, Subchapter 15 of this Chapter, shall apply. In addition to these requirements, each skilled nursing unit shall have a full-time nursing director for the unit who is a registered nurse. If the director has responsibilities outside the unit, a qualified registered nurse shall serve as the assistant so that there is the equivalent of a full-time nursing director employed. The nursing director of the unit shall be responsible for development of nursing policies and procedures that are specific for long term care patients requiring services of the unit. The nursing director shall also assure appropriate nurse staffing is maintained in the unit.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-37-4. Rehabilitation provisions

Physical and occupational therapy shall be provided for patients in the skilled nursing unit. These services shall conform to requirements specified at 310:667-23-5.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-37-5. Patient restraint**

Patient restraint shall be in accordance with requirements outlined at 310:667-3-5 and 310:667-15-8 & 9.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 39. CRITICAL ACCESS HOSPITAL

310:667-39-1. General
310:667-39-2. Affiliations, communications and agreements
310:667-39-3. Admission criteria
310:667-39-4. Basic requirements and services
310:667-39-5. Governing body
310:667-39-6. Medical and professional staff
310:667-39-7. Quality improvement
310:667-39-8. Infection control program
310:667-39-9. Nursing service
310:667-39-10. Food and nutritional services
310:667-39-11. Medical record services
310:667-39-12. Drug distribution
310:667-39-13. Diagnostic services
310:667-39-14. Emergency services

### 310:667-39-1. General

A critical access hospital (CAH) is a hospital determined by the Department to be a necessary provider of health care services to residents of a rural community. The CAH shall be the sole provider of hospital services in the community and is to allow the provision of primary hospital care in a rural community that is unable to support a general medical surgical hospital.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00]

### 310:667-39-2. Affiliations, communications and agreements

(a) **Affiliations.** The CAH shall be affiliated with at least one (1) general medical surgical hospital to facilitate appropriate referrals and adequate support services. The affiliation shall be through a written agreement, contract for services, network affiliation, lease or through direct ownership by the supporting general medical surgical hospital.

(b) **Communications.** Direct communications shall be established between the CAH and any facility providing support services. These communications shall include the electronic sharing of patient data which may include telemetry and diagnostic imaging if local telecommunications have this capability. As a minimum, the CAH shall be able to send and receive patient information by facsimile and/or computer modem.

(c) **Agreements.** The CAH shall have a written agreement with an emergency medical service to accept and receive emergency transfers. This agreement shall provide arrangements for emergency and non-emergency transfers to and from the CAH and stipulate the stabilizing and treatment services available at the CAH. Direct communications shall be established between the emergency medical service and the CAH which allow the emergency medical service to directly contact the on-call

physician or licensed independent practitioner and the on-call or on-site registered nurse providing emergency services.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-3. Admission criteria**

The CAH shall establish inpatient admission criteria appropriate for the treatment and diagnostic services provided. The criteria may be based on diagnosis and patient acuity established by the medical and professional staff or the CAH may use diagnosis related groups (DRGs). The criteria shall be established and revised as necessary by the medical and professional staff and approved by the governing body. Stabilizing emergency treatment services provided shall not be restricted by inpatient admission criteria.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00]

**310:667-39-4. Basic requirements and services**

The CAH shall provide basic services as described in Sections 5 through 14 of this Subchapter and comply with Subchapters 1, 3, and 5 of this Chapter. The CAH may provide additional services beyond the basic core of required services if applicable sections of this Chapter are met.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-5. Governing body**

(a) **General.** The CAH shall have an effective governing body legally responsible for all services and the quality of patient care provided. The majority of members of this body shall be residents of the incorporated community or service area of the CAH.

(b) **Organization.** The governing body may be an organized board or owner designated individual(s). The method for appointment, terms, officers required, meeting requirements, duties, and responsibilities shall be established in written bylaws which shall be available at the CAH. The governing body shall meet at established intervals and maintain minutes of meetings. Meetings may be conducted by teleconference if not otherwise prohibited by law.

(c) **Responsibilities.** The governing body's responsibilities shall include at least the following:

(1) Appointment and reappointment of members of the medical and

professional staff by methods established in approved bylaws. These appointments shall be made based on recommendations received from the medical and professional staff and be consistent with state law.
(2) Approval of medical and professional staff bylaws, rules and regulations.
(3) Approval or denial of physician or practitioner privilege delineations recommended by the medical and professional staff.
(4) Consideration of reports received from the CAH concerning the quality of care provided. The governing body shall require corrective actions as necessary when inadequate patient care is identified.
(5) Ensure patients are admitted and discharged by a physician or licensed independent practitioner.
(6) Ensure a physician or licensed independent practitioner is available to communicate with CAH staff at all times. A physician or licensed independent practitioner shall be physically available as specified by CAH policy. If a physician or licensed independent practitioner functions as the physician or practitioner on-call for the CAH, the physician or licensed independent practitioner shall be physically available if necessary within twenty (20) minutes.
(7) Ensure the licensed independent practitioners and registered nurses on-call to the CAH are physically available if necessary within twenty (20) minutes.
(8) Designation of an administrator who shall be responsible for managing the facility. This person may have duties in addition to management responsibilities.
(9) Ensure the CAH is constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment appropriate to the needs of the community.
(10) Ensure the CAH is operated under an approved budget.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-6. Medical and professional staff**

(a) **General.** The CAH shall have an organized medical and professional staff responsible for the quality of care provided to all patients. The staff shall operate under bylaws approved by the governing body.

(b) **Composition.** The CAH shall have a medical and professional staff composed of one (1) or more physicians and which may also include one (1) or more licensed independent practitioners with privileges at the CAH. Privileges may also be extended to other health care professionals who are authorized by state law to provide treatment services.
(1) The staff shall periodically reexamine credentials and conduct appraisals of its members and make recommendations regarding reappointments and privilege delineations to the governing body. The staff shall also examine credentials of candidates for staff membership and make recommendations regarding appointments and privileges extended.
(2) Temporary staff privileges may be extended to qualified

physicians, licensed independent practitioners and other professional staff as specified in the medical and professional staff bylaws.

(3) Patient admission quotas or revenue generation minimums shall not be a condition for appointment or reappointment.

(c) **Organization and accountability.** The medical and professional staff shall be well organized and accountable to the governing body for the quality of medical care provided to patients.

(1) The staff shall be organized and elect officers as required by approved medical staff bylaws. Officers of the staff shall hold active privileges and may include elected licensed independent practitioners. The chief of staff (or equivalent) shall be a physician who shall be responsible for organization and enforcement of the bylaws.

(2) The staff shall meet at least monthly as a committee of the whole to review the quality of medical care provided, fulfill committee functions specified in the staff bylaws, and to consider and recommend actions to the governing body. Meetings may include staff from the affiliated general medical surgical hospital or other off-site physicians or practitioners who have privileges at the CAH and may be conducted by teleconference. Minutes of meetings shall be maintained and available for review at the CAH.

(d) **Medical and professional staff bylaws.** The medical and professional staff shall adopt and enforce bylaws to carry out their responsibilities. The medical staff bylaws shall:

(1) Be approved by the governing body.

(2) Include a statement of the duties and privileges of each category of the medical and professional staff. These categories shall include a category of licensed independent practitioner, and may include a category of supervised practitioner in addition to other categories; e.g, active, courtesy, consulting, etc.

(3) Describe the organization of the medical and professional staff.

(4) Describe the qualifications for each category of the medical and professional staff.

(5) Require each inpatient to have a history and physical examination performed no more than thirty (30) days before, or forty-eight (48) hours after, admission by a physician or licensed independent practitioner. The examination shall be approved and signed by the physician or licensed independent practitioner. The approval and signature may be performed electronically or by facsimile.

(6) When the medical history and physical examination are completed within thirty (30) days before admission, the hospital must ensure that an updated medical record entry documenting an examination for any changes in the patient's condition is completed. A timely review of the prior history and physical examination or an updated examination must be completed and documented in the patient's medical record within forty-eight (48) hours.

(7) Specify the procedure for determining the privileges to be granted to individual physicians and practitioners initially and on reappointment and the process for physicians and practitioners to request these privileges.

(8) Specify the mechanism to withdraw privileges of staff members

and the circumstances when privileges shall be withdrawn.

(9) Specify the mechanism for appeal of decisions regarding staff membership and privilege delineations.

(10) Specify the mechanism for monitoring and controlling the use of preventive antibiotics and the use of antibiotics in the presence of infection.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008]

**310:667-39-7. Quality improvement**

(a) **General.** There shall be an ongoing quality improvement program, approved by the governing body, which shall identify problems in the facility, suggest solutions, and monitor results.

(b) **Quality improvement plan.** A written quality improvement plan shall be developed, approved, and implemented by the governing body with advice from the medical and professional staff. The plan shall include but not be limited to the following:

(1) Methods of evaluating all patient services to ensure quality of care, including those provided under contract.

(2) Methods of evaluating off-site health care services for appropriateness of use and the degree to which the services aid in the provision of quality patient care.

(3) The evaluation of nosocomial infections and accompanying medication therapy shall be linked to the hospital-wide quality improvement program through regular reporting by appropriate hospital committees and functions such as pharmacy and therapeutics, infection control, pharmaceutical services, etc.

(4) Evaluation of all surgical procedures if surgery is performed at the facility.

(5) Methods of evaluating licensed independent practitioner services to ensure these services are provided in conformance with facility policy and state law.

(6) Methods of evaluating on-call services to ensure staff are available as required.

(c) **Quality improvement committee.** The CAH may establish a quality improvement committee or this function may be fulfilled by the medical and professional staff committee of the whole. Quality improvement activities shall be reported by facility staff to the committee at least every three (3) months or more frequently if findings require immediate action by the committee.

(d) **Quality improvement implementation.** There shall be documentation that the CAH has taken appropriate action to address problems identified. The CAH shall document the monitoring of the effectiveness of the proposed solutions.

(e) **Communication.** Quality improvement committee reports shall be communicated at least every three (3) months to the governing body. If the quality improvement committee meets separately from the medical and

professional staff committee of the whole, these reports shall also be communicated at least every three (3) months to the medical and professional staff.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-8. Infection control program**

(a) **General.** The CAH shall establish an infection control program to provide a sanitary environment and avoid sources and transmission of infections. The program shall include written policies and procedures for identifying, reporting, evaluating and maintaining records of infections among patients and personnel. The program shall provide an ongoing review and evaluation of all aseptic, isolation and sanitation techniques employed in the hospital and coordinate training programs in infection control for all personnel.

(b) **Infection control committee.** The CAH may establish an infection control committee (or equivalent) or this function may be fulfilled by the medical and professional committee of the whole. The committee shall meet at least quarterly.

(c) **Policies and procedures review.**

(1) The infection control committee shall evaluate, revise as necessary, and approve the type and scope of surveillance activities utilized at least annually.

(2) Infection control policies and procedures shall be reviewed periodically and revised as necessary, based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.

(d) **Policies and procedures content.** The policies and procedures outlined for the infection control program shall be approved by the infection control committee and contain at least the following:

(1) A requirement that a record of all reported infections generated by surveillance activities include the identification and location of the patient, the date of admission, onset of the infection, the type of infection, the cultures taken, the results of cultures when known, any antibiotics administered and the physicians or practitioners responsible for care of the patient.

(2) Specific policies related to the handling and disposal of biomedical waste.

(3) Specific policies and procedures related to admixture and drug reconstitution, and the manufacture of intravenous and irrigating fluids.

(4) Specific policies regarding the indications for and types of isolation to be used for each infectious disease. These policies shall incorporate the concepts of Standard Precautions and the recommended transmission-based categories of Contact, Airborne, and Droplet isolation procedures as deemed appropriate by the medical and professional staff.

(5) A definition of nosocomial infection.

(6) Designation of an infection control officer, who coordinates the infection control program.

(7) Policies for orienting new employees and an ongoing continuing education program for currently employed personnel concerning infection control. Written documentation shall be maintained indicating new employees have completed orientation and that all current personnel have attended continuing education.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-9. Nursing service**

(a) **General.** Each CAH shall have an organized nursing service which provides twenty-four (24) hour nursing services for patients. The nursing service shall be supervised by a registered nurse.

(b) **Organization.** The nursing service shall be well-organized with written policies delineating administrative and patient care responsibilities. The director of nursing shall be a registered nurse who shall be responsible for the operation of the service, including determining the staff necessary to provide nursing care for all areas of the CAH. Nursing care shall be provided as specified by written procedures approved by the director of nursing and the governing body. All nursing procedures shall be consistent with state and federal law and current standards of practice. Procedures shall be reviewed and revised as necessary.

(c) **Staffing.** The nursing service shall have adequate numbers of licensed nurses and other nursing personnel available to provide nursing care to all patients as needed based on patient census and acuity. At least one (1) registered nurse shall be on duty on-site to furnish or supervise all nursing services whenever patient care is provided. If the CAH has no inpatients, the registered nurse may be available on an on-call basis provided he or she is available to return to the CAH in a period of time not to exceed twenty (20) minutes.

(d) **Qualifications.**

(1) Individuals selected for the nursing staff shall be qualified by education and experience for the positions they are assigned. The CAH shall verify current licensure of licensed nurses and maintain documentation of verification.

(2) The selection and promotion of nursing service personnel shall be based on their qualifications and capabilities. The director of nursing shall have input regarding the employment, promotion, evaluation and termination of all nursing service personnel.

(3) The qualifications required for each category of nursing staff shall be in written policy and job descriptions, and shall be available in the CAH for reference. The functions of all nursing service personnel shall be clearly defined by written policy.

(e) **Delivery of care.**

(1) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.

(2) Each inpatient shall have a nursing care plan that includes assessment, planning, intervention, and evaluation. Nursing care plans shall be revised as necessary.

(3) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.

(4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs, biologicals, treatments and tests shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, biologicals, treatments and tests are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing practitioner or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(5) Blood products and intravenous medications shall be administered as required by CAH written policy in accordance with state and federal law. CAH staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(6) There shall be an effective procedure for reporting transfusion and adverse drug reactions to the attending physician or licensed independent practitioner and the prescribing physician or practitioner. Errors in drug administration and adverse reactions shall be compiled and reported through the quality assurance committee to the medical and professional staff.

(7) All nursing service personnel shall be trained and currently certified to perform cardio-pulmonary resuscitation (CPR) and shall be knowledgeable of all CAH emergency protocols.

(f) **Patient restraint.** If patients are physically restrained, the CAH shall comply with all requirements specified in OAC 310:667-15-8. If patients are chemically restrained, the CAH shall comply with all requirements specified in OAC 310:667-15-9.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-1995 (emergency); Added at 12 Ok Reg 2429, eff 6-26-1995; Amended at 17 Ok Reg 692, eff 12-16-1999 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-2000; Amended at 18 Ok Reg 2032, eff 6/11/2001; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008; Amended at 30 Ok Reg 1966, eff 7-25-2013]

**310:667-39-10. Food and nutritional services**

(a) **General.** The CAH shall directly provide or contract for organized food and nutritional services that are directed and staffed by qualified personnel. If the CAH has a contract with an outside food management company to provide services on-site or cater food to the CAH, the company shall comply with all requirements specified in this section.

(b) **Organization.**

(1) Clinical nutritional services shall be under the supervision and direction of a licensed/registered dietitian on a full-time, part-time, or consultant basis. The dietitian shall be responsible for approval of menus and modified diets, review of clinical policies and procedures, evaluation of nutritional services and staff continuing education. If dietitian services are provided on a part-time or consultant basis, the responsibilities of the dietitian shall be clearly defined in a written job description and summary reports of consultant visits shall be written and on file. The dietitian shall be responsible for, or shall designate a person in writing, to carry out clinical nutritional activities. The clinical nutritional activities shall include but not be limited to patient and family counseling on modified diets as needed, any required nutritional assessments, and development of clinical nutritional policies and procedures. If dietitian services are provided on a part-time or consultant basis, a dietitian shall be available for telephone consultation daily and shall be able to approve menus and modified diets electronically.

(2) The food and nutritional services manager may or may not be a licensed/registered dietitian. If the manager is not a licensed/registered dietitian or certified dietary manager, the manager shall be responsible only for administrative management and shall not direct clinical nutritional activities.

(3) Personnel shall be adequate in number and training to carry out the preparation and serving of foods and other related functions with the proper and necessary sanitary procedures. The food service personnel shall complete a basic orientation program before working in the food service area. This orientation shall include, but not be limited to: basic dietary guidelines, infection control including food safety, and fire and safety precautions.

(c) **Services and facilities.**

(1) Equipment used in the preparation and handling of food shall bear the seal of the National Sanitation Foundation (NSF) or comply with the requirements of the NSF (Rules and Regulations Pertaining to Food Establishments).

(2) A nourishment room accessible to the nursing staff shall be provided for the preparation and serving of light refreshments. This room shall be equipped with equipment for warming food, a refrigerator, and a lavatory. This room may serve as the location for an ice machine.

(d) **Diets and menus.**

(1) At least three (3) palatable meals or their equivalent shall be served daily, at regular times with not more than fifteen (15) hours between a substantial evening meal and breakfast. Menus shall be planned and followed to meet nutritional needs of patients, in

accordance with the prescribing physician or practitioner diet orders and to the extent medically possible, in accordance with the Dietary Reference Intakes (DRIs) of the Food and Nutrition Board of the Institute of Medicine, National Academy of Sciences.

(2) All diets shall be prescribed by the physician or practitioner responsible for the care of the patient. Modified diets shall be prescribed according to the latest edition of the Oklahoma Diet Manual or other equivalent approved manual. The Oklahoma Diet Manual or other equivalent approved diet manual shall be approved by the licensed/registered dietitian, the medical and professional staff and the governing body. The manual shall be available to all medical, nursing, and food service personnel.

(3) Nourishments shall be available and may be offered at anytime in accordance with approved diet orders.

(4) Menus covering all prescribed diets shall be approved, dated, and periodically reviewed by a licensed/registered dietitian. Modified diet orders not covered with an approved menu shall be planned in writing, reviewed, and approved by a licensed/registered dietitian. The licensed/registered dietitian approval of the modified diet may be performed electronically.

(5) The portioning of menu servings shall be accomplished with the use of portion-control serving utensils.

(6) All modified diets shall be prepared separately, as necessary, from regular diets.

(7) An identification system shall be established to ensure that each patient receives the prescribed diet as ordered.

(e) **Food preparation and storage.**

(1) Potentially hazardous food, as defined in chapter 256 of this Title, shall be maintained at one hundred-forty (140)$^{o}$F (approximately 60$^{o}$C) or above or at an internal temperature of forty-one (41)$^{o}$F (approximately 5$^{o}$C) or below. A product thermometer shall be available, metal stem-type numerically scaled indicating temperature, accurate to plus or minus two (2) degrees F and used to check internal food temperatures.

(2) Milk and milk products shall be served, handled and stored in accordance with the requirements of Chapter 256 of this Title.

(3) All ice which is in contact with food or drink shall come from a source approved by the Department. Storage, transportation, handling, and dispensing shall be in a sanitary manner, approved by the Department in accordance with Chapter 256 of this Title.

(f) **Sanitation.**

(1) The food and nutritional services shall be inspected and approved by state or local health agencies and licensed as a Food Service Establishment. Written reports of the inspections; e.g., Food Establishment Inspection Report Forms, shall be maintained with notations made of the action taken to correct violations.

(2) Storage, preparation, and serving of food shall be in compliance with the requirements of Chapter 256 of this Title, including adequate and proper space for each activity.

(3) The system used for dishwashing shall be approved by the Department and operated in accordance with approved procedures and requirements of Chapter 256 of this Title.

(4) Garbage and refuse shall be kept in durable, easily cleanable, insect-proof and rodent-proof containers that do not leak and do not absorb liquids. Adequate carriers and containers shall be provided for the sanitary collection and transportation of garbage and refuse from food service areas to the place of disposal in accordance with the requirements of Chapter 256 of this Title.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-11. Medical record services**

(a) **General.** The CAH shall have medical record services that ensure a medical record is maintained for every patient evaluated or treated in the facility. Medical record services shall be appropriate to the scope and complexity of the services performed and shall ensure prompt completion, filing, and retrieval of records. In general, services such as transcription, computer indexing and coding, and electronic storage may be performed off-site as a contracted service as long as the medical record remains under the control of the CAH. The CAH shall ensure that medical records maintained by a contracted service remain confidential and can be immediately accessed by CAH staff.

(b) **Reports to agencies and the Department.** The CAH shall comply with all requirements specified in OAC 310:667-19-2(a) regarding the reports made to agencies and the Department.

(c) **Content.** The medical record shall contain information to justify patient admission and treatment, support the diagnosis, and describe the patient's progress and response to treatment and services received. All entries shall be legible and complete, and shall be authenticated and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing or evaluating the service furnished.

(1) The author of each entry shall be identified and shall authenticate their entry. Authentication may include written signatures or computerized or electronic entries. If computerized or electronic authentications are used, the CAH shall comply with all requirements specified at OAC 310:667-19-10(e). Telephone and verbal orders shall be authenticated by the physician or practitioner giving the order as soon as possible within forty-eight (48) hours or meet the requirements at OAC 310:667-19-2(c)(4). Reports of history and physical examinations and discharge summaries shall be authenticated by the authorized physician or practitioner who performed the examination or produced the summary or meet the requirements at OAC 310:667-19-10(e) if authenticated by another physician or practitioner. Signature stamps may be used to authenticate entries in the medical record provided the requirements at OAC 310:667-19-10(d) are met.

(2) All inpatient records shall document the following as appropriate:

(A) Patient identifying information including individuals to be contacted in case of an emergency.

(B) Evidence of a physical examination, including a health history, performed not more than thirty (30) days prior to admission or within forty-eight (48) hours after admission. The history and physical examination shall be completed, signed and placed in the record within 48 hours of admission.

(C) Admitting diagnosis.

(D) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

(E) Documentation of complications, hospital acquired infections, and unfavorable reactions to any drug or biological.

(F) Properly executed informed consent forms for procedures and treatments performed. The medical and professional staff shall establish which procedures or treatments require informed consent consistent with Federal and State law.

(G) All physicians' or practitioners' orders, nursing notes, reports of treatment, medication records, diagnostic reports, vital signs and other information necessary to monitor the patient's condition.

(H) Discharge summary with outcome of hospitalization, disposition of case, medications at the time of discharge, and provisions for follow-up care.

(I) Reports. All reports and records shall be completed and filed within a period consistent with good medical practice and not longer than thirty (30) days following discharge.

(J) Final diagnosis.

(d) **Maintenance of records.** The CAH shall maintain a medical record for each inpatient and outpatient. Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible. The CAH shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(1) Medical records shall be retained at least five (5) years after the date the patient was last seen or at least of three (3) years after the date of the patient's death. Records of newborns or minors shall be retained three (3) years past the age of majority. Medical records may be maintained in their original form or may be preserved by other means as specified by OAC 310:667-19-14(b).

(2) The CAH shall have, or provide, a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

(3) Medical records shall be confidentially maintained. Information from, or copies of, records shall be released only to authorized individuals in accordance with state law, and the CAH shall ensure that unauthorized individuals cannot gain access to, or alter medical records. Original medical records shall be released only in accordance with federal or state laws or by court order.

(4) Facsimile copies shall be acceptable as any portion of the medical record. If the facsimile is transmitted on thermal paper, that paper shall be photocopied to preserve its integrity in the record. Facsimile copies shall be considered the same as original

copies.

(5) In the event of closure of the CAH, the CAH shall inform the Department of the disposition of the patient medical records. Disposition shall be in a manner to protect the integrity of the information contained in the medical record. These records shall be retained and disposed of as specified by OAC 310:667-19-14(b)(4).

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-1995 (emergency); Added at 12 Ok Reg 2429, eff 6-26-1995; Amended at 17 Ok Reg 692, eff 12-16-1999 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-2000; Amended at 18 Ok Reg 2032, eff 6/11/2001; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 21 Ok Reg 2785, eff 7-12-2004; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008]

**310:667-39-12. Drug distribution**

(a) **General.** The CAH shall provide routine and emergency drugs and biologicals in a safe and accurate manner to meet the needs of the patients. The CAH may provide all drug distribution services directly with a complete licensed hospital pharmacy or a drug room. The drug room may be provided directly by the CAH or by contract with a licensed pharmacy. The medical and professional staff and the CAH pharmacist shall be responsible for oversight of drug distribution services and shall approve policies and procedures that ensure compliance with state and federal laws and minimize drug errors. If required, the CAH shall annually register with the Oklahoma State Board of Pharmacy.

(b) **Personnel.**

(1) The drug distribution service shall be directed by a pharmacist on a full-time, part-time, or consultant basis. The pharmacist shall be responsible for developing, supervising, and coordinating all activities of drug distribution in the CAH. The responsibility and authority of the pharmacist shall be clearly defined in a written job description. All compounding, packaging, labeling and dispensing of drugs and biologicals shall be performed or directly supervised by the pharmacist.

(2) If the CAH only maintains a drug room, drugs and biologicals shall be distributed and administered only to inpatients of the CAH. The pharmacist director shall be available at least as a consultant and a registered or licensed practical nurse shall be designated in writing as the drug room supervisor to ensure drugs and biologicals are properly distributed and stored. The drug room supervisor may have other job responsibilities in the CAH as long as drug distribution services are adequately maintained.

(c) **Delivery of services.**

(1) Drugs and biologicals shall be kept in a locked storage area and distributed in accordance with applicable standards of practice, consistent with state and federal laws. Outdated, mislabeled, or otherwise unusable drugs and biologicals shall not be maintained available for patient use. Storage of drugs and biologicals shall be in accordance with the manufacturer's instructions.

(2) Records shall be maintained of the transactions of the pharmacy or drug room to account for the receipt, distribution, disposition

and destruction of all drugs and biologicals.

(3) A record of the stock of controlled dangerous drug substances on hand shall be maintained in a manner so that the disposition of any particular item may be readily traced. All Schedule II drugs shall be maintained as specified in OAC 310:667-21-8(c).

(4) All drugs and biologicals shall be provided to patients only upon written order of a physician or practitioner authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. The prescriber's original order or a copy shall be available to the pharmacy or drug room prior to distributing or dispensing the drug or biological. The order may be electronically transmitted. Methods shall be provided to ensure the reconciliation of all drugs distributed for patient administration.

(5) Access to the pharmacy or drug room shall be restricted to authorized individuals when the pharmacist or drug room supervisor is unavailable. The CAH shall establish written procedures which permit authorized individuals access, establish methods of maintaining drug inventory and control, and require record keeping of drugs removed.

(6) Floor stock medications shall be controlled and maintained to limit after hours access to the pharmacy or drug room. Distribution shall be in accordance with a floor stock drug list which shall be established for each floor stock area. A method shall be provided for reconciliation of floor stock drugs distributed for use in a procedure or for a particular patient. The pharmacist shall check all floor stock medication areas at least monthly to ensure records are accurate and stock continues to be suitable for use.

(7) Drugs and biologicals not specifically prescribed as to length of time or number of doses shall be automatically stopped after a reasonable time established by the medical and professional staff.

(8) Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician or licensed independent practitioner. As appropriate, reports of errors and adverse reactions shall be made to the CAH quality assurance committee.

(9) Abuse and loss of controlled substances shall be immediately reported to the pharmacist director and to the administrator who shall make required reports to local, State and Federal authorities. If the CAH maintains a pharmacy or drug room, the administrator, or the administrator's authorized representative, shall inventory pharmacy controlled substances and alcohol at least annually.

(10) Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, routes of administration and poison control shall be made available by the pharmacist director to nursing service and the medical and professional staff.

(11) Drugs and biologicals maintained by the CAH shall be based on a formulary established by the medical and professional staff.

(d) **Physical facilities.** The CAH shall maintain, as appropriate, adequate facilities to ensure drugs and biologicals are safely compounded, packaged, dispensed and stored as required. Equipment and

supplies shall be provided to adequately protect personnel from toxic substances and to ensure the integrity of any medication or parenteral solution.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-13. Diagnostic services**

(a) **Radiological services.** The CAH shall maintain or have available diagnostic radiological services according to the needs of the patients.

(1) Radiological services shall be free from hazards for patients and personnel. Proper safety precautions shall be maintained against fire and explosion hazards, electrical hazards, and radiation hazards.

(2) Diagnostic x-ray equipment shall have a current permit issued by the Department and shall be inspected at least every two (2) years by a certified health physicist or by Department staff. Any identified hazards shall be promptly corrected.

(3) The hospital shall identify those employees who are subject to significant occupational exposure to radiation while performing their job duties. All such workers shall be checked periodically for amounts of radiation exposure by the use of exposure meters or badge tests.

(4) The CAH shall have a qualified radiologist available on a full-time, part-time or consulting basis both to supervise services and interpret diagnostic images that require specialized knowledge for accurate reading. Diagnostic images may be electronically transmitted or delivered off-site for interpretation by the radiologist. The interpretation of radiological examinations shall be made by physicians or licensed independent practitioners competent in the field according to individually granted clinical privileges. Reports of interpretations shall be written or dictated and signed by the radiologist, physician, or licensed independent practitioner making the interpretation. All diagnostic image interpretations shall be incorporated into the patient's medical record with a duplicate copy kept with the image.

(5) The use of diagnostic x-ray equipment shall be limited to personnel designated as qualified by the radiologist or the medical and professional staff. Fluoroscopic procedures may be performed by radiology technologists only upon the written authorization of a qualified radiologist, and in the presence of a physician or licensed independent practitioner or by real time visualization through electronic means.

(6) The CAH shall maintain copies of reports and diagnostic images for at least five (5) years.

(7) If the CAH provides imaging services other than routine diagnostic x-ray, the CAH shall comply with appropriate sections of OAC 310:667-23-2.

(b) **Laboratory services.**

(1) The CAH shall have a well-organized, adequately supervised clinical laboratory with necessary staff, space, facilities, and equipment to perform those services commensurate with the needs of its patients. All or part of these services may be provided by arrangements with certified reference laboratories as long as services are available on an emergency basis twenty-four (24) hours a day.

(2) If a CAH directly provides laboratory services, it shall meet all conditions as set forth in 42 CFR part 493 and be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). The CAH shall possess a current, unrevoked or unsuspended certificate appropriate for the extent of testing performed issued by the Department of Health and Human Services applicable to the category of examinations or procedures performed by the facility.

(3) If a CAH provides laboratory services under arrangement, the referral laboratory shall also meet the requirements of this section. Referral laboratories used by the CAH shall have the ability to electronically transmit emergency test results.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-39-14. Emergency services**

(a) **General.** The CAH shall provide emergency stabilization and treatment services commensurate with emergency medical needs of the community and CAH service area. All services shall be provided in accordance with acceptable standards of practice, compliant with applicable state and federal laws.

(b) **Organization and direction.** The service shall be directed by personnel deemed qualified by the governing body and integrated with other services of the CAH. Although the service may function as a separate department, the CAH may also provide this service with staff from other areas who are trained in emergency services and who are available if needed in the emergency area.

(1) Services shall be organized under the direction of a qualified member of the medical and professional staff. Nursing functions shall be the responsibility of a registered nurse and shall be supervised by the director of nursing.

(2) There shall be written policies and procedures that establish protocols for emergency services provided. Policies shall also include written procedures for stabilization and transfer of patients whose treatment needs cannot be met at the CAH. If the CAH does not offer maternity services, emergency service policies shall include protocols for emergency deliveries.

(c) **Facilities, medications, equipment and supplies.** Facilities, medications, equipment and supplies shall be provided to ensure prompt diagnosis and emergency medical treatment.

(1) Facilities shall be separate and independent from operating,

delivery, or inpatient rooms. The emergency services area shall be in close proximity to an exterior entrance of the CAH.

(2) Medications commonly used in life-saving procedures shall be provided. These shall include but not be limited to the following drugs and biologicals: analgesics, local anesthetics, antibiotics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, electrolytes, plasma expanders and replacement solutions.

(3) Equipment and supplies commonly used in life-saving procedures shall be provided. These shall include but not be limited to: airways, endotracheal tubes, laryngoscope, ambu bag/valve/mask, obstetrics pack, tracheostomy set, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.

(4) The emergency service shall be equipped with a base station radio using medical frequencies VHF 155.340 or UHF Medical Channels 1 through 10 and/or compatible frequencies with emergency medical services operating in the area. Direct communications between the emergency service and the on-call physician or licensed independent practitioner and the on-call or on-site registered nurse shall be established as specified at OAC 310:667-39-2(b).

(d) **Medical and nursing personnel.** There shall be adequate medical and nursing personnel qualified in emergency care available at all times to meet the emergency service needs of the CAH.

(1) A physician or licensed independent practitioner shall be available at all times to directly communicate with CAH staff providing emergency care. The physician or licensed independent practitioner shall be able to be physically present at the CAH as specified by written facility policy.

(2) A physician or licensed independent practitioner shall be on duty or on call at all times. This physician or practitioner shall be able to present at the CAH in a period of time not to exceed twenty (20) minutes.

(3) A registered nurse shall be available at all times to assess, evaluate, and supervise the nursing care provided. If the CAH has no inpatients, the registered nurse may be available on an on-call basis if he or she can return to the CAH in a period of time not to exceed twenty (20) minutes when a patient presents to the emergency service. All emergency medical patients shall be evaluated on-site by a registered nurse unless the patient is evaluated on-site by a physician or licensed independent practitioner.

(4) Adequate support staff shall be available on-site to meet the emergency service needs of the CAH. If the CAH has no inpatients and registered nursing services are provided on an on-call basis, the emergency service shall be staffed with at least an intermediate or paramedic level emergency medical technician. All CAH staff providing emergency services shall have current CPR certification.

(e) **Emergency medical records.**

(1) Adequate medical records on every patient shall be kept. Each record shall contain the following as applicable:

(A) Patient identification.

(B) Time and means of injury.
(C) History of disease or injury.
(D) Physical findings.
(E) Laboratory and x-ray reports, if any.
(F) Diagnosis and therapeutic orders.
(G) Record of treatment including vital signs.
(H) Disposition of the case.
(I) Signature of the registered nurse.
(J) Signature of the licensed independent practitioner, if applicable.
(K) Signature of the physician, if applicable.
(L) Documentation if the patient left against medical advice.

(2) Medical records for patients treated by the emergency service shall be organized and where appropriate integrated with inpatient records. A method of filing (hard copy or electronic) shall be maintained which assures prompt retrieval.

(f) **Drug and biologicals distribution and control.** Drugs and biologicals in the emergency service shall be securely maintained and controlled by staff at all times. If the service does not have staff present at all times, all drugs and biologicals shall be secured in sealed or locked storage with devices placed to denote tampering. All Schedule II drugs shall be stored as specified by OAC 310:667-21-8(c). All drugs and biologicals shall be administered and dispensed as required by state law.

(g) **Patient examinations, treatments and transfers.** Patient examinations, treatments and transfers shall be conducted in accordance with 42 U.S.C. (1395dd) and 42 U.S.C. (1395cc) and with the regulations at 42 CFR part 489.20 and 489.24.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 692, eff 12-16-99 (emergency); Amended at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 40. EMERGENCY HOSPITAL

310:667-40-1. General
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310:667-40-3. Stabilization or observational admissions
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### 310:667-40-1. General

An emergency hospital (EH) is a hospital that provides emergency treatment and stabilization services on a twenty four (24) hour basis that has the ability to admit and treat patients for short periods of time. The EH shall be the sole provider of hospital services in the community and is to allow the provision of emergency and stabilizing care in a community that is unable to support a general medical surgical or critical access hospital. The EH shall only provide emergency medical services and limited inpatient stabilization or observational care. Non-emergent surgical, scheduled obstetrical deliveries, and invasive diagnostic services requiring anesthesia or sedation shall not be provided. The EH shall be limited to no more that ten (10) inpatient stabilization and observational beds.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-40-2. Affiliations, communications and agreements

(a) **Affiliations.** The EH shall be affiliated with at least one (1) general medical surgical hospital to facilitate appropriate referrals and adequate support services. The affiliation shall be through a written agreement, contract for services, network affiliation, lease or through direct ownership by the supporting general medical surgical hospital.

(b) **Communications**. Direct communications shall be established between the EH and any facility providing support services. These communications shall include the electronic sharing of patient data which may include telemetry and diagnostic imaging if local telecommunications have this capability. As a minimum, the EH shall be able to send and receive patient information by facsimile and/or computer modem.

(c) **Agreements.** The EH shall have a written agreement with an

emergency medical service to accept and receive emergency transfers. This agreement shall provide arrangements for emergency and non-emergency transfers to and from the EH and stipulate the emergency and stabilizing treatment services available at the EH. Direct communications shall be established between the emergency medical service and the EH which allow the emergency medical service to directly contact the on-call physician or licensed independent practitioner and the on-call or on-site registered nurse providing emergency services.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-3. Stabilization or observational admissions**

The EH shall establish inpatient stabilization and observational admission criteria appropriate to treat patients that require short periods of extended care that cannot be provided in an emergency room setting. The criteria may be based on diagnosis and patient acuity established by the medical and professional staff or the EH may use diagnosis related groups (DRGs). Such admission criteria shall not in any way be based on payer source. The criteria shall be established and revised as necessary by the medical and professional staff and approved by the governing body. Stabilizing emergency treatment services provided shall not be restricted by inpatient admission criteria.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-4. Basic requirements and services**

The EH shall provide basic services as described in Sections 5 through 16 of this Subchapter and comply with Subchapters 1, 3 and 5 of this Chapter. The EH shall not provide additional services.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-5. Governing body**

(a) **General.** The EH shall have an effective governing body legally responsible for all services and the quality of patient care provided.

(b) **Organization.** The governing body may be an organized board or owner designated individual(s). The method for appointment, terms, officers required, meeting requirements, duties, and responsibilities shall be established in written bylaws which shall be available at the EH. The governing body shall meet at established intervals and maintain minutes of meetings. Meetings may be conducted by teleconference if not otherwise prohibited by law.

(c) **Responsibilities.** The governing body's responsibilities shall include at least the following:

(1) Appointment and reappointment of members of the medical and professional staff by methods established in approved bylaws. These appointments shall be made based on recommendations received from the medical and professional staff and be consistent with state law.

(2) Approval of medical and professional staff bylaws, rules and

regulations.
(3) Approval or denial of physician and practitioner privilege delineations recommended by the medical and professional staff.
(4) Consideration of reports received from the EH concerning the quality of care provided. The governing body shall require corrective actions as necessary when inadequate patient care is identified.
(5) Ensure patients are admitted and discharged for inpatient stabilization or observational care by a physician or licensed independent practitioner.
(6) Ensure a physician or licensed independent practitioner is available to communicate with EH staff at all times. A physician or licensed independent practitioner shall be physically available if necessary as specified by EH policy.
(7) Ensure adequate EH staff are physically available on-site to provide required emergency, stabilization, and observational services.
(8) Designation of an administrator who shall be responsible for managing the facility. This person may have duties in addition to management responsibilities.
(9) Ensure the EH is constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for emergency, stabilization, and observational care provided.
(10) Ensure the EH is operated under an approved budget.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-6. Medical and professional staff**

(a) **General.** The EH shall have an organized medical and professional staff responsible for the quality of care provided to all patients. The staff shall operate under bylaws approved by the governing body. The medical and professional staff may function as a part of an affiliated hospital's organized staff as long as individual physician and practitioner privileges are independently recommended and approved by the EH governing body. If staff functions are combined with an affiliated hospital, EH functions required by the medical and professional staff bylaws shall be independently identified and reviewed during combined staff meetings.

(b) **Composition.** The EH shall have a medical and professional staff composed of one (1) or more physicians or licensed independent practitioners. Privileges may also be extended to other health care professionals who are authorized by state law to provide treatment services.
(1) The staff shall periodically reexamine credentials and conduct appraisals of its members and make recommendations regarding reappointments and privilege delineations to the governing body. The staff shall also examine credentials of candidates for staff membership and make recommendations regarding appointments and privileges extended.
(2) Temporary staff privileges may be extended to physicians and licensed independent practitioners and other professional staff as

specified in the medical and professional staff bylaws.

(3) Patient admission quotas or revenue generation minimums shall not be a condition for appointment or reappointment.

(c) **Organization and accountability.** The medical and professional staff shall be well organized and accountable to the governing body for the quality of medical care provided to patients.

(1) The staff shall be organized and elect officers as required by approved medical staff bylaws.

(2) The staff shall meet at least quarterly as a committee of the whole to review the quality of medical care provided, fulfill committee functions specified in the staff bylaws, and to consider and recommend actions to the governing body. Meetings may include staff from the affiliated hospitals or other off-site physicians or practitioners who have privileges at the EH and may be conducted by teleconference. Minutes of meetings shall be maintained and available for review at the EH.

(d) **Medical and professional staff bylaws**. The medical and professional staff shall adopt and enforce bylaws to carry out their responsibilities. The medical staff bylaws shall:

(1) Be approved by the governing body.

(2) Include a statement of the duties and privileges of each category of the medical and professional staff. These categories shall include a category of licensed independent practitioner, and may include a category of supervised practitioner. All physicians and licensed independent practitioners with privileges may admit patients for stabilization or observational care.

(3) Describe the organization of the medical and professional staff.

(4) Describe the qualifications for each category of the medical and professional staff.

(5) Require each inpatient to have a history and physical examination performed no more than thirty (30) days before, or forty-eight (48) hours after, admission by a physician or licensed independent practitioner. The examination shall be approved and signed by the physician or licensed independent practitioner. The approval and signature may be performed electronically or by facsimile.

(6) When the medical history and physical examination are completed within thirty (30) days before admission, the hospital must ensure that an updated medical record entry documenting an examination for any changes in the patient's condition is completed. A review of the prior history and physical examination or an updated examination must be completed immediately upon admission and documented in the patient's medical record within forty-eight (48) hours.

(7) Specify the procedure for determining the privileges to be granted to individual physicians and practitioners initially and on reappointment and the process for physicians and practitioners to request these privileges.

(8) Specify the mechanism to withdraw privileges of staff members and the circumstances when privileges shall be withdrawn.

(9) Specify the mechanism for appeal of decisions regarding staff membership and privilege delineations.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008]

**310:667-40-7. Quality improvement**

(a) **General.** There shall be an ongoing quality improvement program, approved by the governing body, which shall identify problems in the facility, suggest solutions, and monitor resolutions.

(b) **Quality improvement plan.** A written quality improvement plan shall be developed, approved, and implemented by the governing body with advice from the medical and professional staff. The plan shall include but not be limited to the following:

(1) Methods of evaluating all patient services to ensure quality of care, including those provided under contract.

(2) Methods of evaluating off-site health care services for appropriateness of use and the degree to which the services aid in the provision of quality patient care.

(3) The evaluation of nosocomial infections and accompanying medication therapy shall be linked to the hospital-wide quality improvement program through regular reporting to the medical and professional staff committee of the whole.

(4) Methods of evaluating physician and practitioner services to ensure these services are provided in conformance with facility policy and state law.

(5) Methods of evaluating on-call services to ensure staff are available as required.

(c) **Quality improvement committee.** The EH may establish a quality improvement committee or this function may be fulfilled by the medical and professional staff committee of the whole. Quality improvement activities shall be reported by facility staff to the committee at least every three (3) months or more frequently if findings require immediate action by the committee.

(d) **Quality improvement implementation.** There shall be documentation that the EH has taken appropriate action to address problems identified. The EH shall document the monitoring of the effectiveness of the proposed solutions.

(e) **Communication.** Quality improvement committee reports shall be communicated at least every three (3) months to the governing body. If the quality improvement committee meets separately from the medical and professional staff committee of the whole, these reports shall also be communicated at least every three (3) months to the medical and professional staff.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-8. Infection control program**

(a) **General.** The EH shall establish an infection control program to provide a sanitary environment and avoid sources and transmission of infections. The program shall include written policies and procedures for identifying, reporting, evaluating and maintaining records of infections among patients and personnel. The program shall provide an

ongoing review and evaluation of all aseptic, isolation and sanitation techniques employed in the hospital and coordinate training programs in infection control for all personnel.

(b) **Infection control committee.** The EH may establish an infection control committee (or equivalent) or this function may be fulfilled by the medical and professional committee of the whole. The committee shall meet at least quarterly.

(c) **Policies and procedures review.**

(1) The infection control committee shall evaluate, revise as necessary, and approve the type and scope of surveillance activities utilized at least annually.

(2) Infection control policies and procedures shall be reviewed periodically and revised as necessary, based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.

(d) **Policies and procedures content.** The policies and procedures outlined for the infection control program shall be approved by the infection control committee and contain at least the following:

(1) A requirement that a record of all reported infections generated by surveillance activities include the identification and location of the patient, the date of admission, onset of the infection, the type of infection, the cultures taken, the results of cultures when known, any antibiotics administered and the physicians or practitioners responsible for care of the patient.

(2) Specific policies related to the handling and disposal of biomedical waste.

(3) Specific policies and procedures related to admixture and drug reconstitution, and the manufacture of intravenous and irrigating fluids.

(4) Specific policies regarding the indications for and types of isolation to be used for each infectious disease. These policies shall incorporate the concepts of standard precautions and the recommended transmission-based categories of contact, airborne, and droplet isolation procedures as deemed appropriate by the medical and professional staff.

(5) A definition of nosocomial infection.

(6) Designation of an infection control officer, who coordinates the infection control program.

(7) Policies for orienting new employees and an ongoing continuing education program for currently employed personnel concerning infection control. Written documentation shall be maintained indicating new employees have completed orientation and that all current personnel have attended continuing education.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-9. Nursing service**

(a) **General.** Each EH shall have an organized nursing service which provides twenty-four (24) hour nursing services for patients. The nursing service shall be supervised by a registered nurse.

(b) **Organization.** The nursing service shall be well-organized with

written policies delineating administrative and patient care responsibilities. The director of nursing shall be a registered nurse who shall be responsible for the operation of the service, including determining the staff necessary to provide nursing care for the EH. Nursing care shall be provided as specified by written procedures approved by the director of nursing and the governing body. All nursing procedures shall be consistent with state and federal law and current standards of practice. Procedures shall be reviewed and revised as necessary.

(c) **Staffing.** The nursing service shall have adequate numbers of licensed nurses and other nursing personnel available to provide nursing care to all patients as needed based on patient census and acuity. At least one (1) registered nurse shall be on duty on-site to furnish or supervise all nursing services whenever patient care is provided. If the EH has no inpatients, the registered nurse may be available on an on-call basis provided he or she is available to return to the EH in a period of time not to exceed twenty (20) minutes.

(d) **Qualifications.**

(1) Individuals selected for the nursing staff shall be qualified by education and experience for the positions they are assigned. The EH shall verify current licensure of licensed nurses and maintain documentation of verification.

(2) The selection and promotion of nursing service personnel shall be based on their qualifications and capabilities. The director of nursing shall have input regarding the employment, promotion, evaluation and termination of all nursing service personnel.

(3) The qualifications required for each category of nursing staff shall be in written policy and job descriptions, and shall be available in the EH for reference. The functions of all nursing service personnel shall be clearly defined by written policy.

(e) **Delivery of care.**

(1) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.

(2) Each inpatient shall have a nursing care plan that includes assessment, planning, intervention, and evaluation. Nursing care plans shall be revised as necessary.

(3) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.

(4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs and biologicals shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, biologicals, treatments, and tests are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing physician or practitioner or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or

verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(5) Blood products and intravenous medications shall be administered as required by EH written policy in accordance with state and federal law. EH staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(6) There shall be an effective procedure for reporting transfusion and adverse drug reactions to the attending physician or licensed independent practitioner and the prescribing physician or practitioner. Errors in drug administration and adverse reactions shall be compiled and reported through the quality assurance committee to the medical and professional staff.

(7) All nursing service personnel shall be trained and currently certified to perform cardio-pulmonary resuscitation (CPR) and shall be knowledgeable of all EH emergency protocols.

(f) **Patient restraint.** If patients are physically restrained, the EH shall comply with all requirements specified in OAC 310:667-15-8. If patients are chemically restrained, the EH shall comply with all requirements specified in OAC 310:667-15-9.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008; Amended at 30 Ok Reg 1966, eff 7-25-2013]

**310:667-40-10. Food and nutritional services**

(a) **General.** The EH shall directly provide or contract for organized food and nutritional services that are directed and staffed by qualified personnel. If the EH has a contract with an outside food management company to provide services on-site or cater food to the EH, the company shall comply with all requirements specified in this section.

(b) **Organization.**

(1) Clinical nutritional services shall be under the supervision and direction of a licensed/registered dietitian on a full-time, part-time, or consultant basis. The dietitian shall be responsible for approval of menus and modified diets, review of clinical policies and procedures, evaluation of nutritional services and staff continuing education. If dietitian services are provided on a part-time or consultant basis, the responsibilities of the dietitian shall be clearly defined in a written job description and summary reports of consultant visits shall be written and on file. The dietitian shall be responsible for, or shall designate a person in writing, to carry out clinical nutritional activities. The clinical nutritional activities shall include but not be limited to patient and family counseling on modified diets as needed, any required nutritional assessments, and development of clinical nutritional policies and procedures. If dietitian services are provided on a part-time or

consultant basis, a dietitian shall be available for telephone consultation daily and shall be able to approve menus and modified diets electronically.

(2) The food and nutritional services manager may or may not be a licensed/registered dietitian. If the manager is not a licensed/registered dietitian or certified dietary manager, the manager shall be responsible only for administrative management and shall not direct clinical nutritional activities.

(3) Personnel shall be adequate in number and training to carry out the preparation and serving of foods and other related functions with the proper and necessary sanitary procedures. The food service personnel shall complete a basic orientation program before working in the food service area. This orientation shall include, but not be limited to: basic dietary guidelines, infection control including food safety, and fire and safety precautions.

(c) **Services and facilities.**

(1) Equipment used in the preparation and handling of food shall bear the seal of the National Sanitation Foundation (NSF) or comply with the requirements of the NSF (Rules and Regulations Pertaining to Food Establishments).

(2) A nourishment room accessible to the nursing staff shall be provided for the preparation and serving of light refreshments. This room shall be equipped with equipment for warming food, a refrigerator, and a lavatory. This room may serve as the location for an ice machine.

(d) **Diets and menus.**

(1) At least three (3) palatable meals or their equivalent shall be served daily, at regular times with not more than fifteen (15) hours between a substantial evening meal and breakfast. Menus shall be planned and followed to meet nutritional needs of patients, in accordance with the prescribing physician or practitioner diet orders and to the extent medically possible, in accordance with the Dietary Reference Intakes (DRIs) of the Food and Nutrition Board of the Institute of Medicine, National Academy of Sciences.

(2) All diets shall be prescribed by the physician or practitioner responsible for the care of the patient. Modified diets shall be prescribed according to the latest edition of the Oklahoma Diet Manual or other equivalent approved manual. The Oklahoma Diet Manual or other equivalent approved diet manual shall be approved by the licensed/registered dietitian, the medical and professional staff and the governing body. The manual shall be available to all medical, nursing, and food service personnel.

(3) Nourishments shall be available and may be offered at anytime in accordance with approved diet orders.

(4) Menus covering all prescribed diets shall be approved, dated, and periodically reviewed by a licensed/registered dietitian. Modified diet orders not covered with an approved menu shall be planned in writing, reviewed, and approved by a licensed/registered dietitian. The licensed/registered dietitian approval of the modified diet may be performed electronically.

(5) The portioning of menu servings shall be accomplished with the use of portion-control serving utensils.

(6) All modified diets shall be prepared separately, as necessary, from regular diets.

(7) An identification system shall be established to ensure that each patient receives the prescribed diet as ordered.

(e) **Food preparation and storage.**

(1) Potentially hazardous food, as defined in chapter 256 of this Title, shall be maintained at one hundred-forty (140)$^{o}$F (approximately 60$^{o}$C) or above or at an internal temperature of forty-one (41)$^{o}$F (approximately 5$^{o}$) or below. A product thermometer shall be available, metal stem-type numerically scaled indicating temperature, accurate to plus or minus two (2) degrees F and used to check internal food temperatures.

(2) Milk and milk products shall be served, handled and stored in accordance with the requirements of Chapter 256 of this Title.

(3) All ice which is in contact with food or drink shall come from a source approved by the Department. Storage, transportation, handling, and dispensing shall be in a sanitary manner, approved by the Department in accordance with Chapter 256 of this Title.

(f) **Sanitation.**

(1) The food and nutritional services shall be inspected and approved by state or local health agencies and licensed as a Food Service Establishment. Written reports of the inspections; e.g., Food Establishment Inspection Report Forms, shall be maintained with notations made of the action taken to correct violations.

(2) Storage, preparation, and serving of food shall be in compliance with the requirements of Chapter 256 of this Title, including adequate and proper space for each activity.

(3) The system used for dishwashing shall be approved by the Department and operated in accordance with approved procedures and requirements of Chapter 256 of this Title.

(4) Garbage and refuse shall be kept in durable, easily cleanable, insect-proof and rodent-proof containers that do not leak and do not absorb liquids. Adequate carriers and containers shall be provided for the sanitary collection and transportation of garbage and refuse from food service areas to the place of disposal in accordance with the requirements of Chapter 256 of this Title.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-11. Medical record services**

(a) **General.** The EH shall have medical record services that ensure a medical record is maintained for every patient evaluated or treated in the facility. Medical record services shall be appropriate to the scope and complexity of the services performed and shall ensure prompt completion, filing, and retrieval of records. In general, services such as transcription, computer indexing and coding, and electronic storage may be performed off-site as a contracted service as long as the medical record remains under the control of the EH. The EH shall ensure that medical records maintained by a contracted service remain confidential and can be immediately accessed by EH staff.

(b) **Reports to agencies and the Department.** The EH shall comply with

all requirements specified in OAC 310:667-19-2(a) regarding the reports made to agencies and the Department.

(c) **Content.** The medical record shall contain information to justify patient admission and treatment, support the diagnosis, and describe the patient's progress and response to treatment and services received. All entries shall be legible and complete, and shall be authenticated and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing or evaluating the service furnished.

(1) The author of each entry shall be identified and shall authenticate their entry. Authentication may include written signatures or computerized or electronic entries. If computerized or electronic authentications are used, the EH shall comply with all requirements specified at OAC 310:667-19-10(e). Telephone or verbal orders shall be authenticated by the physician or practitioner giving the order or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician. Reports of history and physical examinations and discharge summaries shall be authenticated by the authorized physician or practitioner who performed the examination or produced the summary or meet the requirements at OAC 310:667-19-10(e) if authenticated by another physician or practitioner. Signature stamps may be used to authenticate entries in the medical record provided the requirements at OAC 310:667-19-10(d) are met.

(2) All inpatient records shall document the following as appropriate:

(A) Patient identifying information including individuals to be contacted in case of an emergency.

(B) Evidence of a physical examination, including a health history, performed not more than thirty (30) days prior to admission or within forty-eight (48) hours after admission. The history and physical examination shall be completed, signed and placed in the record within 48 hours of admission.

(C) Admitting diagnosis.

(D) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

(E) Documentation of complications, hospital acquired infections, and unfavorable reactions to any drug or biological.

(F) Properly executed informed consent forms for procedures and treatments performed. The medical and professional staff shall establish which procedures or treatments require informed consent consistent with Federal and State law.

(G) All physicians' and practitioners' orders, nursing notes, reports of treatment, medication records, diagnostic reports, vital signs and other information necessary to monitor the patient's condition.

(H) Discharge summary with outcome of hospitalization,

disposition of case, medications at the time of discharge, and provisions for follow-up care.

(I) Reports. All reports and records shall be completed and filed within a period consistent with good medical practice and not longer than thirty (30) days following discharge.

(J) Final diagnosis.

(d) **Maintenance of records**. The EH shall maintain a medical record for each emergency, stabilization, or observational patient. Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible. The EH shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(1) Medical records shall be retained at least five (5) years after the date the patient was last seen or at least of three (3) years after the date of the patient's death. Records of minors shall be retained three (3) years past the age of majority. Medical records may be maintained in their original form or may be preserved by other means as specified by OAC 310:667-19-14(b).

(2) The EH shall have, or provide, a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

(3) Medical records shall be confidentially maintained. Information from, or copies of, records shall be released only to authorized individuals in accordance with state law, and the EH shall ensure that unauthorized individuals cannot gain access to, or alter medical records. Original medical records shall be released only in accordance with federal or state laws or by court order.

(4) Facsimile copies shall be acceptable as any portion of the medical record. If the facsimile is transmitted on thermal paper, that paper shall be photocopied to preserve its integrity in the record. Facsimile copies shall be considered the same as original copies.

(5) In the event of closure of the EH, the EH shall inform the Department of the disposition of the patient medical records. Disposition shall be in a manner to protect the integrity of the information contained in the medical record. These records shall be retained and disposed of as specified by OAC 310:667-19-14(b)(4).

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003; Amended at 21 Ok Reg 2785, eff 7-12-2004; Amended at 24 Ok Reg 1189, eff 4-2-2007(emergency); Amended at 25 Ok Reg 2472, eff 7-11-2008; Amended at 30 Ok Reg 1966, eff 7-25-2013]

**310:667-40-12. Drug distribution**

(a) **General**. The EH shall provide routine and emergency drugs and biologicals in a safe and accurate manner to meet the needs of the patients. The EH may provide all drug distribution services directly with a complete licensed hospital pharmacy or drug room, or services may be provided by contract with a licensed pharmacy. The medical and professional staff and the EH pharmacist shall be responsible for

oversight of drug distribution services and shall approve policies and procedures that ensure compliance with state and federal laws and minimize drug errors. If required, the EH shall annually register with the Oklahoma State Board of Pharmacy.

(b) **Personnel.**

(1) The drug distribution service shall be directed by a pharmacist on a full-time, part-time, or consultant basis. The pharmacist shall be responsible for developing, supervising, and coordinating all activities of drug distribution in the EH. The responsibility and authority of the pharmacist shall be clearly defined in a written job description. All compounding, packaging, labeling and dispensing of drugs and biologicals shall be performed or directly supervised by the pharmacist.

(2) If the EH only maintains a drug room, drugs and biologicals shall be distributed and administered only to patients of the EH. The pharmacist director shall be available at least as a consultant and a registered or licensed practical nurse shall be designated in writing as the drug room supervisor to ensure drugs and biologicals are properly distributed and stored. The drug room supervisor may have other job responsibilities in the EH as long as drug distribution services are adequately maintained.

(c) **Delivery of services.**

(1) Drugs and biologicals shall be kept in a locked storage area and distributed in accordance with applicable standards of practice, consistent with state and federal laws. Outdated, mislabeled, or otherwise unusable drugs and biologicals shall not be maintained available for patient use. Storage of drugs and biologicals shall be in accordance with the manufacturer's instructions.

(2) Records shall be maintained of the transactions of the pharmacy or drug room to account for the receipt, distribution, disposition and destruction of all drugs and biologicals.

(3) A record of the stock of controlled dangerous drug substances on hand shall be maintained in a manner so that the disposition of any particular item may be readily traced. All Schedule II drugs shall be maintained as specified in OAC 310:667-21-8(c).

(4) All drugs and biologicals shall be provided to patients only upon written order of a physician or practitioner authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. The prescriber's original order or a copy shall be available to the pharmacy or drug room prior to distributing or dispensing the drug or biological. The order may be electronically transmitted. Methods shall be provided to ensure the reconciliation of all drugs distributed for patient administration.

(5) Access to the pharmacy or drug room shall be restricted to authorized individuals when the pharmacist or drug room supervisor is unavailable. The EH shall establish written procedures which permit authorized individuals access, establish methods of maintaining drug inventory and control, and require record keeping of drugs removed.

(6) Floor stock medications shall be controlled and maintained to limit after hours access to the pharmacy or drug room. Distribution

shall be in accordance with a floor stock drug list which shall be established for each floor stock area. A method shall be provided for reconciliation of floor stock drugs distributed for use in a procedure or for a particular patient. The pharmacist shall check all floor stock medication areas at least monthly to ensure records are accurate and stock continues to be suitable for use.

(7) Drugs and biologicals not specifically prescribed as to length of time or number of doses shall be automatically stopped after a reasonable time established by the medical and professional staff.

(8) Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician or licensed independent practitioner. As appropriate, reports of errors and adverse reactions shall be made to the EH quality assurance committee.

(9) Abuse and loss of controlled substances shall be immediately reported to the pharmacist director and to the administrator who shall make required reports to local, state and federal authorities. If the EH maintains a pharmacy or drug room, the administrator, or the administrator's authorized representative, shall inventory pharmacy controlled substances and alcohol at least annually.

(10) Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, routes of administration and poison control shall be made available by the pharmacist director to nursing service and the medical and professional staff.

(11) Drugs and biologicals maintained by the EH shall be based on a formulary established by the medical and professional staff.

(d) **Physical facilities.** The EH shall maintain, as appropriate, adequate facilities to ensure drugs and biologicals are safely compounded, packaged, dispensed and stored as required. Equipment and supplies shall be provided to adequately protect personnel from toxic substances and to ensure the integrity of any medication or parenteral solution.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-13. Diagnostic services**

(a) **Radiological services.** The EH shall maintain or have available diagnostic radiological services according to the needs of the patients.

(1) Radiological services shall be free from hazards for patients and personnel. Proper safety precautions shall be maintained against fire and explosion hazards, electrical hazards, and radiation hazards.

(2) Diagnostic x-ray equipment shall have a current permit issued by the Department and shall be inspected at least every two (2) years by a certified health physicist or by Department staff. Any identified hazards shall be promptly corrected.

(3) The hospital shall identify those employees who are subject to significant occupational exposure to radiation while performing their job duties. All such workers shall be checked periodically for amounts of radiation exposure by the use of exposure meters or badge

tests.

(4) The EH shall have a qualified radiologist available on a full-time, part-time or consulting basis both to supervise services and interpret diagnostic images that require specialized knowledge for accurate reading. Diagnostic images may be electronically transmitted or delivered off-site for interpretation by the radiologist. The interpretation of radiological examinations shall be made by physicians or licensed independent practitioners competent in the field according to individually granted clinical privileges. Reports of interpretations shall be written or dictated and signed by the radiologist, physician, or licensed independent practitioner making the interpretation. All diagnostic image interpretations shall be incorporated into the patient's medical record with a duplicate copy kept with the image.

(5) The use of diagnostic x-ray equipment shall be limited to personnel designated as qualified by the radiologist and the medical and professional staff. Fluoroscopic procedures may be performed by radiology technologists only upon the written authorization of a qualified radiologist, and in the presence of a physician or licensed independent practitioner or by real time visualization through electronic means.

(6) The EH shall maintain copies of reports and diagnostic images for at least five (5) years.

(7) If the EH provides imaging services other than routine diagnostic x-ray, the EH shall comply with appropriate sections of OAC 310:667-23-2.

(b) **Laboratory services.**

(1) The EH shall have a well-organized, adequately supervised clinical laboratory with necessary staff, space, facilities, and equipment to perform those services commensurate with the needs of its patients. All or part of these services may be provided by arrangements with certified reference laboratories as long as services are available on an emergency basis twenty-four (24) hours a day.

(2) If a EH directly provides laboratory services, it shall meet all conditions as set forth in 42 CFR part 493 and be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). The EH shall possess a current, unrevoked or unsuspended certificate appropriate for the extent of testing performed issued by the Department of Health and Human Services applicable to the category of examinations or procedures performed by the facility.

(3) If an EH provides laboratory services under arrangement, the referral laboratory shall also meet the requirements of this section. Referral laboratories used by the EH shall have the ability to electronically transmit emergency test results.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-14. Emergency services**

(a) **General**. The EH shall provide emergency stabilization and

treatment services commensurate with emergency medical needs of the community and EH service area. All services shall be provided in accordance with acceptable standards of practice, compliant with applicable state and federal laws.

(b) **Organization and direction**. The service shall be directed by personnel deemed qualified by the governing body and integrated with the nursing stabilization and observation unit of the EH.

(1) Services shall be organized under the direction of a qualified member of the medical and professional staff. Nursing functions shall be the responsibility of a registered nurse and shall be supervised by the director of nursing.

(2) There shall be written policies and procedures that establish protocols for emergency services provided. Policies shall also include written procedures for stabilization and transfer of patients whose treatment needs cannot be met at the EH. EH emergency service policies shall include protocols for emergency deliveries if the patient cannot be safely transferred.

(c) **Facilities, medications, equipment and supplies.** Facilities, medications, equipment and supplies shall be provided to ensure prompt initial diagnosis and emergency medical treatment.

(1) The emergency services area shall be in close proximity to an exterior entrance of the EH.

(2) Medications commonly used in life-saving procedures shall be provided. These shall include but not be limited to the following drugs and biologicals: analgesics, local anesthetics, antibiotics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, electrolytes, plasma expanders and replacement solutions.

(3) Equipment and supplies commonly used in life-saving procedures shall be provided. These shall include but not be limited to: airways, endotracheal tubes, laryngoscope, ambu bag/valve/mask, obstetrics pack, tracheostomy set, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.

(4) The emergency service shall be equipped with a base station radio using medical frequencies VHF 155.340 or UHF Medical Channels 1 through 10 and/or compatible frequencies with emergency medical services operating in the area. Direct communications between the emergency service and the on-call physician or licensed independent practitioner and the on-call or on-site registered nurse shall be established as specified at OAC 310:667-40-2(b).

(d) **Medical and nursing personnel.** There shall be adequate medical and nursing personnel qualified in emergency care available at all times to meet the emergency service needs of the EH.

(1) A physician or licensed independent practitioner shall be available at all times to directly communicate with EH staff providing emergency care. The physician or licensed independent practitioner shall be able to be physically present at the EH as specified by written facility policy.

(2) A physician or licensed independent practitioner shall be on duty or on call at all times. This physician or practitioner shall

be able to present at the EH in a period of time not to exceed twenty (20) minutes.

(3) A registered nurse shall be available at all times to assess, evaluate, and supervise the nursing care provided. If the EH has no inpatients, the registered nurse may be available on an on-call basis if he or she can return to the EH in a period of time not to exceed twenty (20) minutes when a patient presents to the emergency service. All emergency medical patients shall be evaluated on-site by a registered nurse unless the patient is evaluated on-site by a physician or licensed independent practitioner.

(4) Adequate support staff shall be available on-site to meet the emergency service needs of the EH. If the EH has no inpatients and registered nursing services are provided on an on-call basis, the emergency service shall be staffed with at least an intermediate or paramedic level emergency medical technician. All EH staff providing emergency services shall have current CPR certification.

(e) **Emergency medical records.**

(1) Adequate medical records on every patient shall be kept. Each record shall contain the following as applicable:

(A) Patient identification.

(B) Time and means of injury.

(C) History of disease or injury.

(D) Physical findings.

(E) Laboratory and x-ray reports, if any.

(F) Diagnosis and therapeutic orders.

(G) Record of treatment including vital signs.

(H) Disposition of the case.

(I) Signature of the registered nurse.

(J) Signature of the physician or licensed independent practitioner, if applicable.

(K) Documentation if the patient left against medical advice.

(2) Medical records for patients treated by the emergency service shall be organized and where appropriate integrated with inpatient records. A method of filing (hard copy or electronic) shall be maintained which assures prompt retrieval.

(f) **Drug and biologicals distribution and control.** Drugs and biologicals in the emergency service shall be securely maintained and controlled by staff at all times. If the service does not have staff present at all times, all drugs and biologicals shall be secured in sealed or locked storage with devices placed to denote tampering. All Schedule II drugs shall be stored as specified by OAC 310:667-21-8(c). All drugs and biologicals shall be administered and dispensed as required by state law.

(g) **Patient examinations, treatments and transfers.** Patient examinations, treatments and transfers shall be conducted in accordance with 42 U.S.C. (1395dd) and 42 U.S.C. (1395cc) and with the regulations at 42 CFR part 489.20 and 489.24.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-15. Outpatient services**

(a) **General.** The EH may provide limited outpatient services consistent with the diagnostic and treatment capabilities of the facility. These services may be provided in the emergency services area or in a separate examination or treatment room.

(b) **Personnel.** There shall be adequate professional staffing to ensure personnel can effectively provide outpatient services while continuing to meet the needs of emergency patients.

(1) A physician or licensed independent practitioner shall be responsible for the services provided to each patient.

(2) The director of nursing shall be responsible for all nursing services provided.

(3) Additional EH staff shall be available as necessary to provide required diagnostic and treatment services.

(c) **Medical records.** Medical records shall be maintained and integrated with the EH medical record system. Information contained in the medical record shall be complete and sufficiently detailed relative to the patient's history, physical examination, diagnosis, diagnostic procedures, medication administration, and treatment to facilitate continuity of care.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-40-16. Therapy services**

(a) **Respiratory therapy.** If the EH provides respiratory therapy either directly or by contract, the services shall meet the requirements specified at OAC 310:667-23-5.

(b) **Physical and occupational therapy.** If the EH provides physical and/or occupational therapy either directly or by contract, the services shall meet the requirements specified at OAC 310:667-23-6.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 41. GENERAL CONSTRUCTION PROVISIONS

310:667-41-1. General
310:667-41-2. Renovation
310:667-41-3. Design standards for the disabled
310:667-41-4. Provisions for disasters
310:667-41-5. Codes and standards

### 310:667-41-1. General

(a) These requirements are intended as minimum standards for constructing and equipping hospital and specialized hospital projects. For brevity and convenience these standards are presented in "code language". Use of words such as "shall" is mandatory. Insofar as practical, these standards relate to desired performance or results or both. Details of construction and engineering are assumed to be part of good design practice and local building regulations. Design and construction shall conform to the requirements of these standards. Requirements set forth in these standards shall be considered as minimum. For aspects of design and construction not included, local governing building codes shall apply. Where there is no local governing building code, the prevailing model code used within the geographic area is hereby specified for all requirements not otherwise specified in these standards. (See OAC 310:667-41-4(b) for wind and seismic local requirements.) Where American Society of Civil Engineers (ASCE 9-72) is referenced, similar provisions in the model building code are considered substantially equivalent.

(b) These standards are not intended to restrict innovations and improvements in design or construction techniques. Accordingly, the Department may approve plans and specifications which contain deviations if it is determined that the respective intent or objective has been met.

(c) Some projects may be subject to the regulations of several different programs, including those of other state agencies, local agencies, and federal authorities. While every effort has been made for coordination, individual project requirements shall be verified, as appropriate.

(d) The Centers for Medicare & Medicaid Services (CMS), which is responsible for Medicare and Medicaid reimbursement, has adopted the National Fire Protection Association 101 Life Safety Code (NFPA 101). To ensure non-conflicting requirements, the 2000 version of this code is hereby adopted by the Department and all new construction shall comply with that code. Existing construction may continue to comply with the version of NFPA 101 for which construction was approved.

(e) The health-care provider shall supply for each project a functional program for the facility that describes the purpose of the project, the projected demand or utilization, staffing patterns, departmental relationships, space requirements, and other basic information relating to fulfillment of the institution's objectives. This program shall include a description of each function or service; the operational space required for each function; the quantity of staff or other occupants of the various spaces; the numbers, types, and areas

(in net square feet) of all spaces; the special design features; the systems of operation; and the interrelationships of various functions and spaces. The functional program shall include a description of those services necessary for the complete operation of the facility and shall also include the Infection Control Risk Assessment (ICRA). Services available elsewhere in the institution or community need not be duplicated in the facility. The functional program shall also address the potential future expansion of essential services which may be needed to accommodate increased demand. The approved functional program shall be available for use in the development of project design and construction documents.

(f) An ICRA is a determination of the potential risk of transmission of various agents in the facility. This continuous process is an essential component of a facility functional or master program to provide a safe environment of care. The ICRA shall be conducted by a panel with expertise in infection control, risk management, facility design, construction, ventilation, safety, and epidemiology. The design professional shall incorporate the specific, construction related requirements of the ICRA in the contract documents. The contract documents shall require the contractor to implement these specific requirements during construction. The ICRA is initiated in design and planning and continues through construction and renovation. After considering the facility's patient population and programs, The ICRA shall address but not be limited to the following key elements:

(1) The impact of disrupting essential services to patients and employees;

(2) Patient placement or relocation;

(3) Placement of effective barriers to protect susceptible patients from airborne contaminants such as Aspergillus sp.

(4) Air handling and ventilation needs in surgical services, airborne infection isolation and protective environment rooms, laboratories, local exhaust systems for hazardous agents, and other special areas;

(5) Determination of additional numbers of airborne infection isolation or protective environment room requirements;

(6) Consideration of the domestic water system to limit Legionella sp. and waterborne opportunistic pathogens.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-41-2. Renovation**

(a) Where renovation or replacement work is done within an existing facility, all new work or additions, or both, shall comply, insofar as practical, with applicable sections of these standards and with appropriate parts of NFPA 101, 2000 edition, covering New Health Care Occupancies. Where major structural elements make total compliance impractical or impossible, exceptions may be considered by the Department. This does not guarantee that an exception shall be granted, but does attempt to minimize restrictions on those improvements where total compliance would not substantially improve safety, but would

create an unreasonable hardship. These standards shall not be construed as prohibiting a single phase of improvement. For example, a facility may plan to replace a flammable ceiling with noncombustible material but lacks funds to do other corrective work. However, they are not intended as an encouragement to ignore deficiencies when resources are available to correct life-threatening problems.

(b) When construction is complete, the facility shall satisfy functional requirements for the appropriate classification (general medical surgical hospital, psychiatric hospital, etc.) in an environment that shall provide acceptable care and safety to all occupants.

(c) In renovation projects and those making additions to existing facilities, only that portion of the total facility affected by the project shall comply with applicable sections of these standards and with appropriate parts of NFPA 101, 2000 edition, covering New Health Care Occupancies.

(d) Those existing portions of the facility which are not included in the renovation but which are essential to the functioning of the complete facility, as well as existing building areas that receive less than substantial amounts of new work shall, at a minimum, comply with that section of NFPA 101, 2000 edition, for Existing Health Care Occupancies.

(e) Conversion to other appropriate use or replacement shall be considered when cost prohibits compliance with acceptable standards.

(f) When a building is converted from one occupancy to another, it shall comply with the new occupancy requirements. For purpose of life safety, a conversion from a hospital to a nursing home or vice versa is not considered a change in occupancy.

(g) When parts of an existing facility essential to continued overall facility operation cannot comply with particular standards, those standards may be waived by the Commissioner of Health if patient care and safety are not jeopardized.

(h) Renovations, including new additions, shall not diminish the safety level that existed prior to the start of the work; however, safety in excess of that required for new facilities is not required.

(i) Nothing in this Chapter shall be construed as restrictive to a facility that chooses to do work or alterations as part of a phased long-range safety improvement plan. It is emphasized that all hazards to life and safety and all areas of noncompliance with applicable codes and regulations, shall be corrected as soon as possible in accordance with a plan of correction.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-41-3. Design standards for the disabled**

(a) The Americans with Disabilities Act (ADA) extends comprehensive civil rights protection to individuals with disabilities. Under Titles II and III of the ADA, public, private, public service hospitals and other health care facilities shall comply with the "Accessibility Guidelines for Buildings and Facilities" (ADAAG) for alterations and new construction. The "Uniform Federal Accessibility Standards" (UFAS) also

provides criteria for the disabled. United States government facilities shall comply with a combination of UFAS and ADAAG using the most stringent criteria. Also available for use in providing quality design for the disabled is the American National Standards Institute (ANSI) A117.1 "American National Standard for Accessible and Usable Buildings and Facilities."

(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAS, or ANSI A 117.1. Designers and owners, therefore, shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-41-4. Provisions for disasters**

(a) **General.** In locations where there is a history of tornadoes, flooding, earthquakes, or other regional disasters, planning and design shall consider the need to protect the life safety of all health care facility occupants and the potential need for continuing services following such a disaster. When consistent with their functional program and disaster planning, acute care facilities with emergency services can serve as receiving, triage and initial treatment centers in the event of nuclear, biological, or chemical (NBC) exposure. These facilities shall designate specific area(s) for these functions.

(b) **Wind and earthquake resistant design for new buildings.** Facilities shall be designed to meet the requirements of the building codes specified in OAC 310:667-41-1, provided these requirements are substantially equivalent to American Society of Civil Engineers ASCE 7-93. Design shall meet the requirements of ASCE 7-93.

(1) For those facilities that must remain operational in the aftermath of a disaster, special design shall be required to protect systems and essential building services such as power, water, medical gas systems, and, in certain areas, air conditioning. In addition, consideration shall be given to the likelihood of temporary loss of externally supplied power, gas, water, and communications.

(2) The owner shall provide special inspection during construction of seismic systems described in Section A.9.1.6.2 and testing in Section A.9.1.6.3 of ASCE 7-93.

(3) Roof coverings and mechanical equipment shall be securely fastened or ballasted to the supporting roof construction and shall provide weather protection for the building at the roof. Roof covering shall be applied on clean and dry decks in accordance with the manufacturer's instructions, these standards, and related references. In addition to the wind force design and construction requirements specified, particular attention shall be given to roofing, entryways, glazing, and flashing design to minimize uplift, impact damage, and other damage that could seriously impair functioning of the building. If ballast is used it shall be designed so as not to become a projectile.

(c) **Flood protection.** Possible flood effects shall be considered when selecting and developing the site. Insofar as possible, new facilities

shall not be located on designated flood plains. Where this is unavoidable, the United States Corps of Engineers regional office shall be consulted for the latest applicable regulations pertaining to flood insurance and protection measures that may be required.

(d) **Supplies.** Should normal operations be disrupted, the facility shall provide adequate storage capacity for, or a functional program contingency plan to obtain, the following supplies: food, sterile supplies, pharmacy supplies, linen, and water for sanitation. Such storage capacity or plans shall be sufficient for at least four (4) continuous days of operation.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-41-5. Codes and standards**

(a) **Environment.** Every hospital shall provide and maintain a safe environment for patients, personnel, and the public.

(b) **References.** References made in these standards to appropriate model codes and standards do not, generally, duplicate wording of the referenced codes.

(1) NFPA's standards, especially the NFPA 101, are the basic codes of reference; but other codes and/or standards may be included as part of these standards. In the absence of state or local requirements, the project shall also comply with approved nationally recognized building codes except as modified in the 2000 edition of the NFPA 101, and/or herein.

(2) Referenced code material is contained in the issue current at the time of this publication. The latest revision of code material is usually a clarification of intent and/or general improvement in safety concepts and may be used as an explanatory document for earlier code editions. Questions of applicability shall be addressed as the need occurs. The actual version of a code adopted by a jurisdiction may be different. Confirm the version in a specific area with the authority having jurisdiction.

(c) **Equivalency.** Insofar as practical, these model standards have been established to obtain a desired performance result. Prescriptive limitations, when given, such as exact minimum dimensions or quantities, describe a condition that is commonly recognized as a practical standard for normal operation. For example, reference to a room area is for patient, equipment, and staff activities; this avoids the need for complex descriptions of procedures for appropriate functional planning.

(1) In all cases where specific limits are described, equivalent solutions shall be acceptable if the authority having jurisdiction approves them as meeting the intent of these standards. Nothing in this document shall be construed as restricting innovations that provide an equivalent level of performance with these standards in a manner other than that which is prescribed by this document, provided that no other safety element or system is compromised in order to establish equivalency.

(2) National Fire Protection Association (NFPA) document 101A is a technical standard for evaluating equivalency to certain Life Safety

Code 101 requirements. The Fire Safety Evaluation System (FSES) has become widely recognized as a method for establishing a safety level equivalent to the Life Safety Code. It may be useful for evaluating existing facilities that will be affected by renovation. However, for purposes of these standards, the FSES shall not be used as a design code for new construction or major renovation in existing facilities.

(d) **English/Metric measurements.** Where measurements are a part of this document, English units are given as the basic standards with metric units in parenthesis. Either method shall be consistently used throughout a given design.

(e) **List of referenced codes and standards.** Codes and standards which have been referenced in whole or in part in the various sections of this document are listed below. Names and Internet addresses of originators are also included for information. The issues available at the time of publication are used. Later issues shall normally be acceptable where requirements for function and safety are not reduced; however, editions of different dates may have portions renumbered or retitled. Care shall be taken to ensure that appropriate sections are used.

(1) Access Board (an independent federal agency). "Uniform Federal Accessibility Standard" (UFAS). (http://www.access-board.gov/ufas-html/ufas.htm)

(2) American Society of Civil Engineers. ASCE 7-98, formerly ANSI A58.1, "Minimum Design Loads for Buildings and Other Structures." ASCE 7-98 (http://www.pubs.asce.org/BOOKdisplay.cgi?9990609)

(3) American Society of Heating, Refrigerating, and AirConditioning Engineers (ASHRAE). Standard 52.1-1992,"Gravimetric and Dust-Spot Procedures for Testing Air-Cleaning Devices Used in General Ventilation for Removing Particulate Matter" (http://www.ashrae.org).

(4) American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE). Standard 62-1999, "Ventilation for Acceptable Indoor Air Quality" (http://www.ashae.org).

(5) American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) 1999 ASHRAE Handbook- HVAC Applications (http://www.ashae.org).

(6) American Society of Mechanical Engineers (ASME). ANSI/ASME A17.1, "Safety Code for Elevators and Escalators", 1999 (http:www.asme.org/cns/departments/Safety/Public/A17/ or www.ansi.org).

(7) American Society of Mechanical Engineers (ASME). ANSI/ASME A17.3, "Safety Code for Existing Elevators and Escalators" (http:www.asme.org/cns/departments/Safety/Public/A17/ or www.ansi.org).

(8) Americans with Disabilities Act. US Department of Justice ADA Information Line, 1-800-514-0301 or 1-800-514-0383 (TDD). (http://www.usdoj.gov/disabilities.htm)

(9) Association for the Advancement of Medical Instrumentation. ANSI/AAMI RD5:1992, "Hemodialysis Systems". (http://www.aami.org)

(10) Building Officials and Code Administrators International "The BOCA National Building Code" 1999 ed. (http://www.bocai.org)

(11) Building Seismic Safety Council (National Institute of Building Services). "NEHRP (National Earthquake Hazards Reduction Program)

Recommended Provisions for Seismic Regulations for New Buildings", 1997 ed., and "Proposals for Change to the 1997 NEHRP Recommended Provisions for Issuance as the 2000 Provisions". (http://www.bssconline.org)
(12) Center for Disease Control and Prevention (CDC) "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Facilities", 1994 ed., "Mortality Weekly Report (MMWR) 1994:43 (No. RR-13) and "Guidelines for Prevention of Nosocomial Pneumonia," 1994 ed., "American Journal of Infection Control" (22:247-292). (http://www.cdc.gov/)
(13) College of American Pathologists "Medical Laboratory Planning and Design," 1985 ed., (1-800-323-4040 or http://www.cap.org)
(14) Compressed Gas Association (CGA) Publication #E-10, "Maintenance of Medical Gas and Vacuum Systems in Health-Care Facilities," 1997 ed.(http://www.cganet.com/Pubs/)
(15) Department of Defense, MIL STD 282, "Filter Units, Protective Clothing, Gas-Mask Components and Related Products: performance- Test Methods." (http://www.astimage.daps.dla.mil/)
(16) Food and Drug Administration "FDA Food Code," 1999 ed. (http://vm.cfsan.fda.gov/~dms/foodcode.html)
(17) Hydronics Institute Division of the Gas Appliance Manufacturers Association, "I-B-R Ratings for Boilers, Baseboard Radiation and Finned Tube (Commercial)," January 1, 2000 ed. (http://www.gamanet.org/publist/hydroordr.htm)
(18) Illuminating Engineering Society of North America (IESNA), IESNA Publication HB-99 "IESNA Lighting Handbook" 9th ed., IESNA Publication RP-29-95 "Lighting for Hospitals and Health Care Facilities ANSI Approved", and IESNA Publication RP-28-98 "Lighting and the Visual Environment for Senior Living" (http://www. Iesna.org)
(19) International Code Council (ICC) "International Fuel Gas Code 2000 ed. (http://www.bocai.org/) or (http://www.intlcode.org/)
(20) International Code Council (ICC) "International Mechanical Code" 2000 ed. (http://www.bocai.org or (http://www.intlcode.org)
(21) International Code Council (ICC) "International Plumbing Code" 2000 ed. International Code Council (ICC) "International Plumbing Code" 2000 ed. (http://www.bocai.org or (http://www.intlcode.org)
(22) National Council on Radiation Protection and Measurements (NCRP) Report #49 "Structural Shielding Design and Evaluation for Medical Use of X-Rays and Gamma Rays of Energies up to 10MeV" 1976, Report #51 "Radiation Protection Design Guidelines for 0.1-100 MeV Particle Accelerator Facilities" 1977, and Report #102 "Medical X-Ray, Electron Beam and Gamma-Ray Protection for Energies Up to 50 MeV (Equipment Design, Performance and Use) 1989. (http://www.ncrp.com/ncrprpts.html
(23) National Fire Protection Association. NFPA 20. "Standard for the Installation of Stationary Fire Pumps for Fire Protection" 1999 ed.
(24) NFPA 70. "National Electrical Code." 2002 ed.
(25) NFPA 80, "Standard for Fire Door, Fire Windows" 1999 ed.
(26) NFPA 82, "Standard on Incinerators and Waste and Linen Handling Systems and Equipment" 1999 Ed.
(27) NFPA 90A, "Standard for the Installation of Air Conditioning and

Ventilating Systems" 1999 ed.

(28) NFPA 96, "Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations" 1998 ed.

(29) NFPA 99, "Standard for Health Care Facilities" 1999 ed.

(30) NFPA 101, "Life Safety Code" 2000 ed.

(31) NFPA 110, "Standard for Emergency and Standby Power Systems" 1999 ed.

(32) NFPA 253, "Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source" 2000 ed.

(33) NFPA 255, "Standard Method of Test of Surface Burning Characteristics of Building Materials" 2000 ed.

(34) NFPA 258, "Standard Research Test Method for Determining the Smoke Generation of Solid Materials" 1997 ed.

(35) NFPA 418, "Standard for Heliports" 1995 ed.

(36) NFPA 701, "Standard Method of Fire Tests for Flame Resistant Textiles and Films" 1999 ed.

(37) NFPA 801, "Recommended Fire Protection Practice for Facilities Handling Radioactive Materials" 1998 ed.

(38) Nuclear Regulatory Commission (NRC) Code of Federal Regulation (CFR) Title 10- Energy, Chapter 1- Nuclear Regulatory Commission. Part 20 (10 CFR 35), Standards for Protection Against Radiation and Part 35 (10 CFR 35), Medical Use of Byproduct Material. (http://www.nrc.gov)

(39) Occupational Safety and Health Administration, US Department of Labor, Code of Federal Regulations (CFR) Title 29- OSHA Regulations. Part 1910 (10 CFR 1910), Occupational Safety and Health Standards. (http://www.osha.org)

(40) Plumbing-Heating-Cooling Contractors- National Association (PhCC- National Association) "National Standard Plumbing Code". (http://www.naphcc.org/)

(f) **Availability of codes and standards.** The codes and standards that are government publications can be ordered from the Superintendent of Documents, U.S. Government Printing Office (GPO), Washington, D.C. 20402. Copies of nongovernment publications can be obtained at the addresses listed below.

(1) Air Conditioning and Refrigeration Institute, 4301 North Fairfax Drive, Suite 425 Arlington,VA 22203 Tel.703-524-8800 (http://www.ari.org)

(2) Architectural and Transportation Barriers Compliance Board, Office of Technical and Information Services, 1331 F St., NW, Suite 1000, Washington, DC 20530-0001 Tel. 202-272-5434, 1-800-872-2253 (http://www.access-board.gov)

(3) Americans with Disabilities Act, US Department of Justice, 950 Pennsylvania Av., NW, Washington, DC 20530-0001 Tel. 1-800-514-0301 (http://www.usdoj.gov/crt/ada)

(4) American National Standards Institute (ANSI), 11 West 42nd St., New York, NY. 10036 Tel. 212-642-4900 (http://www.ansi.org

(5) American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Ci., NE, Atlanta, Ga. 30329 Tel. 1-800-527-4723, 404-636-8400 (http://www.ashrae.org)

(6) American Society of Civil Engineers, 1801 Alexander Bell Drive, Reston, Va. 20191-4400 Tel. 1-800-548-2723, 703-295-6300

(http://www.asce.org)
(7) American Society of Mechanical Engineers (ASME), Three Park Av., New York, NY. 10016-5990 Tel. 1-800-THE-ASME (http://www.asme.org)
(8) American Society for Testing and Materials, 100 Barr Harbor Dr., West Conshocken, Pa. 19428-2959 Tel. 610-832-9585 (http:www.astm.org)
(9) Association for the Advancement of Medical Instrumentation, 1110 N. Glebe Rd., Suite 220, Arlington, Va. 22201-5762 Tel. 1-800-332-2264, 703-525-4890 (http://www.aami.org)
(10) Building Officials and Code Administrators International, Inc.(BOCA), 4051 Flossmoor Rd., Country Club Hill, IL. 60478-5795 Tel. 708-799-2300 (http://www.bocai.org)
(11) Building Seismic Safety Council, National Institute of Building Services, 1090 Vermont Av. NW, Washington, DC 20005-4905 Tel. 202-289-7800 (http://www.bssconline.org)
(12) Centers for Disease Control and Prevention, Hospital Infection Control Practices (HIPAC), Center for Infection Control, 1600 Clifton Rd., Atlanta, Ga. 30333 Tel. 1-404-639-3311, 1-800-311-3435 (http://www.cdc.gov)
(13) College of American Pathologists, 325 Waukegan Rd., Northfield, IL. 60093 Tel. 1-800-323-4040, 874-832-7000 (http://www.cap.org)
(14) Compressed Gas Association, 1725 Jefferson Davis Highway, Suite 1004, Arlington, Va. 22202 Tel. 703-412-0900 (http://www.cganet.com)
(15) Food and Drug Administration (FDA), Center for Food Safety and Applied Nutrition, 200 C Street, SW, Washington, DC 20204 Tel. 1-888-463-6332 (http://vn.cfsan.fda.gov)
(16) General Services Administration, National Capital Region, 7th and D Streets, SW, Washington, DC 20407 (http://www.gsa.gov)
(17) Hydronics Institute (Division of Gas Appliance Manufacturer Association (GAMA)), 35 Russo Place, PO Box 218, Berkley Heights, NJ 07922 Tel. 908-464-8200 (http://www.gamanet.org)
(18) Illuminating Engineering Society of North America (IESNA), 120 Wall Street, Floor 17, New York, NY 10005 Tel. 212-248-5000 (http://www.iesna.org)
(19) International Code Council, 5203 Leesburg Pike, Suite 600, Falls Church, VA 22041-3401 Tel. 703-931-4533 (http://www.intlcode.org)
(20) International Conference of Building Officials (ICBO), 5360 Workman Mill Rd., Whittier, CA 90601-2298 Tel. 1-800-423-6587 ext. 3278 (http://www. Icbo.org)
(21) National Council on Radiation Protection and Measurement, 7910 Woodmont Av., Suite 800, Bethesda, MD 20814-3095 Tel. 301-657-2652 (http://www.ncrp.com)
(22) National Fire Protection Association (NFPA), 1 Batterymarch Park, PO Box 9101, Quincy, MA 02269-9101 Tel. 617-770-3000 (http://www.nfpa.org)
(23) National Institute of Standards and Technology, 100 Bureau Dr., Stop 3460, Gaithersburg, MD 20899-3460 Tel. 301-975-6478 (http://www.nist.gov)
(24) National Technical Information Service (NITS), US Department of Commerce Technology Administration, 5285 Port Royal Rd., Springfield, VA 22161 Tel. 703-605-6000, 703487-4600 (http://www.ntis.gov)
(25) Naval Publications and Form Center, 5801 Tabor Dr., Philadelphia, PA 19120 (http://astimage.daps.dla.mil/)

(26) Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738 Tel. 301-415-7000 (http://www.nrc.gov)
(27) Occupational Safety and Health Administration, US Department of Labor, 200 Constitution Av., NW, Room N3647, Washington, DC 20210 Tel. 202-693-1999 (http://www.osha.org)
(28) Plumbing-Heating-Cooling Contractors- National Association, 180 South Washington Street, PO Box 6808, Falls Church, VA 22046 Tel. 1-800-533-7694 (http://www.naphcc.org/)
(29) Southern Building Code Congress International, Inc., 900 Montclair Rd., Birmingham, AL 22046 Tel. 205-591-1853 (http://www.sbcci.org)
(30) Underwriters Laboratories, Inc., 333 Pfingsten Rd., Northbrook, IL. 60062-2096 Tel. 847-272-8800 (http://www.ul.com)

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 43. SITE

310:667-43-1. Location
310:667-43-2. Facility site design
310:667-43-3. Environmental pollution control
310:667-43-4. Energy conservation

### 310:667-43-1. Location

(a) **Access.** The site of any hospital shall be convenient to the public and to service vehicles, including fire protection apparatus, etc.

(b) **Availability of transportation.** Hospitals shall be located so that they are convenient to public transportation where available.

(c) **Security.** Hospitals shall have security measures for patients, personnel, and the public consistent with the conditions and risks inherent in the location of the facility. These measures shall include a program designed to protect human and capital resources.

(d) **Availability of utilities.** Facilities shall be located to provide reliable utilities (water, gas, sewer, electricity). The water supply shall have the capacity to provide normal usage plus fire-fighting requirements. The electricity shall be of stable voltage and frequency.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-43-2. Facility site design

(a) **Roads.** Paved roads shall be provided within the property for access to all entrances and to loading and unloading docks for delivery trucks. Hospitals with an organized emergency service shall have the emergency access well marked to facilitate entry from public roads or - streets serving the site. Other vehicular or pedestrian traffic shall not conflict with access to the emergency station. In addition, access to emergency services shall be located to incur minimal damage from floods and other natural disasters. Paved walkways shall be provided for pedestrian traffic.

(b) **Parking.** Parking shall be available for patients, personnel, and the public.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-43-3. Environmental pollution control

(a) **Environmental pollution.** The design, construction, renovation, expansion, equipment, and operation of hospitals are subject to provisions of all applicable federal, state, and local environmental pollution control laws and associated agency regulations; e.g., air quality related to incinerators and gas sterilizers; underground storage tanks; hazardous materials and wastes storage, handling, and disposal; storm water control; medical waste storage and disposal; and asbestos in

building materials.
(b) **Equipment.** Equipment shall minimize the release of chlorofluorocarbons (CFCS) and any potentially toxic substances that may be used in their place; i.e., the design of air conditioning systems shall specify CFC alternatives and recovery systems as may be practicable.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-43-4. Energy conservation**

The importance of energy conservation shall be considered in all phases of facility development or renovation. Proper planning and selection of mechanical and electrical systems, as well as efficient utilization of space and climatic characteristics, can significantly reduce overall energy consumption. The quality of the hospital environment shall, however, be supportive of the occupants and functions served. Design for energy conservation shall not adversely affect patient health, safety, or accepted personal comfort levels. New and innovative systems that accommodate these considerations while preserving cost effectiveness are encouraged.
[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 45. EQUIPMENT

310:667-45-1. General
310:667-45-2. Classification of equipment
310:667-45-3. Major technical equipment
310:667-45-4. Equipment shown on drawings
310:667-45-5. Electronic equipment

### 310:667-45-1. General

(a) An equipment list showing all items of equipment necessary to operate the facility shall be included on the drawings submitted for review or be on an attached list. This listing shall assist in the overall coordination of the acquisition, installation, and relocation of equipment. The equipment list shall include the classifications identified at 310:667-45-1(b) and whether the items are new, existing to be relocated, owner provided, or not-in-contract.

(b) The drawings shall indicate provisions for the installation of equipment that requires dedicated building services, or special structures, or that illustrate a major function of the space. Adjustments shall be made to the construction documents when final selections are made.

(c) Space for accessing and servicing fixed and building service equipment shall be provided.

(d) Some equipment may not be included in the construction contract but may require coordination during construction. Such equipment shall be shown in the construction documents as owner-provided or not-in-contract for purposes of coordination.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

### 310:667-45-2. Classification of equipment

Equipment may vary to suit individual construction projects. Equipment to be used in projects shall be classified as building service equipment, fixed equipment, or movable equipment.

(1) **Building service equipment.** Building service equipment shall include such items as heating, air conditioning, ventilation, humidification, filtration, chillers, electrical power distribution, emergency power generation, energy management systems, conveying systems, and other equipment with a primary function of building service.

(2) **Fixed equipment - medical and nonmedical.** Fixed equipment includes items that are permanently affixed to the building or permanently connected to a service distribution system that is designed and installed for the specific use of the equipment. Fixed equipment may require special structural designs, electromechanical requirements, or other considerations.

(A) Fixed medical equipment includes, but is not limited to, such items as fume hoods, sterilizers, communication systems, built-in casework, imaging equipment, radiotherapy equipment, lithotripters, hydrotherapy tanks, audiometry testing chambers,

and lights.

(B) Fixed nonmedical equipment includes, but is not limited to, items such as walk-in refrigerators, kitchen cooking equipment, serving lines, conveyors, mainframe computers, laundry, and similar equipment.

(3) **Movable equipment - medical and nonmedical.** Movable equipment includes items that require floor space or electrical connections but are portable, such as wheeled items, portable items, office-type furnishings, and monitoring equipment. Movable equipment may require special structural design or access, electromechanical connections, shielding, or other considerations.

(A) Movable medical equipment includes, but is not limited to, portable x-ray, electroencephalogram (EEG), electrocardiogram (EKG), treadmill and exercise equipment, pulmonary function equipment, operating tables, laboratory centrifuges, examination and treatment tables, and similar equipment.

(B) Movable nonmedical equipment includes, but is not limited to, personal computer stations, patient room furnishings, food service trucks, and other portable equipment.

(C) Facility planning and design shall consider the convenient and dedicated placement of equipment requiring floor space and mechanical connections and the voltage required for electrical connections where the portable equipment is expected to be used. An equipment utility location drawing shall be produced to locate all services required by the equipment.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-45-3. Major technical equipment**

Major technical equipment is specialized medical or nonmedical equipment that is customarily installed by the manufacturer or vendor. Major technical equipment may require special structural designs, electromechanical requirements, or other considerations, close coordination between owner, building designer, installer, construction contractors, and others.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-45-4. Equipment shown on drawings**

Equipment that is not included in the construction contract but requires mechanical or electrical service connections or construction modifications shall, insofar as practical, be identified on the design development documents to provide coordination with the architectural, mechanical, and electrical phases of construction.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-45-5. Electronic equipment**

Special consideration shall be given to protecting computerized equipment such as multiphasic laboratory testing units, as well as computers, from power surges and spikes that might damage the equipment or programs. Consideration shall also be given to the addition of a constant power source where loss of data input might compromise patient care.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 47. SUBMITTAL REQUIREMENTS

310:667-47-1. Submission of plans and specifications
310:667-47-2. Preparation of plans and specifications
310:667-47-3. Construction and inspection
310:667-47-4. Construction phasing
310:667-47-5. Nonconforming conditions
310:667-47-6. Drawings
310:667-47-7. Equipment manuals
310:667-47-8. Design data
310:667-47-9. Space occupied by other entities

### 310:667-47-1. Submission of plans and specifications

(a) Before construction is begun, plans and specifications, covering the construction of new buildings or major alterations to existing buildings, shall be submitted to the Department for review and approval.
(b) Each construction project submission shall be accompanied by a check for the appropriate review fee based on the cost of design and construction of the project. Review fees are as follows:
(1) Project cost less than $10,000.00: $250.00 Fee
(2) Project cost $10,000.00 to $50,000.00: $500.00 Fee
(3) Project cost $50,000.00 to $250,000.00:$1000.00 Fee
(4) Project cost $250,000.00 to $1,000,000.00: $1500.00 Fee
(5) Project cost greater than $1,000,0000.00: $2000.00 Fee
(c) The review fee shall cover the cost of review for up to two (2) stage one and two (2) stage two submittals. If a stage one or stage two submittal is not approved after two (2) submissions, another review fee based on the cost of the project shall be required with the third submittal. Fast-track projects shall be allowed two reviews for each package submitted. If a fast-track stage package is not approved after the second submittal, another review fee based on the cost of the project shall be required with the third submittal of the package.
(d) All construction project submittals shall be reviewed within 45 calendar days of receipt by the Department.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 2992, eff 7-13-00]

### 310:667-47-2. Preparation of plans and specifications

(a) **Stage one.** Preliminary plans and outline specifications shall be submitted and include sufficient information to establish the following: scope of project; project location; required fire-safety and exiting criteria; building-construction type, compartmentation showing fire and smoke barriers, bed count and services; the assignment of all spaces, areas, and rooms for each floor level, including the basement.
(b) **Stage two.** A proposed construction document shall be submitted that includes final drawings and specifications adequate for proposed contract purposes. All final plans and specifications shall be appropriately sealed and signed by an architect registered by the State of Oklahoma. All construction modifications of approved documents are

subject to review and approval, and shall be submitted timely.

(c) **Special submittals.**

(1) **Fast-track projects.** Fast-track projects shall have prior approval and be submitted in no more than four (4) separate packages.

(A) Site work, foundation, structural, underslab mechanical, electrical, plumbing work, and related specifications.

(B) Complete architectural plans and specifications.

(C) All mechanical, electrical, and plumbing plans and specifications.

(D) Equipment and furnishings.

(2) **Automatic sprinkler-systems.** At least two (2) sets of sprinkler-system show drawings, specifications, and calculations (if applicable), prepared by the installer, shall be submitted to the Office of the State Fire Marshal for review and approval prior to installation of the proposed system in the project.

(3) **Radiation protection.** Any project that includes radiology or special imaging equipment used in medical diagnosis, treatment, and therapy of patients, shall include plans, specifications, and shielding criteria, prepared by a qualified medical physicist. These plans shall be submitted and approved by the Department prior to installation of the equipment.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-47-3. Construction and inspection**

(a) Construction other than minor alterations, shall not be commenced until Stage Two plan-review deficiencies have been satisfactorily resolved.

(b) Prior to commencing construction, the contractor shall submit a construction schedule which includes, as a minimum, the start date, dates that the heating-ventilation air-conditioning (HVAC), plumbing, and medical gas installation shall commence, and projected date of completion.

(c) The completed construction shall comply with the approved drawings and specifications, including all addenda or modifications approved for the project.

(d) A final construction inspection of the facility shall be conducted by the Department for the purpose of verifying compliance with these requirements and the approved plans and specifications. The facility shall not allow patient occupancy until a final approval is granted by the Department.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-47-4. Construction phasing**

Projects involving alterations and/or additions to existing buildings shall be programmed and phased to minimize disruptions of retained, existing functions and shall not disrupt or interfere with patient care.

Access, exits, and fire protection shall be maintained so that the occupants' safety shall not be jeopardized during construction.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-47-5. Nonconforming conditions**

It is not always financially feasible to renovate the entire existing structure in accordance with these standards. In such cases, the Department may grant approval to renovate portions of the structure if facility operation and patient safety in the renovated areas are not jeopardized by the existing features of facility sections retained without complete corrective measures. In major modernization projects and additions to existing facilities, those unrenovated areas that do not comply with NFPA 101 requirements for existing buildings, shall be separated from sections to be modernized by fire walls or partitions rated not less that two (2) hour fire resistance, extending through the full height of the building, and by labeled fire doors of class "B" one and one half (1-1/2) hour construction.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-47-6. Drawings**

Upon occupancy of the building or portion thereof, the owner shall be provided with a complete set of legible drawings showing construction, fixed equipment, and mechanical and electrical systems, as installed or built. Drawings shall include a life safety plan for each floor reflecting NFPA 101 requirements. The life safety drawing shall include, but shall not be limited to the following:

(1) Smoke compartmentation;
(2) Exit signage;
(3) Fire extingushers;
(4) Fire alarm devices;
(5) Pull stations; and
(6) Sprinklered areas.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-47-7. Equipment manuals**

Upon completion of the contract, the owner shall be furnished with a complete set of manufacturer's operating, maintenance, and preventive maintenance instructions; parts lists; and procurement information with numbers and a description for each piece of equipment. Operating staff shall also be provided with instructions on how to properly operate systems and equipment. The required information shall include energy ratings as needed for future conservation calculations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-47-8. Design data**

The owners shall be provided with complete design data for the facility. This shall include structural design loadings; summary of heat loss assumption and calculations; estimated water consumption; and electric power requirements of installed equipment. All such data shall be supplied to facilitate future alterations, additions, and changes, including, but not limited to, energy audits and retrofit for energy conservation.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-47-9. Space occupied by other entities**

(a) Areas within a licensed hospital facility that are leased to, or occupied by, a separate entity and comply with Health Care Occupancy requirements as specified by NFPA 101, 2000 edition, shall be separated from the licensed hospital by demising partitions that are rated not less than one (1) hour fire resistance. Lease areas that do not comply with Health care Occupancy requirements as specified by NFPA 101, 2000 edition, shall be separated from the licensed hospital by demising partitions that are rated not less than two (2) hour fire resistance.

(b) Lease areas shall have signage that clearly identifies tenant areas from hospial areas.

(c) The lease between the hospital and the tenant entity shall require that the tenant area shall be:

(1) Maintained to comply with NFPA 101 for Health care Occupancies;

(2) Included in the hospital’s sprinkler systems, fire alarm systems, and fire drills; and

(3) Accessible to representatives of the Department to determine compliance with these standards.

(d) A copy of the executed lease agreement shall be submitted to the Department for review as part of the plan approval application process and a current copy shall be available for review by Department staff upon request.

**[Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 49. GENERAL MEDICAL SURGICAL HOSPITAL CONSTRUCTION REQUIREMENTS

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310:667-49-36. Renal dialysis unit (acute and chronic)

### 310:667-49-1. General considerations

(a) **Functions.** A functional facility program as specified in 310:667-41-1(e) shall be submitted for each project.

(b) **Standards.** The general medical surgical hospital shall meet all the construction standards described in this Subchapter. Any deviation from these standards shall be described and justified in the functional program and shall be approved by the Department.

(c) **Sizes.** Department sizes and clear floor areas shall depend upon program requirements and organization of services within the hospital. Some functions may be combined or shared providing the layout does not

compromise safety standards and medical and nursing practices.

(d) **Parking.** Each new hospital, major addition, or major change in function shall have parking space to satisfy the needs of patients, personnel, and public. A formal parking study is desirable. In the absence of such a study, one (1) parking space for each bed plus one (1) space for each employee shall normally be present on any single weekday shift. This ratio may be reduced in an area convenient to public transportation or public parking facilities, or where carpool or other arrangements to reduce traffic have been developed. Additional parking may be required to accommodate outpatient and other services. Separate and additional space shall be provided for service delivery vehicles and vehicles used for emergency patients.

(e) **Swing beds.** When the concept of swing beds is part of the functional program, care shall be taken to include requirements for all intended categories. Facility design for swing beds may require additional corridor doors and provisions for switching nurse call operations from a nurse station to another nurse station depending on use.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-2. Nursing unit - medical and surgical**

Each nursing unit shall include the following:

(1) **Patient rooms.** Each patient room shall meet the following standards:

(A) Maximum room capacity shall be two (2) patients.

In new construction, the maximum room capacity shall be two patients. Where renovation work is undertaken and the present capacity is four (4) patients, maximum room capacity may be four (4) patients.

(B) In new construction, patient rooms shall have a minimum of one hundred (100) square feet (9.29 square meters) of clear floor area per bed in multiple-bed rooms and one hundred-twenty (120) square feet (10.8 square meters) of clear floor area for single-bed rooms, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules. The dimensions and arrangement of rooms shall be such that there is at least three (3) feet (0.91 meter) between the sides and foot of the bed and any wall or any other fixed obstruction. In multiple-bed rooms, a clearance of four (4) feet (1.22 meters) shall be available at the foot of each bed to permit the passage of equipment and beds. Minor encroachments, including columns and lavatories, that do not interfere with functions may be ignored when determining space requirements for patient rooms. Where renovation work is undertaken, patient rooms shall have at least eighty (80) square feet (7.43 square meters) of clear floor area per bed in multiple-bed areas and at least one hundred (100) square feet (9.29 square meters) of clear floor area in single-bed rooms. These requirements do not prohibit the use of larger rooms where required for needs and functions. The degree of acuteness of care

being provided shall be the determining factor.

(C) Each patient room shall have a window in accordance with OAC 310:667-49-28(b)(1)(J).

(D) Nurse call systems for two-way voice communication shall be provided in new construction in accordance with OAC 310:667-49-32(g).

(E) In new construction, handwashing facilities shall be provided in each patient room. A handwashing station shall be located in the toilet room. In new construction, a handwashing station or a dispenser containing a hand degerming agent that does not require water for use, such as an alcohol based foam, rinse, or gel, shall be provided in the patient room in addition to the handwashing station in the toilet room. This handwashing station or dispenser shall be located outside the patient’s cubicle curtain so that it is accessible to staff. In renovation projects, the handwashing fixture may be omitted from the bedroom where a water closet and handwashing fixture are provided in a toilet room designed to serve a single-bed room or one two (2) bed room. This exception does not apply to postpartum rooms.

(F) Each patient shall have access to a toilet room without having to enter the general corridor area. One (1) toilet room shall serve no more than four (4) beds and no more than two (2) patient rooms. The toilet room shall contain a water closet and a handwashing fixture and the door shall swing outward or be double acting

(G) Each patient shall have a separate wardrobe, locker, or closet suitable for hanging full-length garments and for storing personal effects.

(H) In multiple-bed rooms, visual privacy from casual observation by other patients and visitors shall be provided for each patient. The design for privacy shall not restrict patient access to the entrance, lavatory, or toilet.

(I) Ventilation, oxygen, vacuum, air, and electrical standards are specified at OAC 310:667-49-31 and OAC 310:667-49-32.

(2) **Service areas.** Provision for the services listed below shall be in, or readily available to, each nursing unit. The size and location of each service area shall depend upon the numbers and types of beds served. Identifiable spaces are required for each of the indicated functions. Each service area may be arranged and located to serve more than one (1) nursing unit but, unless noted otherwise, at least one (1) such service area shall be provided on each nursing floor. Where the words "room" or "office" are used, a separate, enclosed space for the named function is intended; otherwise, the described area may be a specific space in another room or common area.

(A) Administrative center or nurse station which shall have space for counters and storage and shall have convenient access to handwashing facilities. It may be combined with, or include, centers for reception and communication. Preferably, the station shall permit visual observation of all traffic into the unit.

(B) Dictation area which shall be adjacent to, but separate from the nurse station.

(C) Nurse or supervisor office.
(D) Handwashing fixtures, conveniently accessible to the nurse station, medication station, and nourishment center. One (1) handwashing fixture may serve several areas if convenient to each.
(E) Charting facilities shall have linear surface space to ensure that staff and physicians may chart and have simultaneous access to information and communication systems.
(F) Toilet room(s) conveniently located for staff use (may be unisex).
(G) Staff lounge facilities shall be provided and shall be programmatically sized, but shall not be less than 100 square feet (9.3 square meters).
(H) Securable closets or cabinet compartments for the personal articles of personnel, located in or near the nurse station. These compartments shall be at least large enough for purses and billfolds. Coats may be stored in closets or cabinets on each floor or in a central staff locker area.
(I) Multipurpose room(s) for staff, patients, patients' families, reports, education, training sessions, and consultation. These rooms shall be accessible to each nursing unit. They may be on other floors if convenient for regular use. One (1) such room may serve several nursing units and/or departments.
(J) Examination/treatment room(s) which may be omitted if all patient rooms in the nursing unit are single-bed rooms. Centrally located examination and treatment room(s) may serve more than one (1) nursing unit on the same floor. Such rooms shall be at least one hundred-twenty (120) square feet (10.8 square meters). The room shall contain a handwashing fixture; storage facilities; and a desk, counter, or shelf space for writing. Provisions shall be made to preserve patient privacy from observation from outside the exam room through an open door.
(K) Clean workroom or clean supply room. If the room is used for preparing patient care items, it shall contain a work counter, a handwashing fixture, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile materials, the work counter and handwashing fixture may be omitted. Soiled workrooms or holding rooms shall be separated from and have no direct connection with the clean workroom or clean supply room.
(L) Soiled workroom or soiled holding room which shall be separate from the clean workroom and shall have separate access doors. The soiled workroom shall contain a clinical sink or equivalent flushing-rim fixture. The room shall contain a lavatory or handwashing fixture. The above fixtures shall both have a hot and cold mixing faucet. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter. If the flushing-rim clinical sink is eliminated, facilities for cleaning bedpans shall be provided elsewhere.
(M) Medication station. Provision shall be made for twenty-four (24) hour distribution of medications. This may be done from a

medicine preparation room or unit, from a self-contained medicine dispensing unit, or by another approved system.

(i) Medicine preparation room shall be under visual control of the nursing staff. It shall contain a work counter, a sink adequate for handwashing, refrigerator, and locked storage for controlled drugs, and shall have at least fifty (50) square feet (4.65 square meters). When a medicine preparation room is to be used to store one (1) or more self-contained medicine dispensing units, the room shall be designed with adequate space to prepare medicines with the self-contained medicine dispensing units present.

(ii) A self-contained medicine dispensing unit may be located at the nurse station, in the clean workroom, or in an alcove, provided the unit has adequate security for drugs and adequate lighting to easily identify drugs. Convenient access to hand-washing facilities shall be provided. The standard cup-sinks provided in many self-contained units are not adequate.

(N) Clean linen storage. Each nursing unit shall contain a designated area for clean linen storage. This may be within the clean workroom, a separate closet, or an approved distribution system on each floor. If a closed cart system is used, storage may be in an alcove. It shall be out of the path of normal traffic and under staff control.

(O) Nourishment station. There shall be a nourishment station with sink, work counter, refrigerator, storage cabinets, and equipment for hot and cold nourishments between scheduled meals. The nourishment station shall include space for trays and dishes used for nonscheduled meal service. Provisions and space shall be included for separate temporary storage of unused and soiled dietary trays not picked up at meal time. Handwashing facilities shall be in or immediately accessible from the nourishment station.

(P) Ice machine. Each nursing unit shall have equipment to provide ice for treatments and nourishment. Ice-making equipment may be in the clean work room/holding room or at the nourishment station. Ice intended for human consumption shall be from a self-dispensing ice maker.

(Q) Equipment storage room or alcove. An appropriate room or alcove shall be provided for storage of equipment necessary for patient care and as required by the functional program. Each unit shall provide sufficient storage area(s) located on the patient floor to keep its required corridor width free of all equipment and supplies, but not less that 10 square feet ((0.93 square meters) per patient bed shall be provided.

(R) Storage space for stretchers and wheelchairs. Storage space for stretchers and wheelchairs shall be provided in a strategic location, without restricting traffic flow.

(S) Showers and bathtubs. When an individual bathing facility is not provided in a patient room, there shall be at least one (1) shower and/or bathtub for each twelve (12) beds without such facilities. Each bathtub or shower shall be in an individual room or enclosure that provides privacy for bathing, drying, and dress-

ing. Special bathing facilities, including space for an attendant, shall be provided for patients on stretchers, carts, and wheelchairs at the ratio of one (1) per one-hundred (100) beds or a fraction thereof. This may be on a separate floor if convenient for use.

(T) Patient toilet room(s), in addition to those serving bed areas, shall be conveniently located to multipurpose room(s) and within or directly accessible to each central bathing facility. Patient toilet rooms serving multipurpose rooms may also be designated for public use.

(U) Emergency equipment storage. Space shall be provided for emergency equipment that is under direct control of the nursing staff, such as a cardiopulmonary resuscitation (CPR) cart. This space shall be located in an area appropriate to the functional program, but out of usual traffic.

(V) Housekeeping room. One (1) housekeeping room shall be provided for each nursing unit or nursing floor. It shall be directly accessible from the unit or floor and may serve more than one (1) nursing unit on a floor. At least one (1) housekeeping room per floor shall contain a service sink or floor receptor and provide storage for supplies and housekeeping equipment. The housekeeping room shall not be used for other departments and nursing units that require separate housekeeping rooms.

(3) **Airborne infection isolation room.**

(A) Details and numerical ratios of this Subsection apply to those areas of the hospital covered by new design, replacement and/or major renovation. Existing nursing units and beds not affected by project work that have approved isolation procedures may be acceptable without changes or additions. Existing beds that are retained without change and psychiatric beds need not be counted in the ratios required below.

(B) At least one (1) airborne infection isolation room, designed to minimize infection hazards from airborne droplet nuclei from the patient, shall be provided for each thirty (30) acute-care beds or a fraction thereof (except as noted above). The number of airborne infection isolation beds required shall be increased where the ICRA identifies large numbers of patients likely to transmit airborne diseases; e.g., tuberculosis. These may be located within an individual nursing unit and used for normal acute care when not required for airborne infection isolation cases, or they may be grouped as a separate isolation unit. Each airborne infection isolation room shall contain only one (1) bed and shall comply with the acute-care patient room section of this document as well as the following:

(i) Room entry shall be through a work area that provides for facilities that are separate from patient areas for handwashing, masking, and storage of clean and soiled materials. The work area shall be located directly outside or immediately inside the entry door to the room. The work area entry may be a separate enclosed anteroom. The vestibule workspace open to the room may be used for other functions when not needed for isolation. However, where the program function requires protective

environments, e.g. to accommodate patients who have undergone allogenic hematopoietic stem cell transplant and other patients with severe and prolonged neutropenia, at least one (1) airborne infection isolation room shall be designed for entry only through an enclosed anteroom.

(ii) Separate enclosed anteroom(s) for airborne infection isolation rooms are not required but, if used, viewing panel(s) shall be provided for observation of each patient by staff from the anteroom.

(iii) One (1) separate anteroom may serve several airborne infection isolation rooms.

(iv) Toilet, bathtub (or shower), and handwashing facilities are required for each isolation room. These shall be arranged to permit access from the bed area without the need to enter or pass through the work area of the vestibule or anteroom.

(v) Airborne infection isolation room perimeter walls, ceilings, and floors, including penetrations, shall be sealed tightly so that air does not infiltrate the environment from outside or from other spaces. Ventilation requirements are specified in Appendix A.

(vi) Airborne infection isolation rooms shall have self-closing devices on all room exit doors.

(vii) Airborne infection isolation rooms shall have a permanently installed visual mechanism to constantly monitor the pressure status of the room when occupied by patients with an airborne infectious disease. The mechanism shall constantly monitor the direction of the airflow.

(4) **Protective environment rooms.** In facilities where procedures such as allogenic hematopoietic stem cell transplants and other patients with severe and prolonged neutropenia are treated, special design provisions, including special ventilation, shall be required to meet the needs of the functional program. Ventilation requirements are specified in Appendix A.

(i) Each protective environment room shall have an area for handwashing, gowning, and storage of clean and soiled materials located directly outside or immediately inside the entry door to the room.

(ii) Protective environment room perimeter walls, ceiling, and floors, including penetrations, shall be sealed tightly so that air does not infiltrate the environment from the outside or from other spaces.

(iii) Protective environment room(s) shall have self-closing devices on all room exit doors.

(iv) Separate toilet, bathtub (or shower), and handwashing stations shall be provided in each protective environment room.

(v) Protective environment rooms shall have a permanently installed visual mechanism to constantly monitor the pressure status of the room when occupied by patients with an infectious disease. The mechanism shall constantly monitor the direction of the airflow.

(vi) When immunocompromised patients who would benefit from a protective environment room also have an airborne infectious

disease (e.g., tuberculosis) they should be placed in a room especially designed to maintain positive air pressure for the patient, by utilizing an anteroom to ensure proper air balance relationships and provide independent exhaust of contaminated air.

(5) **Security and/or seclusion room(s).** The hospital shall provide one (1) or more single bedrooms for patients needing close supervision for medical and/or psychiatric care. This may be part of the psychiatric unit described at OAC 310:667-49-6. If the single bedroom(s) is part of the acute-care nursing unit, the provisions of OAC 310:667-49-6(d)(1) shall apply, with the following exceptions: each room shall be for single occupancy; each shall be located to permit staff observation of the entrance, preferably adjacent to the nurse station; and each shall be designed to minimize the potential for escape, hiding, injury, or suicide. If vision panels are used for observation of patients, the arrangement shall insure patient privacy and prevent casual observation by visitors and other patients.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-3. Critical care unit**

(a) **General.** The critical care unit requires special space and equipment for safe and effective patient care, staff functions and family participation. Design shall address such issues as privacy, atmosphere, and aesthetics for all involved in the care and comfort of patients in critical care units. In addition, space arrangement shall provide immediate access for emergency equipment from other departments. Each hospital may not provide all types of critical care. Some hospitals may have a small combined unit; others may have separate, sophisticated units for highly specialized treatments. Critical care units shall comply in size, number, and type with these standards and with the functional program. The following standards are intended for the more common types of critical care services and shall be appropriate to needs defined in functional programs. Where specialized services are required, additions and/or modifications shall be made as necessary for efficient, safe, and effective patient care.

(b) **Critical care - general.** The following shall apply to all types of critical care units unless otherwise noted. Each unit shall comply with the following provisions:

(1) The location shall offer convenient access from the emergency, respiratory therapy, laboratory, radiology, surgery, and other essential departments and services as defined by the functional program. It shall be located so that the medical emergency resuscitation teams may be able to respond promptly to emergency calls with minimum travel time.

(2) The location shall be arranged to eliminate the need for through traffic. Transportation of patients to and from the critical care unit shall ideally be separated from public corridors and visitor waiting areas. Where elevator transport is required for critically

ill patients, the size of the cab and mechanisms and controls shall be carefully planned to meet the specialized needs.

(3) In new construction, each patient space, whether separate rooms, cubicles, or multiple bed space, shall have at least Two hundred (200) square feet (18.58 square meters) of clear floor area with headwall width of at least (13) feet (3.96 meters) per bed, exclusive of anterooms, vestibules, toilet rooms, closets, lockers, wardrobes, and/or alcoves. In renovation of existing intensive care units, separate rooms or cubicles for single patient use shall be at least one hundred-fifty (150) square feet (18.58 square meters) and multiple bed space shall contain at least one hundred-thirty (130) square feet (12.08 square meters) per bed.

(4) A staff emergency assistance system shall be provided on the most accessible side of the bed. The system shall annunciate at the nurse station with backup from another staffed area from which assistance can be summoned. Rapid and easily accessible information exchange and communication shall be available within the unit and the hospital. The unit shall provide the ability to continuously monitor the physiological parameters appropriate for the types of patients the unit is expected to care for.

(5) When private rooms or cubicles are provided, view panels to the corridor shall be required with a means to provide visual privacy. Where only one (1) door is provided to a bed space, it shall be at least four (4) feet (1.22 meters) wide and arranged to minimize interference with movement of beds and large equipment. Sliding doors shall not have floor tracks and shall have hardware that minimizes jamming possibilities. Where sliding doors are used for access to cubicles within a suite, a three (3) foot wide swinging door may also be provided for personnel communication.

(6) Each patient bed area shall have space at each bedside for visitors, and provisions for visual privacy from casual observation by other patients and visitors. For both adult and pediatric units, there shall be at least eight (8) feet (2.44 meters) between beds.

(7) Each patient bed shall have visual access, other than skylights, to the outside environment with not less than one (1) outside window in each patient bed area. In renovation projects, clerestory windows with windowsills above the heights of adjacent ceilings may be used, provided they afford patients a view of the exterior and are equipped with appropriate forms of glare and sun control. Distance from the patient bed to the outside window shall not exceed fifty (50) feet (15.24 meters). When partitioned cubicles are used, a patient's view to outside windows may be through no more than two (2) separate clear vision panels.

(8) A nurse call system for two-way voice communication shall be provided in accordance with OAC 310:667-49-32(g). The call system for the unit shall provide an emergency code resuscitation alarm to summon assistance from outside the critical care unit.

(9) Handwashing fixtures shall be convenient to nurse stations and patient bed areas. There shall be at least one (1) handwashing fixture for every three (3) beds in open plan areas, and one (1) in each patient room. The handwashing fixture shall be located near the entrance to the patient cubicle or room, shall be sized to minimize

splashing water onto the floor, and shall be equipped with elbow-, knee-, or foot-operated controls.

(10) An administrative center or nurse station that shall have space for counters and storage. It may be combined with or include centers for reception and communication. Patients shall be visually observed at all times. If a central station is chosen, it shall be geographically located to allow for complete visual control of all patient beds in the critical care unit. It shall be designed to maximize efficiency in traffic patterns. There shall be visual contact between the nurse and the patient at all times. Patients shall be oriented so that they can see the nurse but cannot see the other patients. There shall be an ability to communicate with the clerical staff without having to enter the central station.

(11) Each unit shall contain equipment for continuous monitoring, with visual displays for each patient at the bedside and at the nurse station. Monitors shall be located to permit easy viewing and access but not interfere with access to the patient.

(12) Emergency equipment storage space that is easily accessible to the staff shall be provided for emergency equipment such as a CPR cart.

(13) A medication station shall be provided for twenty-four (24) hour storage and distribution of emergency drugs and routine medications. This may be done from a medicine preparation room or unit, from a self-contained medicine dispensing unit, or by another system. If a medicine preparation room or unit is used, it shall be under visual control of nursing staff. It shall contain a work counter, cabinets for storage of supplies, sink with hot and cold water supply, refrigerator for pharmaceuticals, and double locked storage for controlled substances, and shall have at least fifty (50) square feet (4.65 square meters). The area shall be enclosed to minimize distraction of those preparing medications. A glass wall or walls may be advisable to permit visualization of patients and unit activities. A self contained medicine dispensing unit may be located at the nurses station, in the clean workroom, in an alcove, or in another area directly under visual control of nursing or pharmacy staff. Convenient access to handwashing facilities shall be provided. The standard cup sinks provided in many self contained units are not adequate.

(14) The electrical, medical gas, heating, and air conditioning shall support the needs of the patients and critical care team members under normal and emergency situations. Specific requirements are specified at OAC 310:667-49-31 and OAC 310:667-49-32.

(15) Airborne infection isolation rooms with separate washing and masking facilities shall be provided within the critical care unit. An isolation room shall contain at least two hundred (200) square feet (18.58 square meters) plus space for an anteroom. An anteroom shall be provided that is at least twenty (20) square feet (1.86 square meters) to accommodate washing, gowning, and storage. If the functional program requires, both airborne infection isolation rooms and protective environment rooms shall be provided as identified by the ICRA. If a toilet is provided, it shall be connected only to this room. If a toilet is not provided, a means shall be provided

within the room or anteroom for the disposal of the patient's body waste.

(16) The following additional service spaces shall be immediately available within each critical care unit. These may be shared by more than one critical care unit provided that direct access is available from each.

(A) Securable closets or cabinet compartments for the personal effects of nursing personnel, located in or near the nurse station. These shall be at least large enough for purses and billfolds. Coats may be stored in closets or cabinets on each floor or in a central staff locker area.

(B) Clean workroom or clean supply room. If the room is used for preparing patient care items, it shall, contain a work counter, a handwashing fixture, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile supply materials, the work counter and handwashing fixture may be omitted. Soiled and clean workrooms or holding rooms shall be separated and have no direct connection.

(C) Clean linen storage. There shall be a designated area for clean linen storage. This may be within the clean workroom, a separate closet, or an approved distribution system on each floor. If a closed cart system is used, storage may be in an alcove. It shall be out of the normal traffic flow and under staff control.

(D) Soiled workroom or soiled holding room. This room shall be separate from the clean workroom and shall have separate access doors. The soiled workroom shall contain a clinical sink or equivalent flushing-rim fixture. The room shall contain a lavatory or handwashing fixture. The fixtures shall both have a hot and cold mixing faucet. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter. If the flushing-rim clinical sink is eliminated, facilities for cleaning bedpans shall be provided elsewhere.

(E) Nourishment station. There shall be a nourishment station with sink, work counter, refrigerator, storage cabinets, and equipment for hot and cold nourishments between scheduled meals. The nourishment station shall include space for trays and dishes used for nonscheduled meal service. Provisions and space shall be included for separate temporary storage of unused and soiled dietary trays not picked up at meal time. Handwashing facilities shall be in, or immediately accessible from, the nourishment station.

(F) Ice machine. There shall be equipment to provide ice for treatments and nourishment. Ice-making equipment may be in the clean work room or at the nourishment station. Ice intended for human consumption shall be from a self-dispensing ice maker.

(G) Equipment storage room or alcove. Appropriate room(s) or alcove(s) shall be provided for storage of large items of equipment necessary for patient care. Each critical care unit shall provide sufficient storage area(s) located on the patient

floor to keep its required corridor width free of all equipment and supplies, but not less than 20 square feet (1.86 square meters) per bed shall be provided.

(H) An x-ray viewing facility shall be in the unit.

(I) Twenty-four (24) hour laboratory, radiology, and pharmacy services shall be available. These services may be provided from the central departments or from satellite facilities as required by the functional program.

(17) The following additional areas shall be provided and may be located outside the unit if conveniently accessible.

(A) A visitors waiting room shall be provided that is designed to accommodate long stays and stressful conditions, including provisions for privacy, means to facilitate communications, and access to the toilets. The locations and size shall be appropriate for the number of patients and units served, with a capacity for not less than one family member seating per patient bed.

(B) Adequate office space immediately adjacent to the critical care unit shall be available for critical care medical and nursing management/administrative personnel. The offices shall be large enough to permit consulting with members of the critical care team and visitors. The offices shall be linked with the unit by telephone or an intercommunications system.

(C) Staff lounge(s) and toilet(s) located so that staff can be recalled quickly to the patient area in emergencies. The lounge shall have telephone or intercom and emergency code alarm connections to the critical care unit it serves. If not provided elsewhere, storage of coats and personnel belongings, etc., shall be in this area. One lounge may serve adjacent critical care areas.

(D) A special procedures room shall be provided if required by the functional program.

(E) Sleeping and personal care accommodations for staff on twenty-four (24) hour, on-call work schedules.

(F) Multipurpose room(s) for staff, patients, patients' families, reports, education, training sessions, and consultation. These rooms shall be accessible to each nursing unit.

(G) A housekeeping room shall be provided within or immediately adjacent to the critical care unit. It shall not be shared with other nursing units or departments. It shall contain a service sink or floor receptor and provisions for storage of supplies and housekeeping equipment.

(H) Storage space for stretchers and wheelchairs shall be provided in a strategic location, without restricting normal traffic flow.

(c) **Coronary critical care unit.** In addition to the standards set forth in OAC 310:667-49-3(a), the following standards apply to a coronary critical care unit:

(1) Each patient shall have a separate room for acoustical and visual privacy.

(2) Each patient shall have access to a toilet in the room. Portable commodes may be used in lieu of individual toilets, but provisions shall be made for their storage, servicing, and odor control.

(3) Each unit shall include equipment for continuous monitoring, with visual displays for each patient at the bedside and at the nurse station. Monitors shall be located to permit easy viewing and access but not interfere with access to the patient.

(d) **Combined medical/surgical and cardiac critical care unit.** If medical, surgical, and cardiac critical care services are combined in one critical care unit, at least fifty (50) percent of the beds shall be located in private rooms or cubicles. Medical/surgical patients may utilize open areas or private rooms as needed and available but, insofar as possible, coronary patients shall not be accommodated in open ward areas.

(e) **Pediatric critical care.** If a facility has a pediatric critical care unit, the functional program shall include consideration for staffing, control, and the safe transportation of critically ill pediatric patients, along with life support and environmental systems, from other areas. In addition to the standards previously listed for critical care units, each pediatric critical care unit shall include:

(1) Space at each bedside for families and visitors in addition to the space provided for staff.

(2) Sleeping space for parents who may be required to spend long hours with the patient. This space may be separate from the patient area, but shall be in communication with the critical care unit staff.

(3) Consultation/demonstration room within, or convenient to, the pediatric critical care unit for private discussions.

(4) Provisions for formula storage. These may be outside the pediatric critical care unit but shall be available for use at all times.

(5) Separate storage cabinets or closets for toys and games for use by the pediatric patients.

(6) Additional storage for cots, bed linens, and other items needed to accommodate parents overnight.

(7) Space allowances for pediatric beds and cribs equal to those required for adult beds, because of the variations in sizes and the potential for change.

(8) Examination and treatment room(s) may be omitted if all rooms in the unit are single-bed patient rooms. Centrally located examination and treatment room(s) may serve more than one (1) floor and/or nursing unit. An examination and treatment room shall have at least one hundred-twenty (120) square feet (11.15 square meters) of floor area. The room shall contain a handwashing fixture; storage facilities; and a desk, counter, or shelf space for writing.

(9) At least one (1) airborne infection room shall be provided, with provisions for observation of the patient. The total number of airborne infection control rooms shall be increased based upon an ICRA. All room(s) shall comply with the requirements of OAC 310:667-49-2(a)(3).

(f) **Newborn intensive care unit.** A newborn intensive care unit shall include or comply with the following:

(1) The NICU shall have a clearly identified entrance and reception area for families. The area shall permit visual observation and contact with all traffic entering the unit.

(2) A scrub/gowning area shall be provided at the entrance of each nursery but separated from the work area. The scrub/gowning area shall contain a sink and separate storage facilities for clean and soiled gowns. In a multiple-bed room, every bed position shall be within 20 feet (6 meters) of a hands-free handwashing station. Where an individual room concept is used, a hands-free handwashing station shall be provided within each infant care room. All sinks throughout the nursing area(s) shall be hands-free operable. One (1) scrub/gowning area may serve more than one (1) room.
(3) At least one (1) door to each room in the unit shall be large enough to accommodate portable x-ray equipment. A door 44 inches (1117.6 millimeters) wide should accommodate most X-Ray equipment. Both width and height shall be considered.
(4) There shall be efficient and controlled access to the unit from the labor and delivery area, the emergency room or other referral entry points.
(5) When viewing windows are provided, provision shall be made to control casual viewing of infants.
(6) As possible, supplies shall flow through special supply entrances from external corridors so that penetration of the semi-sterile zone by non-nursery personnel is unnecessary. Soiled materials shall be sealed and stored in a soiled holding area until removed. This holding area shall be located where there shall be no need to pass back through the semi-sterile zone to remove the soiled materials.
(7) Provisions shall be made for indirect lighting and high-intensity lighting in all nurseries. Controls shall be provided to enable lighting to be adjusted over individual patient care spaces. Darkening sufficient for transillumination shall be available when necessary.
(8) In the interest of noise control, sound attenuation shall be a design factor.
(9) A central area shall serve as a control station, shall have space for counters and storage, and shall have convenient access to handwashing facilities. It may be combined with or include centers for reception and communication and patient monitoring. The station shall permit visual observation of all traffic entering the unit.
(10) Each patient care space shall contain a minimum of 120 square feet (11.2 square meters) per bassinet excluding sinks and aisles. There shall be an aisle for circulation adjacent to each patient care space with a minimum width of 3 feet (0.91 meter). Each infant care space shall be designed to allow privacy for the baby and family.
(11) An airborne infection isolation room is required in at least (1) one level of nursery care. The airborne infection isolation nursery shall be an enclosed and separate room within the nursery unit with provision for observation of the infant from adjacent nurseries or control area. This nursery shall be served by an anteroom that contains sink and separate storage facilities for clean and soiled materials and gowns. Oxygen, suction, and medical air systems outlet requirements are specified in Appendix B.
(12) Ceilings shall be easily cleanable and nonfriable and shall have a noise reduction coefficient (NRC) of at least 0.90. Ceiling

construction shall limit passage of particles from above the ceiling plane into the clinical environment.
(13) The NICU shall be designed as part of an overall safety program to protect the physical security of infants, parents, and staff and to minimize the risk of infant abduction.
(14) Support space shall be accessible for respiratory therapy, social work, laboratory, pharmacy, radiology, and other ancillary services when these activities are routinely performed on the unit.
(15) Physician's sleeping facilities with access to a toilet and shower shall be provided. If not contained within the unit itself, the area shall have a telephone or intercom connection to the patient care area.
(16) A room(s) shall be provided within the NICU that allow(s) parents and infants extended private time together. The room(s) shall have direct, private access to handwashing station and toilet facilities, communication linkage with the NICU staff, sleeping facilities for a least one parent, and sufficient space for the infant's bed and equipment. These rooms can be used for other purposes when they are not required for family use.
(17) Dedicated space shall be provided for lactation support and consultation in or immediately adjacent to the NICU. Provision shall be made, either within the room or conveniently located nearby, for sink, counter, refrigeration and freezing, storage for pump and attachments, and educational materials.
(18) Charting facilities shall have adequate linear surface space to ensure that staff and physicians may chart and have simultaneous access to information and communication systems.
(19) Medication station. See OAC 310:667-49-3(b)(13).
(20) Clean workroom and clean supply room. See OAC 310:667-49-3(b)(16)(B).
(21) Soiled workroom and soiled holding room. See OAC 310:667-49-3(b)(16(D).
(22) Provide a lounge, locker room, and staff toilet within or adjacent to the unit suite for staff use.
(23) Emergency equipment storage. Space shall be provided for emergency equipment that is under direct control of the nursing staff, such as a CPR cart. This space shall be located in an area appropriate to the functional program, but out of the normal traffic.
(24) Housekeeping room. One housekeeping room shall be provided for the unit. It shall be directly accessible from the unit and be dedicated for the exclusive use of the neonatal critical care unit. It shall contain a service sink or floor receptor and provisions for storage of supplies and housekeeping equipment.
(25) Space should be provided for the following:
(A) A visitors' waiting room. See OAC 310:667-49-3(b)(17)(A).
(B) Nurses/supervisors office or station. See OAC 310:667-49-3(b)(17)(B).
(C) Multipurpose room(s) for staff, patients, and patients' families for patient conferences, reports, education, training sessions, and consultation. These rooms must be accessible to each nursing units and/or other departments.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-4. Nurseries**

(a) **Requirement.** All newborn nurseries, other than pediatric nurseries shall be convenient to the postpartum nursing unit and obstetrical facilities. The nurseries shall be located and arranged to preclude the need for unrelated pedestrian traffic. No nursery shall open directly onto another nursery.

(b) **General.** Each nursery shall contain:

(1) At least one (1) lavatory, equipped with handwashing controls that can be operated without use of hands, for each eight (8) infant stations.

(2) Nurse emergency call system, for summoning assistance without leaving the patient area. The system shall be provided in accordance with OAC 310:667-49-32(g).

(3) Glazed observation windows to permit the viewing of infants from public areas, workrooms, and adjacent nurseries.

(4) Convenient, accessible storage for linens and infant supplies at each nursery room.

(5) A consultation, demonstration, breast feeding and pump room shall be provided convenient to the nursery. Provisions shall be made, either within the room or conveniently located nearby, for sink, counter, refrigeration and freezing, storage for pump and attachments, and educational materials. The area provided for the unit for these purposes, when conveniently located, may be shared with other nurseries.

(6) Adequate space shall be provided for parents to stay twenty-four (24) hours.

(7) An airborne infection isolation room is required in or near at least one level of nursery care. The room shall be enclosed and separate the infant from adjacent nurseries or control area(s). All airborne infection isolation rooms shall comply with the requirements of OAC 310:667-49-2(a)(3), except for separate toilet, bathtub, or shower.

(8) Each nursery room shall be served by a connecting workroom. The workroom shall contain scrubbing and gowning facilities at the entrance for staff and housekeeping personnel, work counter, refrigerator, storage for supplies, and handwashing fixture. One (1) workroom may serve more than one (1) nursery room provided that required services are convenient to each. The workroom serving the full-term and continuing care nurseries may be omitted if equivalent work and storage areas and facilities, including those for scrubbing and gowning, are provided within that nursery. Space required for work areas located within the nursery is in addition to the area required for infant care.

(9) Adequate provisions shall be made for storage of emergency cart(s) and equipment out of traffic and for the sanitary storage and disposal of soiled waste.

(10) Neonate examination and treatment areas. Such areas, when required by the functional program, shall contain a work counter,

storage facilities, and a handwashing station.

(11) Where infant formula is prepared on-site, direct access from the formula preparation room to any nursery room is prohibited. The room may be located near the nursery or at other appropriate locations in the hospital, but shall include:

(A) Cleanup facilities for washing and sterilizing supplies including a handwashing fixture, facilities for bottle washing, a work counter, and sterilization equipment.

(B) A separate room for preparing infant formula that contains warming facilities, refrigerator, work counter, formula sterilizer, storage facilities, and a handwashing fixture.

(C) Refrigerated storage and warming facilities for infant formula accessible for use by nursery personnel at all hours.

(12) If commercial neonate formula is used, the separate clean-up and preparation rooms may be omitted. The storage and handling may be done in the nursery workroom or in another appropriate room in the hospital that is conveniently accessible at all hours. The preparation area shall have a work counter, a sink equipped for handwashing, and storage facilities.

(13) A housekeeping/environmental services room shall be provided for the exclusive use of the nursery unit. It shall be directly accessible from the unit and shall contain a service sink or floor receptor and provide for storage of supplies and housekeeping equipment.

(c) **Newborn nursery.**

(1) Each newborn nursery shall contain no more than 16 infant stations. The minimum floor space shall be 24 square feet (2.23 square feet) per bassinet, exclusive of auxiliary work areas. When a rooming-in program is used, the total number of bassinets provided may be appropriately reduced, but the newborn nursery shall not be omitted in its entirety from any facility that includes delivery services. When facilities use a rooming-in program, the size of the nursery shall not be reduced if all the infants are returned to the nursery at night.

(2) The traditional nursery may be replaced with baby holding nurseries in postpartum and labor-delivery-recovery-postpartum (LDRP) units. The minimum floor area per bassinet, ventilation, electrical, and medical vacuum and gasses shall be the same as that required for a full-term nursery.

(A) These holding nurseries shall be located next to the nurse’s station on these units.

(B) The holding nursery shall be sized to accommodate the percentage of newborns who do not remain with their mothers in the postpartum stay.

(d) **Continuing care nursery.** For hospitals providing continuing care for infants requiring close observation as part of the functional program, (for example, low birth-weight babies who are not ill but require more hours of nursing than do normal neonates) the minimum floor space shall be 50 square feet (4.65 square meters) per bassinet, exclusive of auxiliary work areas, with provisions for at least 4 feet (1.22 meters) between and on all sides of each bassinet.

(e) **Pediatric nursery.** To minimize the possibility of cross infection,

each nursery room serving pediatric patients shall contain no more than (8) bassinets; each bassinet shall have a minimum clear floor area of (40) square feet (3.72 square meters). Each room shall contain a lavatory equipped for hands-free handwashing, a nurse's emergency calling system, and a glazed viewing window for observing infants from public areas and workrooms. The limitation on number of patients in a nursery room does not apply to the pediatric critical care unit.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-5. Pediatric and adolescent unit**

(a) **General.** Young children and adolescents shall be housed in a nursing unit separate from adults.

(b) **Patient rooms.** Each patient room shall meet the following standards:

(1) Maximum room capacity shall be four (4) patients.

(2) The space requirements for pediatric patient beds are the same as for adult beds. Additional provisions for hygiene, toilets, sleeping, and personal belongings shall be included where the functional program indicates that parents shall be allowed to remain with young children. Existing crib areas with at least sixty (60) square feet (5.57 square meters) of clear area for each crib and no more than six (6) cribs or beds in a room may continue to be used if the use complies with the functional program. OAC 310:667-49-3(e) and OAC 310:667-49-4 specify requirements for a pediatric critical care unit and a newborn nursery.

(3) In new construction, patient rooms shall have at least one hundred (100) square feet (9.29 square meters) of clear floor area per bed in multiple-bed rooms and one hundred-twenty (120) square feet (11.15 square meters) of clear floor area for single-bed rooms, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules. The dimensions and arrangement of rooms shall be such that there is at least three (3) feet (0.91 meter) between the sides and foot of the bed and any wall, other fixed obstruction, or another bed. In multiple-bed rooms, a clearance of four (4) feet (1.22 meters) shall be available at the foot of each bed to permit the passage of equipment and beds. Minor encroachments, including columns and lavatories, that do not interfere with functions may be ignored when determining space requirements for patient rooms. Where renovation work is undertaken, patient rooms shall have at least of eighty (80) square feet (7.43 square meters) of clear floor area per bed in multiple-bed areas and at least one hundred (100) square feet (9.29 square meters) of clear floor area in single-bed rooms.

(4) Each patient room shall have access to a window in accordance with OAC 310:667-49-28(b)(1)(J).

(c) **Examination/treatment rooms.** This room shall be provided for pediatric and adolescent patients. A separate area for infant examination and treatment may be provided within the pediatric nursery workroom. Examination/treatment rooms shall be at least one hundred-twenty (120) square feet (11.15 square meters). The room shall contain

a handwashing station; storage facilities; and a desk, counter, or shelf space for writing.

(d) **Service areas.** The service areas in the pediatric and adolescent nursing units shall conform to OAC 310:667-49-2(a)(2) and shall also meet the following standards:

(1) Multipurpose or individual room(s) shall be provided for dining, education, and recreation. Insulation, isolation, and structural provisions shall minimize the transmission of impact noise through the floor, walls, or ceiling of these multipurpose room(s).

(2) Space for preparation and storage of infant formula shall be provided within the unit or other convenient location with twenty-four (24) hour access. Provisions shall be made for continuation of special formula that may have been prescribed for the infant prior to admission or readmission.

(3) Patient toilet room(s), in addition to those serving bed areas, shall be conveniently located to multipurpose room(s) and to each central bathing facility.

(4) Storage closets or cabinets for toys and educational and recreational equipment shall be provided.

(5) Storage space shall be provided to permit exchange of cribs and adult beds. Provisions shall also be made for storage of equipment and supplies including cots or recliners, extra linen, etc. for parents who may remain with the patient overnight.

(6) At least one (1) room for airborne infection isolation shall be provided in each pediatric unit as described in OAC 310:667-49-2(a)(3).

(7) Separate clean and soiled workrooms or holding rooms shall be provided as described in OAC 310:667-49-2(a)(2)(K) & (L).

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-6. Psychiatric nursing unit**

(a) When part of a general hospital, these units shall be designed for the care of inpatients. Non-ambulatory inpatients may be treated in a medical unit until their medical condition allows for transfer to the psychiatric nursing unit. Psychiatric care in a medical unit shall meet requirements at OAC 310:667-49-2(a)(5). Provisions shall be made in the design for adapting the area for various types of psychiatric therapies.

(b) The environment of the unit shall be characterized by a feeling of openness with emphasis on natural light and exterior views. Various functions shall be accessible from common areas while not compromising desirable levels of patient privacy. Interior finishes, lighting, and furnishings shall suggest a residential rather than an institutional setting. These shall, however, conform with applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients.

Where glass fragments pose a hazard to certain patients, safety glazing and/or other appropriate security features shall be used.

(c) Details of such facilities shall be as described in the approved functional program. Each nursing unit shall provide the following:

(1) **Patient rooms.** The standard noted in OAC 310:667-49-2(a)(1) shall apply to patient rooms in a psychiatric nursing unit except as follows:

(A) A nurse call system is not required, but if it is included, provisions shall be made for easy removal, or for covering call button outlets.

(B) Bedpan-flushing devices may be omitted from patient room toilets.

(C) Handwashing stations are not required in patient rooms.

(D) Visual privacy in multi-bed rooms; e.g., cubicle curtains, is not required.

(E) The ceiling and the air distribution devices, lighting fixtures, sprinkler heads, and other appurtenances shall be of the tamper-resistant type.

(F) Each patient room shall be provided with a private toilet that meets the following requirements:

(i) The door shall not be lockable from within.

(ii) The door shall be capable of swinging outward.

(iii) The ceiling shall be of tamper-resistant construction and the air distribution devices, lighting fixtures, sprinkler heads, and other appurtenances shall be of the tamper-resistant type.

(2) **Service areas.** The standards noted in OAC 310:667-49-2(a)(2) shall apply to service areas for a psychiatric nursing unit with the following modifications:

(A) A secured storage area shall be provided for patient belongings that are determined to be potentially harmful (e.g., razors, nail files, cigarette lighters) this area shall be controlled by staff.

(B) The medication station shall include provisions for security against unauthorized access.

(C) Food service within the unit may be one, or a combination, of the following:

(i) A nourishment station.

(ii) A kitchenette designed for patient use with staff control of heating and cooking devices.

(iii) A kitchen service within the unit including a handwashing station, storage space, refrigerator, and facilities for meal preparation.

(D) Storage space for stretchers and wheelchairs may be outside the psychiatric unit, provided that provisions are made for convenient access as needed for disabled patients.

(E) In a psychiatric nursing unit, a bathtub or shower shall be provided for each six (6) beds not otherwise served by bathing facilities within the patient rooms. Bathing facilities shall be designed and located for patient convenience and privacy.

(F) A separate charting area shall be provided with provisions for acoustical privacy. A viewing window to permit observation of patient areas by the charting nurse or physician may be used if the arrangement is such that patient files cannot be read from outside the charting space.

(G) At least two (2) separate social spaces, one (1) appropriate

for noisy activities and one (1) for quiet activities, shall be provided. The combined area shall be at least forty (40) square feet (3.72 square meters) per patient with at least one hundred-twenty (120) square feet (11.15 square meters) for each of the two (2) spaces. This space may be shared by dining activities.

(H) Space for group therapy shall be provided. This may be combined with the quiet space noted above when the unit accommodates not more than twelve (12) patients, and when at least two hundred twenty-five (225) square feet (20.90 square meters) of enclosed private space is available for group therapy activities.

(I) Patient laundry facilities with an automatic washer and dryer shall be provided.

(3) The following elements shall also be provided, but may be either within the psychiatric unit or immediately accessible to it unless otherwise dictated by the program:

(A) Room(s) for examination and treatment with a least one hundred-twenty (120) square feet (11.15 square meters). Examination and treatment room(s) for medical-surgical patients may be shared by the psychiatric unit patients. These may be on a different floor if conveniently accessible.

(B) Separate consultation room(s) with at least one hundred (100) square feet (9.29 square meters) each, provided at a room-to-bed ratio of one consultation room for each twelve (12) psychiatric beds. The room(s) shall be designed for acoustical and visual privacy and constructed to achieve a noise reduction of at least forty-five (45) decibels.

(C) Psychiatric units each containing at least fifteen (15) square feet (1.39 square meters) of separate space per patient for occupational therapy, with a total area of at least two hundred (200) square feet (18.58 square meters), whichever is greater. Space shall include provision for handwashing, work counter(s), storage, and displays. Occupational therapy areas may serve more than one (1) nursing unit. When a psychiatric nursing unit contains less than twelve (12) beds, the occupational therapy functions may be performed in the noisy activities area, if at least an additional ten (10) square feet (0.93 square meter) per patient served is included.

(D) A conference and treatment planning room for use by the psychiatric unit.

(4) **Isolation room.** The standards of OAC 310:667-49-2(a)(3) for isolation rooms do not apply to a psychiatric nursing unit. Psychiatric beds shall not be included in the bed count ratio to establish the number of beds required for medical airborne infection isolation.

(5) **Seclusion treatment room.** There shall be at least one (1) seclusion room for up to twenty-four (24) beds or a major fraction thereof. If a facility has more than one (1) psychiatric nursing unit, the number of seclusion rooms shall be a function of the total number of psychiatric beds in the facility. Seclusion rooms may be grouped together.

(A) The seclusion treatment room is intended for short-term occupancy by a violent or suicidal patient. Within the

psychiatric nursing unit, this space provides for patients requiring security and protection. The room(s) shall be located for direct nursing staff supervision. Each room shall be for only one (1) patient.

(B) The seclusion treatment room shall have an area of at least sixty (60) square feet (5.57 square meters) and shall be constructed to prevent patient hiding, escape, injury, or suicide. Where restraint beds are required by the functional program, at least eighty (80) square feet (7.43 square meters) shall be required.

(C) Special fixtures and hardware for electrical circuits shall be used.

(D) The ceiling height shall be at least nine (9) feet (2.74 meters).

(E) Doors shall be at least three (3) feet eight (8) inches (1.12 meters) wide, and shall permit staff observation of the patient while also maintaining provisions for patient privacy.

(F) Seclusion treatment rooms shall be accessed by an anteroom or vestibule that also provides direct access to a toilet room. The toilet room and anteroom shall be large enough to safely manage the patient.

(G) Where the interior of the seclusion treatment room is padded with combustible materials, these materials shall be of a type acceptable to the local authority having jurisdiction.

(H) The room area, including floor, walls, ceilings, and all openings shall be protected with not less than one-hour-rated construction.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-7. Surgical suite**

(a) The number of operating rooms and recovery beds and the sizes of the service areas shall be based on the expected surgical workload. The surgical suite shall be located and arranged to prevent non-related traffic through the suite. Requirements for details, ventilation, and electrical standards at OAC 310:667-49-28, OAC 310:667-49-31, and OAC 310:667-49-32 shall be met.

(b) When bronchoscopy is performed on persons who are known or suspected of having pulmonary tuberculosis, the procedure room shall meet the airborne infection isolation room ventilation requirements.

(c) When invasive procedures are performed on persons who are known or suspected of having airborne infectious disease, these procedures should not be performed in the operating suite. They shall be performed in a room meeting airborne infection isolation ventilation requirements or in a space using local exhaust ventilation. If the procedure must be performed in the operating suite, see the "CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities."

(d) Additions to, and adaptations of, the following elements shall be made for the special-procedure operating rooms found in larger

hospitals.

(e) The following shall be provided:

(1) **Surgery.**

(A) The clinical practice setting shall be designed to facilitate movement of patients and personnel into, through, and out of defined areas within the surgical suite. Signs shall clearly indicate the surgical attire required.

(B) The surgical suite shall be divided into three designated areas, unrestricted; semirestricted; and restricted, that are defined by the physical activities performed in each area.

(i) The unrestricted area includes a central control point established to monitor the entrance of patients, personnel, and materials. Street clothes are permitted in this area, and traffic is not limited.

(ii) The semirestricted area includes peripheral support areas of the surgical suite and has storage areas for clean and sterile supplies, work areas for storage and processing of instruments, and corridors leading to the restricted areas of the surgical suite. Traffic in this area is limited to authorized personnel and patients. Personnel are required to wear surgical attire and cover all head and facial hair.

(iii) The restricted area includes operating and procedure rooms, the clean core and scrub sink areas. Surgical masks and hair coverings are required. Masks are required where open sterile supplies or scrubbed persons may be located.

(C) In new construction, each general operating room shall have at least four hundred (400) square feet (37.16 square meters) of clear area exclusive of fixed or wall-mounted cabinets and built-in shelves, with at least twenty (20) feet (6.10 meters) clear dimension between fixed cabinets and built-in shelves; and a system for emergency communication with the surgical suite control station. X-ray film illuminators for handling at least four (4) films simultaneously shall be provided. In renovation projects, each room shall have at least three hundred-sixty (360) square feet (33.45 square meters) of clear area, exclusive of fixed or wall-mounted cabinets and built-in shelves, with at least eighteen (18) feet (5.49 meters) of clear dimension between fixed cabinets and built-in shelves. For renovation projects, the requirements at OAC 310:667-49-7(e)(1)(F) shall apply.

(D) Room(s) for cardiovascular, orthopedic, neurological, and other special procedures require additional personnel and/or large equipment. When included, these rooms shall have, in addition to the above, at least six hundred (600) square feet (55.74 square meters) of clear area, with at least twenty (20) feet (6.10 meters) clear dimension exclusive of fixed or wall-mounted cabinets and built-in shelves. When open-heart surgery is performed, an additional room in the restricted area of the surgical suite, preferably adjoining this operating room, shall be designated as a pump room where extra corporeal pump(s), supplies and accessories are stored and serviced. Where complex orthopedic and neurosurgical surgery is performed, additional rooms shall be in the restricted area of the surgical suite, preferably adjoining

the specialty operating rooms, which shall be designated as equipment storage rooms for the large equipment used to support these procedures. Appropriate plumbing and electrical connections shall be provided in the cardiovascular, orthopedic, neurosurgical, pump, and storage rooms. In renovation projects, orthopedic surgical rooms shall have at least three hundred-sixty (360) square feet (33.5 square meters) of clear area and at least eighteen (18) feet (5 meters) of dimension. Rooms for cardiovascular, neurological, and other special procedures shall have at least four hundred (400) square feet (44.39 square meters) of clear area.

(E) When rooms for orthopedic surgery are included, these rooms shall, in addition to the above, have enclosed storage space for splints and traction equipment. Storage may be outside the operating room but shall be conveniently located. If a sink is used for the disposal of plaster of paris, a plaster trap shall be provided.

(F) Room(s) for surgical cystoscopic and other endo-urologic procedures shall have at least three hundred-fifty (350) square feet (32.52 square meters) of clear area exclusive of fixed or wall-mounted cabinets and built-in shelves with at least fifteen (15) feet (4.57 meters) of clear dimension between fixed cabinets and built-in shelves. X-ray viewing capability to accommodate at least (4) four films simultaneously shall be provided. In renovation projects, rooms for surgical cystoscopy shall have at least two hundred-fifty (250) square feet (23.28 square meters) of clear area.

(G) An endoscopy suite shall meet requirements at OAC 310:667-49-35.

(H) The functional program may require additional clear space, plumbing, and mechanical facilities to accommodate special functions in one or more of these rooms. When existing functioning operating rooms are modified, and it is impractical to increase the square foot area because of walls or structural members, the operating room may continue in use when requested by the hospital.

(2) **Post-anesthetic care unit (PACU).**

(A) Each PACU shall contain a medication station; handwashing facilities; nurse station with charting facilities; clinical sink; provisions for bedpan cleaning; and storage space for stretchers, supplies, and equipment.

(B) The design shall provide at least eighty (80) square feet for each patient bed with space for additional equipment described in the functional program, and for clearance of at least five (5) feet (1.52 meters) between patient beds and four (4) feet (1.22 meters) between patient bedsides and adjacent walls.

(C) Provisions shall be made for the isolation of infectious patients. An airborne infection isolation room is not required in a PACU. Provisions for the recovery of a potentially infectious patient with an airborne infection shall be determined by the ICRA.

(D) Provisions for patient privacy such as cubicle curtains shall be made.

(E) In new construction, at least one (1) door to the recovery room shall access directly from the surgical suite without crossing public hospital corridors.

(F) Separate and additional recovery space may be necessary to accommodate surgical outpatients and pediatric patients.

(G) A staff toilet shall be located within the working area to maintain staff availability to patients.

(H) Handwashing sinks with foot or elbow controls shall be available in sufficient number, at least one (1) for every four (4) beds uniformly distributed to provide equal access from each patient bed.

(3) **Service areas.** Services, except for the enclosed soiled workroom mentioned in item OAC 310:667-49-7(c)(3)(F) and the housekeeping room in item OAC 310:667-49-7(c)(3)(T), may be shared with the obstetrical facilities if the functional program reflects this concept. Service areas, when shared with delivery rooms, shall be designed to avoid the passing of patients or staff between the operating room and the delivery room areas. The following services shall be provided:

(A) A control station located to permit visual observation of all traffic into the suite.

(B) A supervisor's office or station. The number of offices, stations, and teaching areas in the surgical suite shall depend upon the functional program.

(C) A substerile area acts as a service area between two or more operating or procedure rooms and shall be equipped with a flash sterilizer, warming cabinet, sterile supply storage area, and handwashing station with hands-free controls. Sterilizing facilities with high-speed sterilizer(s) or other sterilizing equipment for immediate or emergency use shall be grouped to several operating rooms for convenient, efficient use. A work space and handwashing facility may be included. Other facilities for processing and sterilizing reusable instruments, etc., may be located in another hospital department such as central services.

(D) Medication station. Provision shall be made for storage and distribution of drugs and routine medications. This may be done from a medicine preparation room or unit, from a self-contained medicine dispensing unit, or by another system. If used, a medicine preparation room or unit shall be under visual control of the nursing staff. It shall contain a work counter, sink, refrigerator, and double-locked storage for controlled substances. Convenient access to handwashing facilities shall be provided. The standard cup-sinks provided in many self-contained units are not adequate.

(E) Scrub facilities. Two (2) scrub positions shall be provided near the entrance to each operating room. Two (2) scrub positions may serve two (2) operating rooms if both are located adjacent to the entrance of each operating room. Scrub facilities shall be arranged to minimize incidental splatter on nearby personnel, medical equipment, or supply carts. In new construction, view windows at scrub stations permitting observation of operating room interiors shall be provided. The scrub sinks shall be recessed

into an alcove out of the main traffic areas. The alcove shall be located off the semirestricted or restricted areas of the surgical suite. Scrub sinks shall be located outside the sterile core.

(F) An enclosed soiled workroom or soiled holding room that is part of a system for the collection and disposal of soiled material for the exclusive use of the surgical suite shall be provided. It shall be located in the restricted area. The soiled workroom shall contain a flushing-rim clinical sink or equivalent flushing-rim fixture, a handwashing fixture, a work counter, and space for waste receptacles and soiled linen receptacles. Rooms used only for temporary holding of soiled material may omit the flushing-rim clinical sink and work counters. However, if the flushing-rim clinical sink is omitted, other provisions for disposal of liquid waste shall be provided. The room shall not have a direct connection with operating rooms or other sterile activity rooms. Soiled and clean workrooms or holding rooms shall be separated.

(G) Clean workroom or clean supply room. A clean workroom is required when clean materials are assembled within the surgical suite prior to use or following the decontamination cycle. It shall contain a work counter, a handwashing fixture, storage facilities for clean supplies, and a space to package reusable items. The storage for sterile supplies shall be separated from this space. If the room is used only for storage and holding as part of a system for distribution of clean and sterile supply materials, the work counter and handwashing fixture may be omitted. Soiled and clean workrooms or holding rooms shall be separated. Clean workrooms shall not be used for food preparation.

(H) Storage space for sterile and clean supplies shall be adequate for the functional plan. The space shall be moisture and temperature controlled and free from cross traffic. An operating room suite design with a sterile core shall provide for no cross traffic of staff and supplies from the decontaminated/soiled areas to the sterile/clean areas. The use of facilities outside the operating room for soiled/decontaminated processing and clean assembly and sterile processing shall be designed to move the flow of goods and personnel from dirty to clean/sterile without compromising standard precautions or aseptic techniques in both departments.

(I) Medical gas storage facilities. Flammable anesthetics, if used, shall be stored in a separate room in accordance with OAC 310:667-49-29. Main storage of medical gases may be outside or inside the facility. Provision shall be made for additional separate storage of reserve gas cylinders necessary to complete at least one (1) day's procedures.

(J) The anesthesia workroom for cleaning, testing, and storing anesthesia equipment shall contain work counter(s) and sink(s) and racks for cylinders. Provisions shall be made for separate storage of clean and soiled items. In new construction, depending on the functional and space programs, the anesthesia workroom should provide space for anesthesia case carts and other

anesthesia equipment.

(K) Equipment storage room(s) for equipment and supplies used in surgical suite. Each surgical suite shall provide sufficient storage area to keep its required corridor width free of equipment and supplies, but not less than (150) square feet (13.94 square meters) or (50) square feet (4.65 square meters) per operating room, whichever is the greater.

(L) Clothing change areas. Appropriate areas shall be provided for male and female staff (orderlies, technicians, nurses, and doctors) working within the surgical suite. The areas shall contain lockers, showers, toilets, lavatories equipped for handwashing, and space for donning scrub suits and booties. These areas shall be arranged to allow a one-way traffic pattern so that personnel entering from outside the surgical suite can change clothing and move directly into the surgical suite.

(M) Staff lounge and toilet facilities. Separate or combined lounges for male and female staff shall be provided. Lounge(s) shall be designed to minimize the need to leave the suite and provide convenient access to the recovery room.

(N) Dictation and report preparation area. This may be accessible from the lounge area.

(O) Phase II Recovery.

(i) Where outpatient surgeries are to be part of the surgical suite, and where outpatients receive Class B or Class C sedation, a Phase II or step-down recovery shall be provided. This requirement shall be satisfied by separate rooms.

(ii) The room shall contain handwashing stations, a nurse’s station with charting facilities, clinical sink, provision for bedpan cleaning, and storage space for supplies and equipment.

(iii) The design shall provide a minimum (50) square feet (4.65 square meters) for each patient in a lounge chair with space for additional equipment described in the functional program and for clearance of (4) feet (1.22 meters) between the sides of the lounge chairs and the foot of the lounge chairs.

(iv) Provisions shall be made for the isolation of infectious patients.

(v) Provisions for patient privacy such as cubicle curtains are required.

(vi) A patient toilet shall be provided with direct access to the Phase II recovery unit for the exclusive use of patients.

(vii) A staff toilet shall be provided with direct access to the working area to maintain staff availability to patients.

(viii) Handwashing stations with hands-free operable controls shall be available with at least one for every four lounge chairs uniformly distributed to provide equal access from each patient bed.

(P) Outpatient surgery change areas. If the functional program defines outpatient surgery as part of the surgical suite, a separate area shall be provided where outpatients may change from street clothing into hospital gowns and be prepared for surgery. This includes locker(s), toilet(s), and clothing change or gowning area. Changing may also be accommodated in a private

holding room or cubicle.

(Q) Provisions shall be made for patient examination, interviews, preparation, testing, and obtaining vital signs of patients for outpatient surgery.

(R) Patient holding area. In facilities with two (2) or more operating rooms, an area shall be provided to accommodate stretcher patients waiting for surgery. This holding area shall be under the visual control of the nursing staff.

(S) Storage areas for portable X-ray equipment, stretchers, fracture tables, warming devices, auxiliary lamps, etc shall be provided. These areas shall be out of corridors and traffic.

(T) Housekeeping facilities. Housekeeping facilities shall be provided for the exclusive use of the surgical suite. It shall be directly accessible from the suite and shall contain a service sink or floor receptor and provisions for storage of supplies and housekeeping equipment.

(U) Area for preparation and examination of frozen sections. This may be part of the general laboratory if immediate results are obtainable without unnecessary delay in the completion of surgery.

(V) Ice machine. An ice machine shall be provided to provide ice for treatments and patient use. Ice intended for human consumption shall be from a self-dispensing ice maker.

(W) Provisions for refrigerated blood bank storage that meets the standards of the American Blood Banking Association.

(X) Where applicable, appropriate provisions for refrigeration facilities for harvested organs.

(Y) Provisions for pathological specimens storage prior to transfer to pathology laboratory.

(Z) Separate outpatient surgical units shall comply with the requirements of OAC 310:667-49-34

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-8. Obstetrical services**

(a) **General.** The obstetrical unit shall be located and designed to prohibit non-related traffic through the unit. When delivery and operating rooms are in the same suite, access and service arrangements shall be such that neither staff nor patients need to travel through one area to reach the other. Except as permitted otherwise, existing facilities being renovated shall, as far as practicable, provide all the required support services. A newborn nursery is required and shall comply with OAC 310:667-49-4.

(b) **Postpartum unit.**

(1) A postpartum bedroom shall have at least one hundred (100) square feet (9.29 square meters) of clear floor area per bed in multi-bed rooms and at least one hundred-twenty (120) square feet (11.15 square meters) of clear floor area in single-bed rooms. These areas shall be exclusive of toilet rooms, closets, alcoves, or vestibules. Where renovation work is undertaken, every effort shall

be made to meet the size standard for new construction. If it is not possible to comply, the Department may approve deviating from this requirement. In such cases, existing postpartum patient rooms shall have at least eighty (80) square feet (7.43 square meters) of clear floor area per bed a in multiple-bed room and one hundred (100) square feet (9.29 square meters) in a single-bed room.

(2) In multi-bed rooms there shall be at least four (4) feet (1.22 meters) of clear distance between the foot of the bed and the opposite wall, three (3) feet (0.91 meter) between the side of the bed and the nearest wall, and four (4) feet (1.22 meters) between beds.

(3) The maximum number of beds per room shall be two (2). In new construction, the maximum room capacity shall be two (2) patients. Where renovation work is undertaken and the present capacity is four (4) patients, maximum room capacity shall be four (4) patients.

(4) Each patient bedroom shall have a window or windows.

(5) Each patient room shall have a nurse call system for two-way voice communication.

(6) Handwashing facilities shall be provided in each patient bedroom. In multi-bed rooms the handwashing sink shall be located outside of the patients' cubical curtains so that it is accessible to staff.

(7) Each patient shall have access to a toilet room or bathroom with handwashing stations without entering a general corridor. One (1) such room shall serve no more than two (2) beds and no more than two (2) patient rooms.

(8) Support services. The following support services for this unit shall be provided.

(A) A nurse station.

(B) A nurse office.

(C) Charting facilities.

(D) Toilet room for staff.

(E) Staff lounge.

(F) Lockable closets or cabinets for personal articles of staff.

(G) Consultation/conference room(s).

(H) Patients' lounge. The patients' lounge may be omitted if all rooms are single-bed rooms.

(I) Clean workroom or clean supply room. A clean workroom is required if clean materials are assembled within the obstetrical suite prior to use. It shall contain a work counter, a handwashing fixture, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile supply materials, the work counter and handwashing fixtures may be omitted. Soiled and clean workrooms or holding rooms shall be separated and have no direct connection.

(J) Soiled workroom or soiled holding room for the exclusive use of the obstetrical suite. This room shall be separate from the clean workroom and shall have separate access doors. The soiled workroom shall contain a clinical sink or equivalent flushing-rim fixture and a handwashing fixture. These fixtures shall both have a hot and cold mixing faucet. The room shall have a work counter

and space covered containers for soiled linen and waste. Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter if the flushing-rim clinical sink is omitted. Facilities for cleaning bedpans shall be provided elsewhere.

(K) Medication station. Provision shall be made for storage and distribution of drugs and routine medications. This may be done from a medicine preparation room or unit, from a self-contained medicine dispensing unit, or by another system. If used, a medicine preparation room or unit shall be under visual control of the nursing staff. It shall contain a work counter, sink, refrigerator, and double-locked storage for controlled substances. Convenient access to handwashing facilities shall be provided. Standard cupsinks provided in many self-contained units are not adequate for handwashing.

(L) Clean linen storage shall be provided. Clean linen storage may be part of a clean workroom or a separate closet. When a closed cart system is used, the cart may be stored in an alcove out of the path of normal traffic.

(M) Nourishment station shall contain sink, work counter, ice dispenser, refrigerator, cabinets, and equipment for serving hot or cold food. Space shall be included for temporary holding of unused or soiled dietary trays.

(N) An equipment storage room. Each unit shall provide sufficient storage areas located on the patient floor to keep its required corridor width free of equipment and supplies, but not less than (10) square feet (0.93 square meter) per postpartum room and (20) square feet (1.86 square meters) per LDR or LDRP outside of the patient room.

(O) Storage space for stretchers and wheelchairs. Storage space for stretchers and wheelchairs shall be provided in a strategic location, out of corridors and away from normal traffic.

(P) When bathing facilities are not provided in patient rooms, there shall be at least one (1) shower and/or bathtub for each six (6) beds or fraction thereof.

(Q) Housekeeping room. A housekeeping room shall be provided for the exclusive use of the obstetrical suite. It shall be directly accessible from the suite and shall contain a service sink or floor receptor and provisions for storage of supplies and housekeeping equipment.

(R) Examination/treatment room and/or multipurpose diagnostic testing room shall have at least one hundred-twenty (120) square feet (11.15 square meters) of clear floor area. When utilized as a multi-patient diagnostic testing room, at least eighty (80) square feet (7.43 square meters) of clear floor area per patient shall be provided. An adjoining toilet room shall be provided for patient use.

(S) Emergency equipment storage shall be located in close proximity to the nurse station.

(9) **Airborne infection isolation room(s).** An airborne infection isolation room is not required for the obstetrical unit. Provisions for the care of the perinatal patient with an airborne infection

shall be determined by the ICRA.

(c) **Caesarian/delivery suite.**

(1) Caesarean/delivery room(s) shall have at least three hundred-sixty (360) square feet (33.45 square meters) of clear floor area with at least sixteen (16) feet (4.88 meters) of clear dimension exclusive of built-in shelves or cabinets. There shall be at least one (1) such room in every obstetrical unit.

(2) Delivery room(s) shall have at least three hundred (300) square feet (27.87 square meters) of clear floor area exclusive of fixed cabinets and built-in shelves. An emergency communication system shall be connected with the obstetrical suite control station.

(3) Infant resuscitation space shall be provided within the caesarean/delivery room(s) and delivery rooms with at least forty (40) square feet (3.72 square meters) of clear floor area in addition to the required area of each room. This area may be provided in a separate but immediately accessible room with a clear floor area of at least one hundred (150) square feet (13.94 square meters). At least six (6) single or three (3) duplex electrical outlets shall be provided for the infant in addition to the facilities required for the mother.

(4) Labor room(s) (Labor delivery recovery rooms may be substituted). In renovation projects, existing labor rooms may have at least one hundred (100) square feet (9.3 square meters) of clear floor area per bed. Where labor-delivery-recovery or labor-delivery-recovery-postpartum rooms are not provided, at least two (2) labor beds shall be provided for each caesarean/delivery room. In facilities that have only one (1) caesarean/delivery room, two (2) labor rooms shall be provided. Each room shall be designed for either one (1) or two (2) beds with at least one hundred (120) square feet (11.15 square meters) of clear floor area per bed. Each labor room shall contain a handwashing fixture and have access to a toilet room. One (1) toilet room may serve two (2) labor rooms. Labor rooms shall have controlled access with doors that are arranged for observation from a nursing station. At least one (1) shower, which may be separate from the labor room if under staff control, for use of patients in labor shall be provided. Windows in labor rooms, if provided, shall be located, draped, or otherwise arranged, to preserve patient privacy from casual observation from outside the labor room.

(5) Recovery room - labor delivery recovery rooms may be substituted. Each recovery room shall contain at least two (2) beds and have a nurse station with charting facilities located to permit visual control of all beds. Each room shall include facilities for handwashing and dispensing medicine. A clinical sink with a flushing rim fixture shall be available, as shall storage for supplies and equipment. There shall be enough space for baby and crib and a chair for the support person. There shall be the ability to maintain visual privacy of the new family.

(6) Service areas. Individual rooms shall be provided as indicated in the following standards; otherwise, alcoves or other open spaces that do not interfere with traffic may be used. Services, except the soiled workroom, control/nurse’s station, and the housekeeping room, may be shared with the surgical facilities, if the functional program

reflects this concept. Where shared, areas shall be arranged to avoid direct traffic between the delivery and operating rooms. The following services shall be provided:

(A) A control/nurse station located to restrict unauthorized traffic into the suite.

(B) A supervisor's office or station.

(C) A waiting room, with toilets, telephones, and drinking fountains conveniently located. The toilets shall have handwashing stations.

(D) Sterilizing facilities with high-speed sterilizers convenient to all caesarean/delivery rooms. Sterilization facilities shall be separate from the delivery area and adjacent to clean assembly. High-speed autoclaves shall only be used in an emergency situation; i.e., a dropped instrument and no sterile replacement readily available. Sterilization facilities may not be necessary if the flow of materials can be properly handled from a central service department based on the usage of the delivery room.

(E) A drug distribution station with handwashing facilities and provisions for controlled storage, preparation, and distribution of medication.

(F) Scrub facilities for caesarean/delivery rooms. At least two (2) scrub positions shall be provided adjacent to entrance to each caesarean/delivery room. Scrub facilities shall be arranged to minimize any splatter on nearby personnel or supply carts. In new construction, view windows at scrub stations to permit the observation of room interiors shall be provided.

(G) Soiled workroom or soiled holding room. This room shall be separate from the clean workroom and shall have separate access doors. The soiled workroom shall contain a clinical sink or equivalent flushing-rim fixture. The room shall contain a handwashing fixture. These fixtures shall both have a hot and cold mixing faucet. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter. If the flushing-rim clinical sink is eliminated, facilities for cleaning bedpans shall be provided elsewhere.

(H) A clean workroom separate from the soiled workroom. A clean workroom shall be provided if clean materials are assembled within the obstetrical suite prior to use. If a clean workroom is provided it shall contain a work counter, sink equipped for handwashing, and space for storage of supplies and distribution of clean and sterile supplies.

(I) Anesthesia storage facilities. Storage space for service cylinders of medical gases shall be provided as needed. If flammable anesthetics are used, a separate room shall be provided for their storage in accordance with the details of at OAC 310:667-49-29.

(J) A clean sterile storage area readily available to the delivery room; size to be determined on level of usage, functions provided, and supplies from the hospital central distribution area.

(K) An anesthesia workroom for cleaning, testing, and storing anesthesia equipment. It shall contain a work counter, sink, and provisions for separation of clean and soiled items.

(L) Equipment storage room(s) for equipment and supplies used in the obstetrical suite.

(M) Staff clothing change areas. The clothing change area shall be designed to encourage one-way traffic and eliminate cross-traffic between clean and contaminated personnel. The area shall contain lockers, showers, toilets, handwashing facilities, and space for donning and disposing scrub suits and booties.

(N) Male and female support persons change area (designed as described above).

(O) Lounge and toilet facilities for obstetrical staff convenient to delivery, labor, and recovery areas. The toilet rooms shall contain handwashing stations.

(P) An on-call room(s) for physicians and/or staff may be located elsewhere in the facility.

(Q) Housekeeping room with a floor receptacle or service sink and storage space for housekeeping supplies and equipment.

(R) An area for storing stretchers out of the path of normal traffic.

(S) Fluid waste disposal.

(d) **Labor-delivery-recovery (LDR) and labor-delivery-recovery-postpartum (LDRP) facilities.**

(1) When provided by the functional program, delivery procedures in accordance with birthing concepts may be performed in the LDR or LDRP rooms. LDR room(s) may be located in a separate LDR suite or as part of the Caesarean/Delivery suite. The postpartum unit may contain LDRP rooms. These rooms shall have at least two hundred-fifty (250) square feet (23.23 square meters) of clear floor area with at least thirteen (13) feet (3.96 meters) of dimension, exclusive of toilet room, closet, alcove, or vestibules. There shall be enough space for a crib and a reclining chair for a support person. An area within the room but distinct from the mother's area shall be provided for infant stabilization and resuscitation. Medical gas and electrical outlets requirements specified in Appendix B shall be met. These outlets shall be located in the room so that they are accessible to the mother's delivery area and infant resuscitation area. When renovation work is undertaken, every effort shall be made to meet the new construction standard. If it is not possible to comply, the Department may approve a deviation from these requirements. In such cases, existing LDR or LDRP rooms shall have at least two hundred (200) square feet (18.58 square meters) of clear floor area.

(2) Each LDR or LDRP room shall be for single occupancy and have direct access to a private toilet with shower or tub. Each room shall be equipped with free-standing handwashing fixture (handwashing fixture with hands-free operation is acceptable for scrubbing). Examination lights may be portable, but shall be immediately accessible.

(3) Finishes shall be selected to facilitate cleaning and resist strong detergents. Windows or doors within a normal sightline that would permit observation into the room shall be arranged or draped as

necessary for patient privacy.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-9. Emergency service**

(a) **General.** The extent and type of emergency service to be provided depends upon community needs and the availability of other services within the area. While initial emergency management shall be available at every hospital, full-scale definitive emergency services may be impractical and/or an unnecessary duplication. All services need adequate equipment and twenty-four (24) hour staffing to ensure no delay in essential treatment. The following standards are intended only as minimums. Additional facilities, as needed, shall be required to satisfy the program. Separate outpatient emergency units shall comply with OAC 310:667-49-34.

(b) **Initial emergency management.** Each hospital shall provide for emergency treatment for staff, employees, and visitors, as well as for persons who may be unaware of or unable to immediately reach services in other facilities. This is not only for minor incidents that may require minimal care but also for persons with severe illness and injuries who shall receive immediate emergency care and assistance prior to transport to other facilities. Initial emergency management shall include:

(1) A well-marked, illuminated, and covered entrance, at grade level. The emergency vehicle entry cover shall provide shelter for both the patient and the emergency medical crew during transfer from an emergency vehicle into the building.

(2) Reception, triage, and control station shall be located to permit staff observation and control of access to treatment area, pedestrian and ambulance entrances, and public waiting area.

(3) A treatment room with at least one hundred-twenty (120) square feet (11.15 square meters) of clear area, exclusive of toilets, waiting area, and storage. Each treatment room shall contain an examination light, work counter, handwashing facilities, medical equipment, cabinets, medication storage, adequate electrical outlets above floor level, and counter space for writing. The treatment room may have additional space and provisions for several patients with cubicle curtains for privacy. Multiple-bed treatment rooms shall provide at least eighty (80) square feet (7.43 Square meters) per patient cubicle.

(4) Storage out of the traffic flow and under staff control for general medical/surgical emergency supplies, medications, and equipment such as a ventilator, defibrillator, splints, etc.

(5) Provisions for reception, control, and public waiting, including a public toilet with handwashing station.

(6) A patient toilet room with handwashing stations convenient to the treatment room(s).

(7) Communication hookup to the Poison Control Center and regional emergency medical system.

(8) Airborne infection control. At least one airborne infection isolation room shall be provided as described in OAC 310:667-49-

2(a)(3). The need for additional airborne infection isolation rooms or for protective environment rooms as described in OAC 310:49-2(a)(4) shall be determined by the ICRA.

(c) **Definitive emergency care.** When definitive emergency service is to be provided, the type, size, and number of the services shall be as defined in the functional program. The following shall be provided:

(1) Grade-level, well-marked, illuminated, and covered entrance with direct access from public roads for ambulance and vehicle traffic. Entrance and driveway shall be clearly marked. If a raised platform is used for ambulance discharge, provide a ramp for pedestrian and wheelchair access.

(2) Paved emergency access to permit discharge of patients from automobiles and ambulances, and temporary parking convenient to the entrance.

(3) Reception, triage, and control station shall be located to permit staff observation and control of access to treatment area, pedestrian and ambulance entrances, and public waiting area. The triage area requires special consideration. As the point of entry and assessment for patients with undiagnosed and untreated airborne infections, the triage area shall be designed and ventilated to reduce exposure of staff, patients, and families to airborne infectious diseases.

(4) Wheelchair and stretcher storage for arriving patients. This shall be out of traffic flow with convenient access from emergency entrances.

(5) Public waiting area with toilet facilities, drinking fountains, and telephones. If so determined by the hospital ICRA, the emergency department waiting area shall require special measures to reduce the risk of airborne infection transmission. These measures may include enhanced general ventilation and air disinfection similar to inpatient requirements for airborne infectious isolation rooms.

(6) Communication center shall be convenient to the nursing station and have a radio, telephone, and intercommunication systems.

(7) Examination and treatment room(s). Examination rooms shall have at least one hundred-twenty (120) square feet (11.15 square meters) of clear floor area. The room shall contain work counter(s); cabinets; handwashing facilities; supply storage facilities; examination lights; and a desk, counter, or shelf space for writing and a vision panel adjacent to and/or in the door. When treatment cubicles are in open multibed areas, each cubicle shall have at least eighty (80) square feet (7.43 square meters) of clear floor space and shall be separated from adjoining cubicles by curtains. Handwashing facilities shall be provided for each four (4) treatment cubicle or major fraction thereof in multiple-bed areas. Oxygen and vacuum requirements of Appendix B shall be met. Treatment/examination rooms used for pelvic exams shall allow for the foot of the examination table to face away from the door.

(8) Trauma/cardiac rooms for emergency procedures, including emergency surgery, shall have at least two hundred-fifty (250) square feet (23.23. square meters) of clear floor space. Each room shall have cabinets and emergency supply shelves, x-ray film illuminators, examination lights, and counter space for writing. Additional space

with cubicle curtains for privacy may be provided to accommodate more than one (1) patient at a time in the trauma room. Provisions shall be made for monitoring the patient. There shall be storage provided for immediate access to attire and equipment used for standard precautions. Doorways leading from the ambulance entrance to the cardiac trauma room shall be at least five (5) feet (1.52 meters) wide to simultaneously accommodate stretchers, equipment, and personnel. In renovation projects, every effort shall be made to have existing cardiac/trauma rooms meet the new construction standard. If this is not possible, the Department may approve deviating from these requirements. In such cases, these rooms shall have a clear area of two hundred-forty (240) square feet (21 square meters), and doorways leading from the ambulance entrance to the room may be four (4) feet (1.22 meters) wide.

(9) Provisions for orthopedic and cast work. These may be in separate room(s) or in the trauma room. They shall include storage for splints and other orthopedic supplies, traction hooks, x-ray film illuminators, and examination lights. If a sink is used for the disposal of plaster of Paris, a plaster trap shall be provided. The clear floor space for this area shall depend on the functional program and the procedures and equipment to be accommodated here.

(10) Scrub stations located in or adjacent and convenient to each trauma and/or orthopedic room.

(11) Convenient access to radiology and laboratory services.

(12) Poison control center and emergency medical service communications center may be a part of the staff work and charting area but shall be provided.

(13) Provisions for disposal of solid and liquid waste. This may be a clinical sink with a flushing rim fixture within the soiled workroom.

(14) Emergency equipment storage. Sufficient space shall be provided for emergency equipment that is under direct control of the nursing staff, such as a CPR cart, pumps, ventilators, patient monitoring equipment, and portable x-ray unit. This space shall be located in an area appropriate to the functional program and easily accessible to staff but out of the normal traffic flow.

(15) A toilet room for patients. If there are more than eight (8) treatment areas, there shall be at least two (2) toilet facilities, with handwashing stations, required.

(16) Storage rooms for clean, soiled, or used supplies.

(A) Soiled workroom or soiled holding room for the exclusive use of the emergency service. This room shall be separate from the clean workroom. The soiled workroom shall contain a clinical sink or equivalent flushing-rim fixture. The room shall contain a lavatory or handwashing fixture. These fixtures shall both have a hot and cold mixing faucet. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter. If the flushing-rim clinical sink is eliminated, facilities for cleaning bedpans shall be provided elsewhere.

(B) Clean workroom or clean supply room. If the room is used for preparing patient care items, it shall contain a work counter, a

handwashing sink, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile supply materials, the work counter and handwashing facilities may be omitted. Soiled and clean workrooms or holding rooms shall be separated and have no direct connection.

(17) Administrative center or nurse station for staff work and charting. This area shall have space for counters, cabinets, and medication storage, and shall have convenient access to handwashing facilities. It may be combined with or include centers for reception and communication or poison control. Visual observation of all traffic into the unit and of all patients should be provided from the nurse's station, where feasible.

(18) Securable closets or cabinet compartments for the personal effects of emergency service personnel, located in or near the nurse station. These shall be at least large enough for purses and billfolds. Coats may be stored in closets or cabinets in the unit or in a central staff locker area.

(19) Convenient and private access to staff toilets, lounge, and lockers shall be provided.

(20) Housekeeping room. A housekeeping room shall be provided for the exclusive use of the emergency service. It shall be directly accessible from the unit and shall contain a service sink or floor receptor and provisions for storage of supplies and housekeeping equipment.

(21) Security station. A security system should be located near the emergency entrances and triage/reception area. The non-selective twenty-four (24) hour accessibility of the emergency department dictates that a security system reflecting local community needs be provided.

(22) Airborne infection isolation room. At least one (1) airborne infection isolation room shall be provided as described in OAC 310:667-49-2(a)(3). The need for additional airborne infection isolation rooms or for protective environment rooms as described in OAC 310:667-49-2(a)(4) shall be determined by the ICRA.

(23) Bereavement room.

(24) Secured holding room. At least one (1) holding/seclusion room of 120 square feet (11.15 square meters) shall be provided. This room shall allow for security, patient and staff safety, and soundproofing.

(25) Decontamination area. A decontamination area shall define the location of the area and the types of exposure (i.e., nuclear, biological, chemical) to be considered. The location of the area shall be permitted to be on the exterior perimeter of the building adjacent to the ambulance entrance or built within the walls of the facility.

(26) Details and finishes; ventilation and mechanical; and electrical standards shall comply with requirements at OAC 310:667-49-28, OAC 310:667-49-31, and OAC 310:667-49-32.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-10. Imaging suite**

(a) **General.**

(1) Equipment and space shall be as necessary to accommodate the functional program. The imaging suite provides diagnostic procedures including fluoroscopy, radiography, mammography, tomography, computerized tomography scanning, ultrasound, magnetic resonance, angiography and other similar techniques. The layouts shall be developed in compliance with manufacturer's recommendations, because area requirements may vary from machine to machine. Since technology changes frequently and from manufacturer to manufacturer, rooms may be sized larger to allow upgrading of equipment over a period of time.

(2) Most imaging requires radiation protection. A certified medical physicist representing the owner shall specify the type, location, and amount of radiation protection to be installed in accordance with the final approved department layout and equipment selections. Where protected alcoves with view windows are required, there shall be at least one (1) foot six (6) inches (0.45 meter) between the view window and the outside partition edge shall be provided. Radiation protection requirements shall be incorporated into the specifications and the building plans.

(3) Beds and stretchers shall have ready access to and from other departments of the institution. The emergency, surgery, cystoscopy, and outpatient clinics shall be accessible to the imaging suite.

(4) Flooring shall be adequate to meet load requirements for equipment, patients, and personnel. Provision for wiring raceways, ducts or conduits shall be made in floors, walls, and ceilings. Ceiling heights may be higher than normal. Ceiling mounted equipment shall have properly designed rigid support structures located above the finished ceiling. A lay-in ceiling shall be permitted to be considered for ease of installation, service, and remodeling.

(b) **Angiography.**

(1) Space shall be provided as necessary to accommodate the functional program.

(2) A control room shall be provided as necessary to meet the needs of the functional program. A view window shall be provided to permit full view of the patient.

(3) A viewing area shall be provided.

(4) A scrub sink located outside the staff entry to the procedure room shall be provided for use by staff.

(5) A patient holding area shall be provided.

(6) Storage for portable equipment and catheters shall be provided.

(7) Provision shall be made within the facility for extended post-procedure observation of outpatients.

(c) **Computerized tomography (CT) scanning.**

(1) CT scan rooms shall be as required to accommodate the equipment.

(2) A control room shall be provided that is designed to accommodate the computer and other controls for the equipment. A view window shall be provided to permit full view of the patient. The angle between the control and equipment shall permit the control operator

to see the patient's head.

(3) The control room shall be located to allow convenient film processing.

(4) A patient toilet shall be provided. It shall be convenient to the procedure room, and if directly accessible to the scan room, arranged so that a patient may leave the toilet without having to reenter the scan room.

(d) **Diagnostic x-ray.**

(1) Radiography rooms shall be of a size to accommodate the functional diagnostic x-ray program.

(2) Each radiography room shall include a shielded control area. This area shall be provided with a view window designed to provide full view of the examination table and the patient at all time, including full view of the patient when the table is in the tilt position or the chest X-Ray is being utilized. For mammography machines with built-in shielding for the operator, the shielded control area may be omitted when approved by the Department.

(e) **Magnetic resonance imaging (MRI).**

(1) Space shall be provided as necessary to accommodate the functional MRI program. The MRI room shall be permitted to range from 325 square feet (30.19 square meters) to 620 square feet (57.6 Square meters) depending on the vendor and magnet strength.

(2) A control room shall be provided with full view of the MRI.

(3) A computer room shall be provided. Self-contained air conditioning supplement shall be provided for the equipment if specified by the manufacturer.

(4) Cryogen storage may be required in areas where service to replenish supplies is not readily available.

(5) A darkroom may be required for loading cassettes and shall be located near the control room, if needed. This darkroom shall be outside the ten (10) gauss field.

(6) When spectroscopy is provided, caution shall be exercised in locating it in relation to the magnetic fringe fields.

(7) Power conditioning and voltage regulation equipment as well as direct current (DC) shall be provided if needed.

(8) Magnetic shielding shall be provided if required to restrict the magnetic field plot. Radio frequency shielding shall be used to attenuate stray radio frequencies.

(9) Cryogen exhaust shall be vented.

(10) Patient holding area.

(f) **Ultrasound.**

(1) Space shall be provided as necessary to accommodate the functional ultrasound program.

(2) A patient toilet, accessible from the procedure room and from the corridor, shall be provided.

(g) **Support spaces.** The following spaces are common to the imaging suites and shall be minimum requirements unless stated otherwise:

(1) Patient waiting area. The area shall be out of the traffic flow, under staff control, and shall have seating capacity in accordance with the functional program. If the suite is routinely used for outpatients and inpatients at the same time, separate waiting areas shall be provided with screening for visual privacy

between the waiting areas.
(2) If so determined by the hospital ICRA, the diagnostic imaging waiting area shall require special measures to reduce the risk of airborne infection transmission. These measures shall include enhanced general ventilation and air disinfection techniques similar to inpatient requirements for airborne infectious isolation rooms.
(3) Control desk and reception area.
(4) Holding area. A convenient holding area under staff control shall be provided to accommodate inpatients on stretchers or beds.
(5) Patient toilet rooms. Toilet rooms shall be provided convenient to the waiting rooms and shall be equipped with an emergency call system. Separate toilets, with handwashing stations, shall be provided with direct access from each radiographic/fluoroscopic (RF) room so that a patient may leave the toilet without having to reenter the RF room. Rooms used only occasionally for fluoroscopic procedures may use nearby patient toilets if they are located for immediate access.
(6) Patient dressing rooms. Dressing rooms shall be provided convenient to the waiting areas and x-ray rooms. Each room shall include a seat or bench, mirror, and provisions for hanging patient clothing and for securing valuables.
(7) Staff facilities. Toilets may be outside the suite but shall be convenient for staff use. In larger suites of three (3) or more procedure rooms, toilets internal to the suite shall be provided.
(8) Film storage (active). A room with cabinets or shelves for filing patient film for immediate retrieval shall be provided.
(9) Film storage (inactive). A room or area for inactive film storage shall be provided. It may be outside the imaging suite, but shall be under imaging's administrative control and properly secured to protect films against loss or damage.
(10) Storage for unexposed film. Storage facilities for unexposed film shall include protection of film against exposure or damage and shall not be warmer than the air of adjacent occupied spaces.
(11) Offices for radiologist(s) and assistant(s). Offices shall include provisions for viewing, individual consultation, and charting of film.
(12) Clerical offices/spaces. Office space shall be provided as necessary for the functional program.
(13) Consultation area. An appropriate area for individual consultation with referring clinicians shall be provided.
(14) Contrast media preparation. This area shall be provided with sink, counter, and storage to allow for mixing of contrast media. One preparation room, if conveniently located, may serve any number of rooms. Where previously prepared media is used, this area may be omitted, but storage shall be provided for the media.
(15) Film processing room. A darkroom shall be provided for processing film unless the processing equipment normally used does not require a darkroom for loading and transfer. When daylight processing is used, the dark room may be minimal for emergency and special uses. Film processing shall be located convenient to the procedure rooms and to the quality control area.
(16) Quality control area. An area or room shall be provided near the

processor for viewing film immediately after it is processed. All view boxes shall be illuminated to provide light of the same color value and intensity for appropriate comparison of several adjacent films.

(17) Cleanup facilities. Provisions for cleanup shall be located within the suite for convenient access and use. It shall include service sink or floor receptacle as well as storage space for equipment and supplies. If automatic film processors are used, there shall be a receptacle of adequate size with hot and cold water for cleaning the processor racks.

(18) Handwashing facilities. Handwashing facilities shall be provided within each procedure room unless the room is used only for routine screening such as chest x-rays where the patient is not physically handled by the staff. Handwashing facilities shall be provided convenient to the MRI room, but need not be within the room.

(19) Clean storage. Provisions shall be made for the storage of clean supplies and linens. If conveniently located, storage may be shared with another department.

(20) Soiled holding. Provisions shall be made for soiled holding. Separate provisions for contaminated handling and holding shall be made. Handwashing facilities shall be provided.

(21) Provision shall be made for locked storage of medications and drugs.

(22) Details and finishes; mechanical; and electrical construction shall meet requirements at OAC 310:667-49-28, OAC 310:667-49-31, and OAC 310:667-49-32.

(h) **Cardiac catheterization lab (cardiology).** The cardiac catheterization laboratory, if used, shall provide space as necessary to accommodate the functional program.

(1) The cardiac catheterization lab is normally a separate suite, but shall be permitted to be within the imaging suite provided that the appropriate sterile environment is provided. It can be combined with angiography in low usage situations.

(2) The procedure room shall be a minimum of 400 square feet (37.16 square meters) exclusive of fixed cabinets and shelves.

(3) A control room or area shall be provided and shall be large enough to contain and provide for the efficient functioning of the X-Ray and image recording equipment. A view window permitting full view of the patient from the control console shall be provided.

(4) An equipment room or area shall be provided and shall be large enough to contain X-Ray transformers, power modules, and associated electronics and electrical gear shall be provided.

(5) Scrub facilities with hands-free operable controls shall be provided adjacent to the entrance of the procedure rooms, and shall be arranged to minimize incidental splatter on nearby personnel, medical equipment, or supplies.

(6) Staff change areas shall be provided and arranged to ensure a traffic pattern so that personnel entering from outside the suite can enter, change their clothing, and move directly into the cardiac catheterization suite.

(7) A patient preparation, holding, and recovery area or room shall be provided and arranged to provide visual observation before and

after the procedure.
(8) A clean workroom or clean supply room shall be provided. If the room is used for preparing patient care items, it shall contain a work counter and handwashing station. If the room is used only for storage and holding of clean and sterile supply materials, the work counter and handwashing station shall be permitted to be omitted.
(9) A soiled workroom shall be provided which shall contain a handwashing station and a clinical sink (or equivalent flushing rim fixtures). When the room is used for temporary holding or soiled materials, the clinical sink shall be permitted to be omitted.
(10) A housekeeping closet containing a floor receptor or service sink and provisions for storage of supplies and housekeeping equipment shall be provided.
(11) The following shall be available for use by the cardiac catheterization suite:
(A) A viewing room.
(B) A film file room.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-11. Nuclear medicine**

(a) Equipment and space shall be provided as necessary to accommodate the functional program. Nuclear medicine includes positron emission tomography, which is not common to most facilities and requires specialized planning for equipment.
(b) A certified medical physicist representing the owner shall specify the type, location, and amount of radiation protection to be installed in accordance with final approved department layout and equipment selection. These specifications shall be incorporated into the plans.
(c) Support services, such as radiology and pathology, shall be accessible to nuclear medicine. The emergency room and outpatient clinics shall be in proximity.
(d) Flooring shall meet load requirements for equipment, patients, and personnel. Floors and walls shall be constructed of materials that are easily decontaminated in case of radioactive spills. Walls shall contain necessary support systems for either built-in or mobile oxygen and vacuum, and vents for radioactive gases. Provision for wiring raceways, ducts or conduits shall be made in floors, walls, and ceilings. Ceilings may exceed 8’-0" (2.44 meters) in height. Ceiling-mounted equipment shall have properly designed rigid support structures. A lay-in type ceiling shall be considered for ease of service, installation, and remodeling.
(e) Space shall be provided as necessary to accommodate the functional program. Where the functional program calls for it, the nuclear medicine room shall accommodate the equipment, a stretcher, exercise equipment (treadmill and/or bicycle) and staff.
(f) If radiopharmaceutical preparation is performed on-site, an area adequate to house a radiopharmacy shall be provided with appropriate shielding. This area shall include adequate space for storage of radionuclides, chemicals for preparation, dose calibrators, and record

keeping. The floors and walls shall be constructed of easily decontaminated materials. Vents and traps for radioactive gases shall be provided if such are used. Hoods for pharmaceutical preparation shall meet applicable standards. If pre-prepared materials are used, storage and calculation area may be considerably smaller than that for on-site preparation. Space shall provide adequately for dose calibration, quality assurance, and record keeping. The area may still require shielding from other portions of the facilities.

(g) The nuclear medicine area, when operated separately from the imaging suite, shall include the following:

(1) Services such as radiology and pathology shall be accessible. The emergency room and outpatient clinics shall be in proximity.

(2) Adequate space to permit entry of stretchers, beds, and able to accommodate imaging equipment, electronic consoles, and if present, computer terminals.

(3) A darkroom on-site for film processing. The darkroom shall contain protective storage facilities for unexposed film that guard the film against exposure or damage. If necessary, special refrigeration and humidity controls, separate from the ambient controls of adjacent occupied areas, shall be provided.

(4) When the functional program requires a centralized computer area, it shall be a separate room with access terminals available within the imaging rooms.

(5) Provisions for cleanup shall be located within the suite for convenient access and use. It shall include service sink or floor receptacle as well as storage space for equipment and supplies.

(6) Film storage with cabinets or shelves for filing patient film for immediate retrieval.

(7) Inactive film storage under the nuclear medicine administrative control and properly secured to protect film against loss or damage.

(8) A consultation area with view boxes illuminated to provide light of the same color value and intensity for appropriate comparison of several adjacent films. Space shall be provided for computer access and display terminals if such are included in the program.

(9) Offices for physicians and assistants equipped for individual consultation, viewing, and charting of film.

(10) Clerical offices and spaces as necessary for the program to function.

(11) Waiting areas out of normal traffic flow, under staff control, and with seating capacity in accordance with the functional program. If the department is routinely used for outpatients and inpatients at the same time, separate waiting areas shall be provided with screening or visual privacy between the waiting areas.

(12) A dose administration area as specified by the functional program located near the preparation area. Since several hours may elapse for the dose to take effect, the area shall provide for visual privacy from other areas.

(13) A holding area for patients on stretchers or beds out of traffic and under control of staff. This area may be combined with the dose administration area with visual privacy between the areas.

(14) Patient dressing rooms convenient to the waiting area and procedure rooms. Each dressing room shall include a seat or bench, a

mirror, and provisions for hanging patient clothing and for securing valuables.

(15) Toilet rooms convenient to waiting and procedure rooms.

(16) Staff toilet(s) convenient to the nuclear medicine laboratory.

(17) Handwashing facilities within each procedure room.

(18) Control desk and reception area.

(19) Storage area for clean linen with a handwashing facility.

(20) Provisions for holding soiled material. Separate provisions shall be made for holding contaminated material.

(21) Details and finishes, mechanical, and electrical construction shall meet requirements at OAC 310:667-49-28, OAC 310:667-49-31, and OAC 310:667-49-32.

(h) **Radiotherapy suite.**

(1) Rooms and spaces shall be provided as necessary to accommodate the functional program.

(2) Equipment manufacturers recommendations shall be followed, since space requirements may vary from one machine to another and one manufacturer to another. The radiotherapy suite may contain either or both electron beam therapy and radiation therapy. Although not recommended, a simulation room may be omitted in small linear accelerator facilities where other positioning geometry is provided.

(3) Cobalt, linear accelerators, and simulation rooms require radiation protection. A certified medical physicist representing the owner shall specify the type, location, and amount of protection to be installed in accordance with final approved department layout and equipment selection. The architect shall incorporate these specifications into the hospital building plans.

(4) Cobalt rooms and linear accelerators shall be sized in accordance with equipment requirements and shall accommodate a stretcher for litter-borne patients. Layouts shall provide for preventing the escape of radioactive particles. Openings into the room, including doors, ductwork, vents, and electrical raceways and conduits, shall be baffled to prevent direct exposure to other areas of the facility.

(5) Simulator, accelerator, and cobalt rooms shall accommodate the equipment with patient access on a stretcher, medical staff access to the equipment and patient, and service access.

(6) Flooring shall be adequate to meet load requirements for equipment, patients, and personnel. Provision for wiring raceways, ducts, or conduit shall be made in floors and ceilings. The ceiling height is normally higher than 8’-0" (2044 meters). Ceiling mounted equipment shall have properly designed rigid support structures. A lay-in type of ceiling shall be considered for ease of installation, service, and remodeling.

(i) **General support areas.** The following areas shall be provided unless they are accessible from other areas such as imaging or the outpatient department:

(1) A stretcher hold area adjacent to the treatment rooms, screened for privacy, and combined with a seating area for outpatients. The size of these areas shall be dependent on the program for outpatients and inpatients.

(2) Exam rooms for each treatment room as specified by the

functional program, each exam room shall be at least one hundred (100) square feet (9 square meters). Each exam room shall be equipped with a handwashing facility.

(3) Darkroom convenient to the treatment room(s) and the quality control area. Where daylight processing is used, the darkroom may be minimal for emergency use. If automatic film processors are used, a receptacle of adequate size with hot and cold water for cleaning the processor racks shall be provided either in the darkroom or nearby.

(4) Patient gowning area with provision for safe storage of valuables and clothing. At least one (1) space shall be large enough for staff assisted dressing.

(5) Business office and/or reception/control area.

(6) Housekeeping room equipped with service sink or floor receptor large enough for equipment or supplies storage.

(7) Film file area.

(8) Film storage area for unprocessed film.

(j) **Optional support areas.** The following areas shall be required if specified by the functional program:

(1) Quality control area with view boxes illuminated to provide light of the same color value and intensity.

(2) Computer control area normally located just outside the entry to the treatment room(s).

(3) Dosimetry equipment area.

(4) Hypothermia room (may be combined with an exam room).

(5) Consultation room.

(6) Oncologist's office (may be combined with consultation room).

(7) Physicist's office (may be combined with treatment planning).

(8) Treatment planning and record room.

(9) Work station/nutrition station.

(k) **Additional support areas for linear accelerator.** The following shall be provided if a linear accelerator is part of the functional program:

(1) Mold room with exhaust hood and handwashing facility.

(2) Block room with storage. The block room may be combined with the mold room.

(l) **Additional support area for cobalt room.** If cobalt therapy is provided, a hot lab shall be available.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-12. Laboratory suite**

(a) Laboratory facilities shall be provided for the performance of tests in hematology, clinical chemistry, urinalysis, microbiology, anatomic pathology, cytology, and blood banking to meet the workload described in the functional program. Provisions shall also be included for specimen collection and processing.

(b) The following physical facilities shall be provided within the hospital if laboratory services are provided on-site and required by the functional program:

(1) Work areas including sinks with water and access to vacuum,

gases, and air, and electrical services as needed.
(2) Refrigerated blood storage facilities for transfusions. The blood storage refrigerator shall be equipped with temperature-monitoring and alarm signals.
(3) Lavatory or counter sink(s) equipped for handwashing as needed. Counter sinks may also be used for disposal of nontoxic fluids.
(4) Storage facilities, including refrigeration, for reagents, standards, supplies, and stained specimen microscope slides, etc., as needed to meet the workload.
(5) Areas for specimen (blood, urine, and feces) collection as appropriate to the functional program. The blood collection area shall have a work counter, space for patient seating, and have access to handwashing facilities. The urine and feces collection room shall be equipped with water closet and lavatory. This area may be located outside the laboratory suite.
(6) Chemical safety provisions including emergency shower, eyeflushing devices, and appropriate storage for flammable liquids.
(7) Facilities and equipment for terminal sterilization of contaminated specimens before transport (autoclave or electric oven). Terminal sterilization is not required for specimens that are incinerated on-site or for materials to be decontaminated off-site from the facility. Materials to be decontaminated outside of the immediate laboratory shall be placed in a durable, leakproof container and closed for transport from the laboratory. All such materials shall be packaged in accordance with applicable local, state and federal regulations before removal from the facility.
(8) Special requirements for handling and storage of radioactive materials, if used. Requirements of authorities having jurisdiction (e.g., Nuclear Regulatory Commission or Oklahoma Department of Environmental Quality) shall be incorporated into laboratory plans.
(9) Administrative areas including offices as well as space for clerical work, filing, and record maintenance as needed by the functional program.
(10) Lounge, locker, and toilet facilities conveniently located for male and female laboratory staff. These may be outside the laboratory area and shared with other departments.
(11) Design for special equipment and instruments. The functional program shall describe the type and location of all special equipment that is to be wired, plumbed, or plugged in, and the utilities required to operate each.
(12) NFPA code requirements applicable to hospital laboratories, including standards clarifying that hospital units do not necessarily have the same fire safety requirements as commercial chemical laboratories.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-13. Rehabilitation therapy department**

(a) **General.** Rehabilitation therapy is primarily for restoration of body functions and may contain include several categories of services.

If a formal rehabilitative therapy service is included in a project, the facilities and equipment shall be as necessary for the effective function of the program. Where two (2) or more rehabilitative services are included, items may be shared, as appropriate.

(b) **Common elements.** Each rehabilitation therapy department shall include the following, which may be shared or provided as separate units for each service:

(1) Office and clerical space with provision for filing and retrieval of patient records.

(2) Reception and control station(s) with visual control of waiting and activities areas; this may be combined with office and clerical space.

(3) Patient waiting area(s) out of the traffic flow with provision for wheelchairs.

(4) Patient toilets with handwashing facilities accessible to wheelchair patients.

(5) Space(s) for storing wheelchairs and stretchers out of the traffic flow while patients are using the services. These spaces may be separate from the service area but shall be conveniently located.

(6) A conveniently accessible housekeeping room and service sink for housekeeping use.

(7) Locking closets or cabinets within the vicinity of each work area for securing staff personal effects.

(8) Convenient access to toilets and lockers.

(9) Access to a demonstration/conference room.

(c) **Physical therapy.** If physical therapy is part of the service, the following, at least, shall be included:

(1) Individual treatment area(s) with privacy screens or curtains. Each space shall have at least seventy (70) square feet (6.51 square meters) of clear floor area.

(2) Handwashing facilities for staff either within or at each treatment space. One (1) handwashing facility may serve several treatment stations.

(3) Exercise area and facilities.

(4) Clean linen and towel storage.

(5) Storage for equipment and supplies.

(6) Separate storage for soiled linen, towels, and supplies.

(7) Patient dressing areas, showers, and lockers. These shall be accessible and usable by the handicapped.

(8) Provisions and space for thermotherapy, diathermy, ultrasonics, and hydrotherapy when required by the functional program.

(d) **Occupational therapy.** If this service is provided, the following, at least, shall be included:

(1) Work areas and counters suitable for wheelchair access.

(2) Handwashing facilities.

(3) Storage for supplies and equipment.

(4) An area for teaching daily living activities shall be provided. It shall contain an area for a bed, kitchen counter with appliances and sink, bathroom, and a table/chair.

(e) **Prosthetics and orthotics.** If this service is provided, the following, at least, shall be included:

(1) Workspace for technicians.

(2) Space for evaluating and fitting, with provision for privacy.
(3) Space for equipment, supplies, and storage.

(f) **Speech and hearing.** If this service is provided, the following, at least, shall be included:
(1) Space for evaluation and treatment.
(2) Space for equipment and storage.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-14. Respiratory therapy service**

(a) The type and extent of respiratory therapy service may vary greatly. In some facilities, therapy is delivered in large sophisticated units, centralized in a specific area; in others, basic services are provided only at patient bedsides. If respiratory service is provided, the following elements shall be included, in addition to those elements stipulated at 310:667-49-13(b)1, 310:667-49-13(b)7, 310:667-49-13(b)8, and 310:667-49-13(b)9:
(1) Storage for equipment and supplies.
(2) Space and utilities for cleaning and sanitizing equipment. Physical separation of the space for receiving and cleaning soiled materials from the space for storage of clean equipment and supplies shall be provided.

(b) Respiratory services shall be located to be conveniently accessible on a twenty-four (24) hour basis to the critical care units.

(c) If respiratory services such as testing and demonstration for outpatients are part of the program, additional facilities and equipment shall be provided as necessary, including but not limited to:
(1) Patient waiting area with provision for wheelchairs.
(2) A reception and control station.
(3) Patient toilets and handwashing facilities.
(4) Room(s) for patient education and demonstration.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-15. Morgue**

(a) The morgue shall be accessible through an exterior entrance and shall be located to avoid the need for transporting bodies through public areas.

(b) The following elements shall be provided when autopsies are performed in the hospital:
(1) Refrigerated facilities for body holding.
(2) An autopsy room containing the following:
(A) A work counter with a sink equipped for handwashing.
(B) A storage space for supplies, equipment, and specimens.
(C) An autopsy table.
(D) A deep sink for washing of specimens.
(3) A housekeeping service sink or receptor for cleanup and housekeeping.

(c) If autopsies are performed outside the facility, a well ventilated, temperature-controlled, body-holding room shall be provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-16. Pharmacy or drug room**

(a) **General.** The size and type of services to be provided depends upon the type of drug distribution system used, number of patients to be served, extent of shared or purchased services and whether the hospital operates a licensed pharmacy or drug room. These shall be described in the functional program. The pharmacy suite or drug room shall be located for convenient access, staff control, and security. Facilities and equipment shall be as necessary to accommodate the functions of the program including satellite facilities, if provided. The following elements shall be included:

(b) **Dispensing or preparation area.** This area shall have the following:

(1) A pickup and receiving area.

(2) An area for reviewing and recording.

(3) An extemporaneous compounding area that includes a sink and sufficient counter space for drug preparation. Floor drainage may also be required, depending on the extent of compounding conducted.

(4) Work counters and space for automated and manual dispensing activities.

(5) An area for temporary storage, exchange, and restocking of carts.

(6) Security provisions for drugs and personnel in the dispensing counter area.

(c) **Manufacturing.** If manufacturing is performed the following shall be provided:

(1) A bulk compounding area.

(2) Provisions for packaging and labeling.

(3) A quality-control area.

(d) **Storage.** Storage shall be provided for the following (may be cabinets, shelves, and/or separate rooms or closets):

(1) Bulk storage.

(2) Active storage.

(3) Refrigerated storage.

(4) Volatile fluids and alcohol storage constructed according to applicable fire safety codes for the substances involved.

(5) Secure storage for narcotics and controlled drugs.

(6) Storage for general supplies and equipment not in use.

(e) **Administration.** Areas for administration shall be provided as follows:

(1) Provision for cross-checking of medication and drug profiles of individual patients.

(2) Poison control, reaction data, and drug information centers.

(3) A separate room or area for office functions including desk, filing, communication, and reference.

(4) Provisions for patient counseling and instruction that may be in

a room separate from the pharmacy.

(5) A room for education and training that may be in a multipurpose room shared with other departments.

(f) **Other.** Other areas shall be provided as follows:

(1) Handwashing facilities within each separate room where open medication is handled.

(2) Provide for convenient access to toilet and locker.

(3) If unit dose procedure is used, provide additional space and equipment for supplies, packaging, labeling, and storage, as well as for the carts.

(4) If IV solutions are prepared in the pharmacy or drug room, provide a sterile work area with a laminar-flow workstation designed for product protection. The laminar-flow system shall include a nonhydroscopic filter rated at 99.97 percent (HEPA), as tested by DOP tests, and have a visible pressure gauge for detection of filter leaks or defects.

(5) Provide for consultation and patient education when the functional program requires the licensed pharmacy to dispense medication to outpatients.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-17. Dietary service facilities**

(a) **General.** Food service facilities and equipment shall conform with these standards and the standards of the National Sanitation Foundation and other appropriate Department rules including Chapter 256 of this Title and shall provide food service for staff, visitors, inpatients, and outpatients as may be appropriate. Patient food preparation areas shall be located in an area adjacent to delivery, interior transportation and storage. Finishes in the dietary facility shall be selected to ensure cleanability and maintenance of sanitary conditions.

(b) **Functional elements.** If on-site conventional food service preparation is used, the following in size and number appropriate for approved function shall be provided:

(1) Receiving/control stations. An area for the receiving and control of incoming dietary supplies shall be provided. This area shall be separated from the general receiving area and shall contain a control station and a breakout for loading, uncrating, and weighing supplies.

(2) Storage spaces. They shall be convenient to the receiving area and shall be located to exclude traffic through the food preparation area to reach them. Storage spaces for bulk, refrigerated, and frozen foods shall be provided. At least four (4) days supplies shall be stocked. Food storage components shall be grouped for convenient access from receiving and to the food preparation areas. All food shall be stored clear of the floor. The lowest shelf shall be at least twelve (12) inches (30 centimeters) above the floor or shall be closed in or sealed tight for ease of cleaning.

(3) Cleaning supplies storage. A separate storage room for the storage of non-food items such as cleaning supplies that might

contaminate edibles shall be provided.
(4) Additional storage rooms as necessary for the storage of cooking wares, extra trays, flatware, plastic and paper products, and portable equipment.
(5) Food preparation work spaces for food preparation, cooking, and baking. These areas shall be as close as possible to the user, i.e., tray assembly and dining. Additional spaces for thawing and portioning shall be provided.
(6) Assembly and distribution. A patient tray assembly area located within close proximity to the food preparation and distribution areas shall be provided.
(7) Food service carts. A cart distribution system shall be provided with spaces for storage, loading, distribution, receiving, and sanitizing of the food service carts. The cart traffic shall be designed to eliminate any danger of cross-circulation between outgoing food carts and incoming, soiled carts, and the cleaning and sanitizing process. Cart circulation shall not be through food processing areas.
(8) Dining area. Dining space(s) for ambulatory patients, staff, and visitors shall be provided. These spaces shall be separate from the food preparation and distribution areas.
(9) Vending services. If vending devices are used for unscheduled meals, a separate room that, preferably, can be accessed without having to enter the main dining area shall be provided. Facilities for the servicing and sanitizing of the machines shall be provided as part of the food service program.
(10) Soiled receiving area. An area for receiving, scraping, and sorting soiled tableware shall be adjacent to ware washing and separate from food preparation areas.
(11) Ware washing facilities shall be designed to prevent contamination of clean wares with soiled wares through cross-traffic. The clean wares shall be transferred for storage or use in the dining area without having to pass through food preparation areas.
(12) Pot washing facilities. Facilities including multicompartmented sinks of adequate size for intended use shall be provided convenient to using service. Supplemental heat for hot water to clean pots and pans may be by booster heater or by steam jet. Mobile carts or other provisions shall be made for drying and storage of pots and pans.
(13) A food waste storage room. This room shall be conveniently located to the food preparation and ware washing areas but not within the food preparation area. It shall have direct access to the hospital's waste collection and disposal facilities.
(14) Handwashing. Fixtures that are operable without the use of hands shall be conveniently accessible at locations throughout the unit.
(15) Office spaces. There shall be an office for the use of the food service manager shall be provided. In smaller hospitals, this space may be located in an area that is part of the food preparation area.
(16) Toilets and locker spaces. There shall be toilet and locker spaces provided for the use of the dietary staff that shall not open directly into the food preparation areas, but shall be in close proximity to them.
(17) Housekeeping rooms. At least one (1) housekeeping room shall be

provided for the exclusive use of the dietary department and shall contain the following: a floor sink and space for mops, pails, and supplies. Where hot water or steam is used for general cleaning, additional space within the room shall be provided for the storage of hoses and nozzles.

(18) Icemaking equipment shall be of a type that is convenient for service and easily cleaned. It shall be provided for both drinks and food products (self-dispensing) and for general use (storage-bin type equipment).

(19) Commissary or contract services from other areas. Items above may be reduced as appropriate if commissary or contract services are provided. Protection of food delivered to insure freshness, retention of hot and cold, and avoidance of contamination shall be maintained. If delivery is from outside sources, protection against weather shall be provided. Provisions shall be made for thorough cleaning and sanitizing of equipment to avoid mix of soiled and clean.

(c) **Equipment.** Mechanical devices shall be heavy duty, suitable for intended use, and easily cleaned. Where equipment is movable, heavy duty locking casters shall be provided. If equipment is to have fixed utility connections, the equipment shall not be equipped with casters. Walk-in coolers, refrigerators, and freezers shall be insulated at floor as well as at walls and top. Coolers and refrigerators shall be capable of maintaining a temperature of thirty-two (32) degrees F. Freezers shall be capable of maintaining a temperature of twenty (20) degrees below zero (0) F. Coolers, refrigerators, and freezers shall be thermostatically controlled to maintain desired temperature settings in increments of two (2) degrees or less. Interior temperatures shall be indicated digitally so as to be visible from the exterior. Controls shall include audible and visible high and low temperature alarm. The time of alarm shall be automatically recorded. Walk-in units lockable from the outside shall have a release mechanism for exit from inside at all times. Interiors shall be lighted. All shelving shall be corrosion resistant, easily cleaned, and constructed and anchored to support a loading of at least one hundred (100) pounds per linear foot. All cooking equipment shall be equipped with automatic shut off devices to prevent excessive heat buildup. Under-counter conduits, piping, and drains shall be arranged to not interfere with cleaning of the floor below or of the equipment.

(d) **Plumbing.** Floor drains and/or floor sinks shall be of a type that can be easily cleaned by removal of cover. Floor drains or floor sinks shall be located at all "wet" equipment, i.e., ice machines and as required for wet cleaning of floors. Removable stainless steel mesh in addition to grilled drain cover shall be provided to prevent entry of large particles of waste that might cause stoppages. Location of floor drains and floor sinks shall be coordinated to avoid conditions where locations of equipment make removal of covers for cleaning difficult. No plumbing lines shall be exposed overhead or on walls where possible accumulation of dust or soil may create a cleaning problem or where leaks create a potential for food contamination. Grease traps shall be of capacity required and shall be accessible from outside of the building without need to interrupt any services.

(e) **Hoods and venting equipment.** Hoods and venting equipment shall

meet the requirements of NFPA 96.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-18. Administration and public areas**

The following shall be provided in administration and public areas:

(1) Entrance. This shall be at grade level, sheltered from inclement weather, and accessible to the handicapped.

(2) Lobby. This shall include:

(A) A counter or desk for reception and information.

(B) Public waiting area(s).

(C) Public toilet facilities.

(D) Public telephones.

(E) Drinking fountain(s).

(3) Interview space(s). These shall include provisions for private interviews relating to social service, business transactions, and admissions.

(4) Admissions area. For initial admission of inpatients, the area shall include:

(A) A separate waiting area for patients and accompanying persons.

(B) A work counter or desk for staff.

(C) A storage area for wheelchairs, out of the path of traffic flow.

(5) General or individual office(s). These shall be provided for business transactions, medical and financial records, and administrative and professional staff.

(6) Multipurpose room(s). These shall be provided for conferences, meetings, and health education purposes, and include provisions for the use of visual aids. One (1) multipurpose room may be shared by several services.

(7) Storage for office equipment and supplies.

(8) Quality assurance and utilization review area.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-19. Medical records**

Rooms, areas, or offices for the following personnel and/or functions shall be provided:

(1) Medical records administrator/technician.

(2) Review and dictation.

(3) Sorting, recording, or microfilming records.

(4) Record storage.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-20. Central services**

Central services shall include at least the following:

(1) **Separate soiled and clean work areas.**

(A) **Soiled workroom.** This room shall be physically separated from all other areas of the department. Workspace shall be provided to handle the cleaning and initial sterilization/disinfection of all medical/surgical instruments and equipment. Work tables, sinks, flush type devices, and washer/sterilizer decontaminators shall be provided as required by the functional program. Passthrough doors and washer/sterilizer decontaminators shall deliver into clean processing area/work rooms.

(B) **Clean assembly/workroom.** This workroom shall contain handwashing facilities, workspace, and equipment for terminal sterilizing of medical and surgical equipment and supplies. Clean and soiled work areas shall be physically separated.

(2) **Storage areas.** Clean/sterile - medical/surgical supplies. A room for breakdown shall be provided for manufacturers clean/sterile supplies. The clean processing area shall not be in this area but adjacent. Storage for packs shall include provisions for ventilation, humidity, and temperature control.

(3) **Administrative/changing room.** If required by the functional program, the administrative/changing room shall be separate from all other areas and provide for staff to change from street clothes into work attire. Lockers, sink, and showers shall be available within the immediate vicinity of the department.

(4) **Storage room for patient care and distribution carts.** This area shall be adjacent, easily available to clean and sterile storage, and close to main distribution point to keep traffic to a minimum and ease work flow.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-21. General stores**

(a) In addition to supply facilities in individual departments, a central storage area shall also be provided. General stores may be located in a separate building on-site with provisions for protection against inclement weather during transfer of supplies.

(b) The following shall be provided:

(1) Off-street unloading facilities.

(2) Receiving area.

(3) General storage room(s). General storage room(s) with a total area at least twenty (20) square feet (1.86 square meters) per inpatient bed shall be provided. Storage may be in separate, concentrated areas within the hospital or in individual buildings on-site. A portion of this storage may be provided off-site.

(4) Additional storage room(s). Additional storage areas for outpatient facilities shall be provided in an amount not less than five (5) percent of the total area of the outpatient facility. This may be combined with, and in addition to, the general stores or be

located in a central area within the outpatient area. A portion of this storage may be provided off-site.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-22. Linen services**

(a) Each hospital shall have provisions for storing and processing of clean and soiled linen for appropriate patient care. Processing may be done within the hospital, in a separate building on or off site, or in a commercial or shared laundry.

(b) Facilities and equipment shall be as required as described in the functional program. The following elements shall be included:

(1) A separate room for receiving and holding soiled linen until ready for pickup or processing.

(2) A central, clean linen storage and issuing room, in addition to the linen storage required at individual patient units.

(3) A cart storage area for separate parking of clean and soiled linen carts out of the traffic flow.

(4) A clean linen inspection and mending room or area. If not provided elsewhere, a clean linen inspection, delinting, folding, assembly and packaging area shall be provided as part of the linen services. Mending shall be provided for in the linen services department. A space for tables, shelving, and storage shall be provided.

(5) Handwashing facilities in each area where unbagged, soiled linen is handled.

(c) If linen is processed outside the building, provisions shall also be made for:

(1) A service entrance, protected from inclement weather, for loading and unloading linen.

(2) Control station for pickup and receiving.

(d) If linen is processed in a laundry facility which is part of the hospital (within or as a separate building), the following shall be provided in addition to that at 310:667-49-22(b):

(1) A receiving, holding, and sorting room for control and distribution of soiled linen. Discharge from soiled linen chutes may be received within this room or in a separate room.

(2) Laundry processing room with commercial type equipment which shall process at least a seven (7) day supply within the regular scheduled work week. This may require a capacity for processing a seven (7) day supply in a forty (40) hour week.

(3) Storage for laundry supplies.

(4) Employee handwashing facilities in each room where clean or soiled linen is processed and handled.

(5) Arrangement of equipment that shall permit an orderly work flow and minimize cross-traffic that might mix clean and soiled operations.

(6) Conveniently accessible staff lockers, showers, and lounge.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-23. Facilities for cleaning and sanitizing carts**

Facilities shall be provided to clean and sanitize carts serving the central service department, dietary facilities, and linen services. These facilities may be centralized or departmentalized.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-24. Employee facilities**

Lockers, lounges, and toilets shall be provided for employees and volunteers. These shall be in addition to, and separate from, those required for the medical staff and the public.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-25. Housekeeping rooms**

In addition to the housekeeping rooms required in certain departments, sufficient housekeeping rooms shall be provided throughout the facility as required to maintain a clean and sanitary environment. Each shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. There shall be at least than one (1) housekeeping room for each floor.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-26. Engineering service and equipment areas**

The following shall be provided for effective service and maintenance functions:

(1) Room(s) or separate building(s) for boilers, mechanical, and electrical equipment, except:

(A) Roof-top air conditioning and ventilation equipment installed in weatherproof housings.

(B) Standby generators where the engine and appropriate accessories, i.e., batteries, are properly heated and enclosed in a weatherproof housing.

(C) Cooling towers and heat rejection equipment.

(D) Electrical transformers and switchgear where required to serve the facility and where installed in a weatherproof housing.

(E) Medical gas parks and equipment.

(F) Air cooled chillers where installed in a weatherproof housing.

(G) Trash compactors and incinerators. Site lighting, post indicator valves, and other equipment normally installed on the exterior of the building.

(2) Engineer's office with file space and provisions for protected

storage of facility drawings, records, manuals, etc.

(3) General maintenance shop(s) for repair and maintenance.

(4) Storage room for building maintenance supplies. Storage for solvents and flammable liquids shall comply with applicable NFPA codes.

(5) Separate area or room specifically for storage, repair, and testing of electronic and other medical equipment. The amount of space and type of utilities may vary with the type of equipment involved and types of outside contracts used.

(6) Yard equipment and supply storage areas. These areas shall be located so that equipment may be moved directly to the exterior without interference with other work.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-27. Waste processing services**

(a) **Storage and disposal.** Facilities shall be provided for sanitary storage and treatment or disposal of waste using techniques acceptable to the Department and other state and local agencies. The functional program shall stipulate the categories and volumes of waste for disposal and shall stipulate the methods for disposal of each.

(b) **Incinerator.** An incinerator shall be provided for the complete destruction of pathological waste. The incinerator may be shared by two or more nearby institutions. The incinerator may be omitted if arrangements are made with a licensed local service to pick up and incinerate pathological wastes.

(1) An incinerator may also be used to dispose of other hospital waste where local regulations permit. All incinerators shall be designed and equipped for the actual quantity and type of waste to be destroyed and shall meet all applicable air pollution regulations.

(2) An incinerator with fifty (50) pounds-per-hour or greater capacities shall be in a separate room or outdoors; those with lesser capacities may be located in a separate area within the hospital boiler room. Rooms and areas containing incinerators shall have adequate space and facilities for incinerator charging and cleaning, as well as necessary clearances for work and maintenance. Provisions shall be made for operation, temporary storage, and disposal of materials so that odors and fumes do not drift into occupied areas. Existing approved incinerator installations, which are not in separate rooms or outdoors, may remain unchanged provided they meet the above criteria.

(3) The design and construction of incinerators and trash chutes shall comply with NFPA 82.

(c) **Nuclear waste disposal.** All radioactive and nuclear wastes shall be disposed of as required by federal requirements specified at CFR 10 parts 20 & 35 and as required by the Oklahoma Department of Environmental Quality.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-28. General standards for details and finishes**

(a) If approved by the Department, retained portions of existing facilities that are not required to be totally modernized due to financial or other hardships shall, as a minimum, comply with applicable requirements of the Existing Health Care Occupancies Section of NFPA 101. However, a long term plan to correct these portions shall be developed, approved by the Department and implemented.

(b) Details and finishes in new construction projects, including additions and alterations, shall comply with the following.

(1) **Details.**

(A) Compartmentation, exits, fire alarms, automatic extinguishing systems, and other fire prevention and fire protection measures, including that within existing facilities, shall comply with NFPA 101, with the following stipulation. The Fire-Safety Evaluation System (FSES) implemented by the CMS for certification evaluation shall not be used as a substitute for the basic NFPA 101 design criteria for new construction or major renovation in existing facilities. The FSES shall be used as an evaluation tool for fire safety only.

(B) Corridors in outpatient suites and in areas not commonly used for patient bed or stretcher transportation may be reduced in width to five (5) feet ( 1.52 meters).

(C) Location of items such as drinking fountains, telephone booths, vending machines, and portable equipment shall not restrict corridor traffic or reduce the corridor width below the required standard.

(D) Rooms that contain bathtubs, sitz baths, showers, and/or water closets for inpatient use shall be equipped with doors and hardware permitting emergency access from the outside. When such rooms have only one (1) opening or are small, the doors shall open outward or in a manner that avoids pressing a patient who may have collapsed within the room.

(E) If required by the functional program, door hardware on patient toilet rooms in psychiatric nursing units may be designed to allow staff to control access.

(F) The door size for inpatient bedrooms in new construction shall be at least three (3) feet eight (8) inches (1.11 meters) wide and seven (7) feet (2.13 meters) high to provide clearance for movement of beds and other equipment. Existing doors of at least two (2) feet ten (10) inches (86.36 centimeters) wide shall be acceptable where function is not adversely affected and replacement is impractical. Doors to other rooms used for stretchers, including hospital wheeled-bed stretchers and/or wheelchairs, shall have a width of at least two (2) feet ten (10) inches (86.36 centimeters). Where used in these standards, door width and height shall be the nominal dimension of the door leaf, ignoring projections of frame and stops.

(G) All doors between corridors, rooms, or spaces subject to occupancy, except elevator doors, shall be of the swing type. Manual or automatic sliding doors may be exempt from this

standard.

(H) Doors, except those to spaces such as small closets not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width. Large walkin-type closets shall be considered inhabitable spaces.

(I) Windows and outer doors that frequently may be left open shall be equipped with insect screens.

(J) Operable windows are not required in patient rooms. If operable windows are provided in patient rooms or suites, operation of such windows shall be restricted to inhibit possible escape or suicide.

(K) Glass doors, lights, sidelights, borrowed lights, and windows located within twelve (12) inches (30.48 centimeters) of a door jamb with a bottom-frame height of less than sixty (60) inches (1.52 meters) above the finished floor shall be constructed of safety glass, wired glass, or plastic, break-resistant material that creates no dangerous cutting edges when broken. Similar materials shall be used for wall openings in active areas such as recreation and exercise rooms, unless otherwise required for fire safety. Safety glass-tempered or plastic glazing materials shall be used for shower doors and bath enclosures. Plastic and similar materials used for glazing shall comply with the flame-spread ratings of NFPA 101. Safety glass or plastic glazing materials, as noted above, shall also be used for interior windows and doors, including those in pediatric and psychiatric unit corridors. In renovation projects, only glazing within eighteen (18) inches (46 centimeters) of the floor shall be changed to safety glass, wire glass, or plastic, break-resistant material. NFPA 101 contains additional requirements for glazing in exit corridors, etc., especially in buildings without sprinkler systems.

(L) Linen and refuse chutes shall meet or exceed the following standards:

(i) Service openings to chutes shall comply with NFPA 101.

(ii) The cross-sectional dimension of gravity chutes shall be at least two (2) feet (60.96 centimeters).

(iii) Chute discharge into collection rooms shall comply with NFPA 101.

(iv) Chutes shall meet the provisions as described in NFPA 82.

(M) Dumbwaiters, conveyors, and material handling systems shall not open directly into a corridor or exit, but shall open into a room enclosed by construction with a fire resistance rating of at least one (1) hour and with class C, three fourth (3/4) hour labeled fire doors. Service entrance doors to vertical shafts containing dumbwaiters, conveyors, and material handling systems shall be at least class B, one and one-half (1 1/2) hour fire doors. Where horizontal conveyors and material-handling systems penetrate fire-rated walls or partitions, such openings shall be provided with class B one and one-half (1 1/2) hour labeled fire doors for two (2) hour walls and class C three-fourth (3/4) hour labeled fire doors for one (1) hour walls or partitions.

(N) Thresholds and expansion joint covers shall be flush with the

floor surface to facilitate the use of wheelchairs and carts. Expansion and seismic joints shall be constructed to restrict the passage of smoke.

(O) Grab bars shall be provided in all patient toilets, showers, bathtubs, and sitz baths at a wall clearance of one and one-half (1 1/2) inches (3.81 centimeters). Bars, including those which are part of such fixtures as soap dishes, shall be sufficiently anchored to sustain a concentrated load of at least two hundred-fifty (250) pounds (113.4 kilograms).

(P) Location and arrangement of fittings for handwashing facilities shall permit their proper use and operation. Particular care shall be given to the clearances required for blade-type operating handles.

(Q) Mirrors shall not be installed at handwashing fixtures in food preparation areas, nurseries, clean and sterile supply areas, scrub sinks, or other areas where asepsis control shall be lessened by hair combing.

(R) Provisions for hand drying shall be included at all handwashing facilities except scrub sinks. These provisions shall be paper or cloth units enclosed to protect against dust or soil and to insure single-unit dispensing. Hot air dryers are permitted provided that installation precludes possible contamination by recirculation of air.

(S) Lavatories and handwashing facilities shall be securely anchored to withstand an applied vertical load of at least two hundred-fifty (250) pounds (113.4 kilograms) on the fixture front.

(T) Radiation protection requirements for x-ray and gamma ray installations shall conform with NCRP Report Nos. thirty-three (33) and forty-nine (49) and all applicable Department and local requirements. Provision shall be made for testing completed installations before use. All defects shall be corrected before approval.

(U) Ceiling height shall be at least seven (7) feet ten (10) inches (2.39 meters), with the following exceptions:

(i) Boiler rooms shall have ceiling clearances of at least two (2) feet six (6) inches (76.20 centimeters) above the main boiler header and connecting piping.

(ii) Ceilings in radiographic, operating and delivery rooms, and other rooms containing ceiling mounted equipment or ceiling-mounted surgical light fixtures shall be of sufficient height to accommodate the equipment or fixtures and their normal movement.

(iii) Ceilings in corridors, storage rooms, and toilet rooms shall be at least seven (7) feet eight (8) inches (2.34 meters) in height. Ceiling heights in small, normally unoccupied spaces may be reduced.

(iv) Suspended tracks, rails, and pipes located in the traffic path for patients in beds and/or on stretchers, including those in inpatient service areas, shall be at least seven (7) feet (2.13 meters) above the floor. Clearances in other areas may be six (6) feet eight (8) inches (2.03 meters).

(v) Where existing structures make the above ceiling clearance

impractical, clearances shall be as required to avoid injury to individuals who are up to six (6) feet four (4) inches (1.93 meters) tall.

(vi) Seclusion treatment rooms shall have at least a ceiling height of nine (9) feet (2.74 meters).

(V) Recreation rooms, exercise rooms, equipment rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed areas or delivery and operating suites, unless special provisions are made to minimize such noise.

(W) Rooms containing heat-producing equipment, such as boiler or heater rooms, or laundries, shall be insulated and ventilated to prevent the floor surface above and/or the adjacent walls of occupied areas from exceeding a temperature of ten (10) degrees F (60 C) above ambient room temperature.

(X) The noise reduction criteria shown in Appendix C shall apply to partitions, floors, and ceiling construction in patient areas.

(Y) Walls required to be fire rated or for smoke compartmentation shall be stenciled above the ceiling with at least two (2) inch high block letters, as follows: "2-HR WALL", "1-HR WALL", or "SMOKE COMPARTMENT WALL".

(2) **Finishes.**

(A) Cubicle curtains and draperies shall be noncombustible or flame-retardant, and shall pass both the large and small scale tests of NFPA 701 and NFPA 13 when applicable.

(B) Materials and certain plastics known to produce noxious gases when burned shall not be used for mattresses, upholstery, and other items insofar as practical. Typical "hard" floor coverings such as vinyl, vinyl composition, and rubber normally do not create a major fire or smoke problem.

(C) Floors in areas and rooms in which flammable anesthetic agents are stored or administered shall comply with NFPA 99. Conductive flooring may be omitted in anesthetizing areas where a written resolution is signed by the hospital board stating that no flammable anesthetic agents shall be used and appropriate notices are permanently and conspicuously affixed to the wall in each such area and room.

(D) Floor materials shall be easily cleanable and appropriately wear-resistant for the location. Floors in areas used for food preparation or food assembly shall be water-resistant. Floor surfaces, including tile joints, shall be resistant to food acids. In all areas subject to frequent wet-cleaning methods, floor materials shall not be physically affected by germicidal cleaning solutions. Floors subject to traffic while wet, such as shower and bath areas, kitchens and similar work areas shall have a non slip surface.

(E) In new construction or major renovation work, the floors and wall bases of operating and delivery rooms used for caesarean sections shall be monolithic and joint free. The floors and wall bases of kitchens, soiled workrooms, and other areas subject to frequent wet cleaning shall also be homogeneous, but may have tightly sealed joints.

(F) Wall finishes shall be washable. In the vicinity of plumbing

fixtures, wall finishes shall be smooth and water-resistant. In dietary and food preparation areas, wall construction, finish, and trim, including the joints between the walls and the floors, shall be free of insect and rodent-harboring spaces. In operating rooms, delivery rooms for caesarean sections, isolation rooms, and sterile processing rooms, wall finishes shall be free of fissures, open joints, or crevices that may retain or permit passage of dirt particles.

(G) Floors and walls penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

(H) Ceilings, including exposed structure in areas normally occupied by patients or staff in food preparation and food-storage areas, shall be cleanable with routine housekeeping equipment. Acoustic and lay-in ceiling, where used, shall not interfere with infection control. In dietary areas and in other areas where dust fallout may present a problem, suspended ceilings shall be provided.

(I) Ceiling finishes in semirestricted areas such as clean corridors, central sterile supply spaces, specialized radiographic rooms, and minor surgical procedure rooms must be smooth, scrubbable, nonabsorptive, nonperforated, capable of withstanding cleaning with chemicals, and without crevices that can harbor mold and bacterial growth. If lay-in ceiling is provided, it shall be gasketed or clipped down to prevent the passage of particles from the cavity above the ceiling plane into the semirestricted environment. Perforated, irregular, serrated cut, or highly textured tiles are not acceptable.

(J) Ceiling finishes in restricted areas such as operating rooms shall be monolithic, scrubbable, and capable of withstanding chemicals. Cracks or perforations in these ceilings are not allowed.

(K) In psychiatric patient rooms, toilets, and seclusion rooms, the ceiling and air distribution devices, lighting fixtures, sprinkler heads, and other appurtenances shall be of a tamper-resistant type.

(L) Rooms used for protective environment shall not have carpeted floors and shall have monolithic ceilings.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-29. Design and construction, including fire-resistive standards**

(a) **Design.** Every building and portion thereof shall be designed and constructed to sustain all live and dead loads, including seismic and other environmental forces, in accordance with accepted engineering practices and standards as prescribed by local jurisdiction or model building codes.

(b) **Construction.** Construction shall comply with the applicable requirements of NFPA 101, the standards contained herein, and the

requirements of authorities having jurisdiction. If there are no applicable local codes, recognized model building codes shall be used. NFPA 101 generally covers fire safety requirements only, whereas most model codes also apply to structural elements. The fire safety items of NFPA 101 shall take precedence over other codes in case of conflict.

(c) **Freestanding buildings.** Separate freestanding buildings for the boiler plant, laundry, shops, general storage or other nonpatient contact areas shall be built in accordance with applicable building codes for such occupancy.

(d) **Interior finishes.** Interior finishing materials shall comply with the flamespread limitations and the smoke-production limitations indicated in NFPA 101. This does not apply to minor quantities of wood or other trim (see NFPA 101) or to wall covering less than four (4) mil thick applied over a noncombustible base.

(e) **Insulation materials.** Building insulation materials, unless sealed on all sides and edges with noncombustible material, shall have a flame-spread rating of twenty-five (25) or less and a smoke-developed rating of one hundred-fifty (150) or less when tested in accordance with NFPA 258.

(f) **Provisions for disasters.**

(1) An emergency-radio communication system shall be provided in each facility. This system shall operate independently of the building's service and emergency power systems during an emergency. The system shall have frequency capabilities to communicate with state emergency communication networks. Additional communication capabilities shall be required of facilities containing a formal community emergency-trauma service or other specialty services such as regional pediatric critical care units that utilize staffed patient transport units.

(2) Unless specifically approved, a hospital shall not be built in areas subject to damage or inaccessibility due to natural floods. Where facilities may be subject to wind or water hazards, provision shall be made to ensure continuous operation.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-30. Special systems**

(a) **General.**

(1) Prior to acceptance by the facility, all special systems shall be tested and operated to demonstrate to the owner or his designated representative that the installation and performance of these systems conform to the design intent. Test results shall be documented for maintenance files.

(2) Upon completion of the special systems equipment installation contract, the owner shall be furnished with a complete set of the manufacturers' operating, maintenance, and preventive maintenance instructions, a parts list, and complete procurement information including equipment numbers and descriptions. Operating staff persons shall also be provided with instructions for proper operation of systems and equipment. Required information shall include all safety

or code ratings as needed.

(3) Insulation shall be provided surrounding special system equipment to conserve energy, protect personnel, and reduce noise.

(b) **Elevators.**

(1) All buildings having patient facilities such as bedrooms, dining rooms, or recreation areas or critical services such as operating, delivery, diagnostic, or therapeutic services located on other than the main entrance floor shall have electric or hydraulic elevators. Installation and testing of elevators shall comply with ANSI/ASME A17.1 for new construction and ANSI/ASME A17.3 for existing facilities.

(2) Engineered traffic studies are recommended, but in their absence the following guidelines for minimum number of elevators shall apply:

(A) At least one (1) hospital-type elevator shall be installed when one (1) to fifty-nine (59) patient beds are located on any floor other than the main entrance floor.

(B) At least two (2) hospital-type elevators shall be installed when sixty (60) to two hundred (200) patient beds are located on any floor other than the main entrance floor, or where the major inpatient services are located on a floor other than those containing patient beds. Elevator service may be reduced for those floors providing only partial inpatient services.

(C) At least three (3) hospital-type elevators shall be installed when 201 to 350 patient beds are located on any floor other than the main entrance floor, or where the major inpatient services are located on a floor other than those containing patient beds. Elevator service may be reduced for those floors providing only partial inpatient services.

(D) For hospitals with more than 350 beds, the number of elevators required shall be determined from a study of the hospital plan and the expected vertical transportation requirements.

(3) Hospital-type elevator cars shall have inside dimensions that accommodate a patient bed with attendants. Cars shall be at least 5 feet 8 inches (1.73 meters) wide by 9 feet (2.74 meters) deep. Car doors shall have a clear opening of not less than 4.5 feet (1.37 meters) wide and 7 feet (2.13 meters) high. In renovations, existing elevators that can accommodate patient beds used in the facility will not be required to be increased in size. Additional elevators installed for visitors and material handling may be smaller than those required in this Section within restrictions set by standards for disabled access.

(4) Elevators shall be equipped with a two-way automatic level-maintaining device with an accuracy of ±1/4 inch (±6.4 millimeters).

(5) Elevators shall have handrails on all sides without entrance doors. Handrail projections of up to 3.5 inches (88.9 millimeters) shall not be construed as diminishing the clear inside dimensions.

(6) Each elevator, except those for material handling, shall be equipped with an independent keyed switch for staff use for bypassing all landing button calls and responding to car button calls only.

(7) Elevator call buttons and controls shall not be activated by

heat or smoke. Light beams, if used for operating door reopening devices without touch, shall be used in combination with door-edge safety devices and shall be interconnected with a system of smoke detectors. This is so that the light control feature will be overridden or disengaged should it encounter smoke at any landing.

(8) Field inspections and tests shall be made and the owner shall be furnished with written certification stating that the installation meets the requirements set forth in this section as well as all applicable safety regulations and codes.

(c) **Waste processing services.**

(1) **Storage and disposal.** Facilities shall be provided for sanitary storage and treatment or disposal of waste using techniques acceptable to the Department and environmental authorities. The functional program shall stipulate the categories and volumes of waste for disposal and shall stipulate the methods of disposal for each.

(2) **Medical waste.** Medical waste shall be disposed of either by incineration or other approved technologies. Incinerators or other major disposal equipment may be shared by two or more institutions.

(A) Incinerators or other major disposal equipment may also be used to dispose of other medical waste where local regulations permit. Equipment shall be designed for the actual quantity and type of waste to be destroyed and should meet all applicable regulations.

(B) Incinerators with 50-pounds-per-hour or greater capacities shall be in a separate room or outdoors; those with lesser capacities may be located in a separate area within the facility boiler room. Rooms and areas containing incinerators shall have adequate space and facilities for incinerator charging and cleaning, as well as necessary clearances for work and maintenance. Provisions shall be made for the operation, temporary storage, and disposal of materials so that odors and fumes do not drift back into occupied areas. Existing approved incinerator installations, which are not in separate rooms or outdoors, may remain unchanged provided they meet the above criteria.

(C) The design and construction of incinerators and trash chutes shall comply with NFPA 82.

(D) Consideration shall be given to the recovery of waste heat from on-site incinerators used to dispose of large amounts of waste materials.

(E) Incinerators shall be designed in a manner fully consistent with the protection of public and environmental health, both on-site and off-site, and in compliance with federal, state, and local statutes and regulations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-31. Mechanical systems**

(a) **General.**

(1) The mechanical system shall be designed for overall efficiency

and life cycle costing. Recognized engineering procedures shall be followed for the most economical and effective results. Different geographic areas may have climatic and use conditions that favor one system over another in terms of overall cost and efficiency. In no case shall patient care or safety be sacrificed for conservation. Mechanical, electrical, and HVAC equipment may be located either internally, externally, or in a separate building.

(2) Remodeling and work in existing facilities may present special problems. As practicality and funding permits, existing insulation, weather stripping, etc., shall be brought upgraded for maximum economy and efficiency.

(3) Facility design consideration shall include site, building mass, orientation, configuration, fenestration, and other features relative to passive and active energy systems.

(4) Insofar as practical, the facility shall provide for recovery of waste cooling and heating energy, i.e., ventilation, exhaust, water and steam discharge, cooling towers, and incinerators.

(5) Facility design consideration shall include recognized energy-saving mechanisms such as variable-air-volume systems, load shedding, programmed controls for unoccupied periods, i.e., nights and weekends, and use of natural ventilation if site and climatic conditions permit.

(6) Air-handling systems shall be designed with an economizer cycle where appropriate to use outside air. Use of mechanically circulated outside air does not reduce the need for filtration.

(7) For rooms listed in Appendix A, where VAV systems are permitted, minimum total air change shall be within the limits noted. Temperature control shall also comply with these standards. To maintain asepsis control, airflow supply and exhaust shall generally be controlled to ensure movement of air from "clean" to "less clean" areas, especially in critical areas.

(8) Prior to acceptance of the facility, all mechanical systems shall be tested, balanced, and operated to demonstrate to the owner or the designated representative that the installation and performance of the systems conform to design intent. The test results shall be documented for maintenance files.

(9) Upon completion of the equipment-installation contract, the owner shall be furnished with a complete set of manufacturers operating, maintenance, and preventive maintenance instructions, a parts list, and complete procurement information including equipment numbers and descriptions. Operating staff persons shall also be provided with instructions for properly operating systems and equipment. The required information shall include energy ratings as needed for future conservation calculations.

(b) **Thermal and acoustical insulation.**

(1) Insulation within the building shall be provided to conserve energy, protect personnel, prevent vapor condensation, and reduce noise and vibration.

(2) Insulation on cold surfaces shall include an exterior vapor barrier. Material that does not absorb or transmit moisture is not required to have separate vapor barrier.

(3) Insulation, including finishes and adhesives on the exterior

surfaces of ducts and equipment, 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 NFPA 255. The smoke-development rating for pipe insulation shall not exceed one hundred-fifty (150). This includes mechanical refrigeration and distribution equipment and hot water distribution equipment such as valves, pumps and chillers.

(4) Remodeling of lined duct systems destroys the integrity of the liner sealant. However, if linings are used in nonsensitive hospital areas, they shall meet ASTM C1071. These linings, including coatings, adhesives, and exterior surface insulation on pipes and ducts in 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 NFPA 255.

(5) Duct linings exposed to air movement shall not be used in ducts serving operating rooms, delivery rooms, LDR rooms, nurseries, and critical care units. Where its use cannot be avoided, terminal filters of at least ninety (90) percent efficiency shall be installed downstream of all lining material. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such lining.

(6) Existing accessible insulation within areas of facilities to be modernized shall be inspected, repaired, and/or replaced, as appropriate.

(7) No lined duct work shall be installed down stream of humidification.

(c) **Steam and hot water systems.**

(1) Boilers shall have the capacity, based upon the net ratings published by the Hydronics Institute or another acceptable national standard, to supply the normal heating, hot water, and steam requirements of all systems and equipment. Their number and arrangement shall accommodate facility needs despite the breakdown or routine maintenance of any one boiler. The capacity of the remaining boiler(s) shall be sufficient to provide hot water service for clinical, dietary, and patient use; steam for sterilization and dietary purposes; and heating for operating, delivery, birthing, labor, recovery, intensive care, nursery, and general patient rooms. However, reserve capacity for facility space heating shall not be required in geographic areas where a design dry-bulb temperature of twenty-five (25) degrees F (-4 degrees C) or more represents not less than ninety-nine (99) percent of the total hours in any one (1) heating month as noted in ASHRAE's Handbook of Fundamentals, under the "Table for Climatic Conditions for the United States."

(2) Boiler accessories including feed pumps, heat-circulating pumps, condensate return pumps, fuel oil pumps, and waste heat boilers shall be connected and installed to provide both normal and standby service.

(3) Supply and return mains and risers for cooling, heating, and steam systems shall be equipped with valves to isolate the various sections of each system. Each piece of equipment shall have valves at the supply and return ends.

(d) **Air conditioning, heating, and ventilation systems.** The ventilation rates shown in Appendix A shall be used as model standards; they do not preclude the use of higher rates. All rooms and areas in the facility used for patient care shall have provisions for ventilation. Though natural window ventilation for nonsensitive areas and patient rooms may be employed, weather permitting, availability of mechanical ventilation shall be considered for use in interior areas and during periods of temperature extremes. Fans serving exhaust systems shall be located at the discharge end and shall be readily serviceable. Exhaust systems may be combined to enhance the efficiency of recovery devices required for energy conservation.

(1) The facility design shall utilize energy-conserving mechanisms, including recovery devices, variable air volume, load shedding, and systems to shut down or reduce ventilation of unoccupied areas, insofar as patient care is not compromised. When appropriate, mechanical ventilation shall employ an economizer cycle that uses outside air to reduce heating and cooling system loads. Filtering requirements shall be met if outside air is used as part of the mechanical ventilation system. Innovative design that provides for additional energy conservation while meeting standards for acceptable patient care shall be acceptable.

(2) Fresh air intakes shall be located at least twenty-five (25) feet (7.62 meters) from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vents, or areas that may collect vehicular exhaust or other noxious fumes. Prevailing winds and/or proximity to other structures may require greater clearances. Plumbing and vacuum vents that terminate at a level above the top of the air intake may be located as close as ten (10) feet (3.05 meters). The bottom of the outdoor air intakes serving central systems shall be as high as practical, but at least six (6) feet (1.83 meters) above ground level, or, if installed above the roof, at least three (3) feet (91 centimeters) above roof level. Exhaust outlets from areas that may be contaminated shall be above roof level and arranged to minimize recirculation of exhaust air into the facility.

(3) The ventilation systems shall be designed and balanced according to the requirements shown in Appendix A and in the applicable notes. Also see note eight (8) of Appendix A for reductions and shutdown of ventilation systems during room vacancy.

(4) In new construction and major renovation work, air supply for operating and delivery rooms shall be from ceiling outlets near the center of the work area to effectively control air movement. Return air shall be from the floor level. Each operating and delivery room shall have at least two (2) return-air inlets located as remotely from each other as practical. Design shall consider turbulence and other factors of air movement to minimize fall of particulates onto sterile surfaces. Where extraordinary procedures are performed, such as organ transplants, special designs shall be justified. Installation shall properly meet performance needs as determined by applicable standards. These special designs shall be reviewed on a case-by-case basis.

(5) Air supply for nurseries, LDRP rooms, and rooms used for

invasive procedures shall be at or near the ceiling. Return or exhaust air inlets shall be near the floor level. Exhaust grills for anesthesia evacuation and other special applications shall be permitted to be installed in the ceiling.

(6) Each space routinely used for administering inhalation anesthesia shall be equipped with a scavenging system to vent waste gases. If a vacuum system is used, the gas-collecting system shall be arranged so that it does not disturb the patient's respiratory system. Gases from the scavenging system shall be exhausted directly to the outside. The anesthesia evacuation system may be combined with the room exhaust system, provided that the part used for anesthesia gas scavenging exhausts directly to the outside and is not part of the recirculation system. Separate scavenging systems shall not be required for areas where gases are used only occasionally, such as the emergency room or offices for routine dental work. Any scavenging system shall be designed to remove as much of the gas as possible from the room environment. Anesthetizing equipment shall be selected and maintained to minimize leakage and contamination of room air.

(7) The bottoms of ventilation supply/return openings shall be at least three (3) inches (7.62 centimeters) above the floor.

(8) All central ventilation or air conditioning systems shall be equipped with filters with efficiencies equal to, or greater than, those specified in Appendix A. Where two (2) filter beds are required, filter bed one (1) shall be located upstream of the air conditioning equipment and filter bed two (2) shall be downstream of any fan or blowers. Filter efficiencies, tested in accordance with ASHRAE 52-76, shall be average. Filter frames shall be durable and proportioned to provide an airtight fit with the enclosing ductwork. All joints between filter segments and enclosing ductwork shall have gaskets or seals to provide a positive seal against air leakage. A manometer shall be installed across each filter bed having a required efficiency of seventy-five (75) percent or more, including hoods requiring HEPA filters.

(9) Duct humidifiers shall be located at least fifteen (15) feet (1.39 meters) in front of the final filters or be fitted with water removal devices that do not allow any water droplets to reach the filter. Humidifiers shall be connected to airflow proving switches that prevent humidification unless the required volume of airflow is present or high limit humidistats are provided. All duct takeoffs should be sufficiently downstream of the humidifier to ensure complete moisture dissemination. Reservoir-type water spray humidifiers shall not be used.

(10) Air-handling duct systems shall meet the requirements of NFPA 90A and those contained herein.

(11) Ducts that penetrate construction intended for x-ray or other radiation protection shall not impair the effectiveness of the protection.

(12) Fire and smoke dampers shall be constructed, located, and installed in accordance with the requirements of NFPA 101 and 90A. Fans, dampers, and detectors shall be interconnected so that damper activation does not damage ducts. Maintenance access shall be

provided at all dampers. All damper locations shall be shown on drawings. Dampers shall be activated by all phases of the fire, sprinkler, and smoke sensors, not by fan cutoff alone. Switching systems for restarting fans may be installed for fire department use in venting smoke after a fire has been controlled. However, provisions shall be made to avoid possible damage to the system due to closed dampers. When smoke partitions are required, heating, ventilation, and air conditioning zones shall be coordinated with compartmentation insofar as practical to minimize need to penetrate fire and smoke partitions.

(13) Hoods and safety cabinets shall not be used for normal exhaust of a space. If air change standards in Appendix A do not provide sufficient air for proper operation of exhaust hoods and safety cabinets when in use, supplementary makeup air, filtered and preheated, shall be provided around these units to maintain the required airflow direction and exhaust velocity. Makeup systems for hoods shall be arranged to minimize "short circuit" of air movement and to avoid reduction in air velocity at the point of contaminant capture.

(14) Laboratory hoods shall meet the following general standards:

(A) Have an average face-velocity of at least seventy-five (75) feet per minute (0.38 meters per second).

(B) Be connected to an exhaust system to the outside that is separate from the building exhaust system.

(C) Have an exhaust fan located at the discharge end of the system.

(D) Have an exhaust duct system of noncombustible corrosion-resistant material as needed to meet the planned usage of the hood.

(15) Laboratory hoods shall meet the following special standards:

(A) Fume hoods, and their associated equipment in the air stream, intended for use with perchloric acid and other strong oxidants, shall be constructed of stainless steel or other material consistent with special exposures, and shall be provided with a water wash and drain system to permit periodic flushing of duct and hood. Electrical equipment intended for installation within such ducts shall be designed and constructed to resist penetration by water. Lubricants and seals shall not contain organic materials. When perchloric acid or other strong oxidants are only transferred from one container to another, standard laboratory fume hoods and the associated equipment may be used in lieu of stainless steel construction. Fume hoods intended for use with radioactive isotopes shall be constructed of stainless steel or other material suitable for the particular exposure and shall comply with NFPA 801, Facilities for Handling Radioactive Materials.

(B) In new construction and major renovation work, each hood used to process infectious or radioactive materials shall have a face velocity of at least one hundred-fifty (150) feet per minute (0.76 meters per second) with suitable static-pressure-operated dampers and alarms to alert staff of fan shutdown. Each shall also have filters with a 99.97 percent efficiency (based on the DOP, dioctyl-phthalate test method) in the exhaust stream, and be

designed and equipped to permit the safe removal, disposal, and replacement of contaminated filters. Filters shall be as close to the hood as practical to minimize duct contamination. Hoods that process radioactive materials shall meet the requirements of the Nuclear Regulatory Commission.

(16) Exhaust hoods in food preparation centers shall comply with NFPA 96. All hoods over cooking ranges shall be equipped with grease filters, fire extinguishing systems, and heat-actuated fan controls. Cleanout openings shall be provided every twenty (20) feet (6.10 meters) in the horizontal exhaust duct systems serving these hoods. Horizontal runs of ducts serving range hoods shall be kept to a minimum.

(17) The ventilation system for anesthesia storage rooms shall conform to the requirements of NFPA 99, including the gravity option. Mechanically operated air systems are optional in this room.

(18) The space that houses ethylene oxide (ETO) sterilizers shall be designed to:

(A) Provide a dedicated local exhaust system with a minimum capture velocity of two-hundred (200) feet per minute (1.02 meters per second]) to allow for the most effective installation of an air handling system, i.e., exhaust over sterilizer door, atmospheric exhaust vent for safety valve, exhaust at sterilizer, drain and exhaust for the aerator, and multiple load station.

(B) Provide exhaust in ETO source areas such as service/aeration areas.

(C) Ensure that general airflow is away from sterilizer operator(s).

(D) Provide a dedicated exhaust duct system for ETO. The exhaust outlet to the atmosphere shall be at least twenty-five (25) feet (7.62 meters) away from any air intake.

(E) Meet OSHA requirements.

(19) Boiler rooms shall be provided with sufficient outdoor air to maintain equipment combustion rates and to limit workstation temperatures.

(20) Gravity exhaust may be used, where conditions permit, for nonpatient areas such as boiler rooms and central storage.

(21) These standards are intended to maximize appropriate use of the energy-saving potential of variable air volume systems. Any system used for occupied areas shall include provisions to avoid air stagnation in interior spaces where thermostat demands are met by temperatures of surrounding areas.

(22) Special consideration shall be given to the type of heating and cooling units, ventilation outlets, and appurtenances installed in patient-occupied areas of psychiatric units. The following shall apply:

(A) All air grilles and diffusers shall be of a type that prohibits the insertion of foreign objects.

(B) All convector or HVAC enclosures exposed in the room shall be constructed with rounded corners and shall have enclosures fastened with tamper-proof screws.

(C) HVAC equipment shall be of a type that minimizes the need for maintenance within the room.

(e) **Plumbing and other piping systems.** Unless otherwise specified, all plumbing systems shall be designed and installed in accordance with the plumbing code adopted by the Department for medical care facility plumbing equipment.

(1) The following standards shall apply to plumbing fixtures:

(A) The material used for plumbing fixtures shall be nonabsorptive and acid-resistant.

(B) Water spouts used in lavatories and sinks shall have clearances adequate to avoid contaminating utensils and the contents of carafes.

(C) All fixtures used by medical and nursing staff and all lavatories used by patients and food handlers shall be trimmed with valves that can be operated without hands (single-lever devices may be used). Blade handles used for this purpose shall not exceed four and one-half (4-1/2) inches (i 1.43 centimeters) in length. Handles on scrub sinks and clinical sinks shall be at least six (6) inches (15.24 centimeters) long.

(D) Clinical sinks shall have an integral trap wherein the upper portion of the water trap provides a visible seal.

(E) Showers and tubs shall have nonslip walking surfaces.

(2) The following standards shall apply to potable water supply systems:

(A) Systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand. Supply capacity for hot and cold water piping shall be determined on the basis of fixture units, using recognized engineering standards. When the ratio of plumbing fixtures to occupants is proportionally more than required by the building occupancy and is in excess of one thousand (1,000) plumbing fixture units, a diversity factor shall be permitted.

(B) Each water service main, branch main, riser, and branch to a group of fixtures shall have valves. Stop valves shall be provided for each fixture. Appropriate panels for access shall be provided at all valves where required.

(C) Vacuum breakers shall be installed on hose bibbs and supply nozzles used for connection of hoses or tubing in laboratories, housekeeping sinks, bedpan-flushing attachments, and autopsy tables, etc.

(D) Bedpan-flushing devices, which may be cold water, shall be provided in each inpatient toilet room; however, installation shall be optional in psychiatric and chemical-abuse units where patients are ambulatory.

(E) Potable water storage vessels (hot and cold) not intended for constant use shall not be installed.

(3) The following standards shall apply to hot water systems:

(A) The water-heating system shall have sufficient supply capacity at the temperatures and amounts indicated in Appendix E. Water temperature shall be measured at the point of use or inlet to the equipment.

(B) Hot-water distribution systems serving patient care areas shall be under constant recirculation to provide continuous hot water at each hot water outlet. The temperature of hot water for

showers and bathing shall be appropriate for comfortable use but shall not exceed 110 degrees F (43 degrees C -- Refer to Appendix E).

(4) The following standards shall apply to drainage systems:

(A) Drain lines from sinks used for acid waste disposal shall be made of acid-resistant material.

(B) Drain lines serving some types of automatic blood-cell counters shall be of carefully selected material that eliminate potential for undesirable chemical reactions and/or explosions between sodium azide wastes and copper, lead, brass, and solder.

(C) Insofar as possible, drainage piping shall not be installed within the ceiling or exposed in operating and delivery rooms, nurseries, food preparation centers, food serving areas, food storage areas, central services, electronic data processing areas, electric closets, and other sensitive areas. Where exposed, overhead drain piping in these areas is unavoidable, special provisions shall be made to protect the space below from leakage, condensation, or dust particles.

(D) Floor drains shall not be installed in operating, delivery, and cystoscopic rooms.

(E) Drain systems for autopsy tables shall be designed to positively avoid splatter or overflow onto floors or back siphonage and for easy cleaning and trap flushing.

(F) Building sewers shall discharge into a community sewage system. Where such a system is not available, the facility shall treat its sewage in accordance with local and state regulations.

(G) Kitchen grease traps shall be located and arranged to permit easy access without the need to enter food preparation or storage areas.

(H) Where plaster traps are used, provisions shall be made for appropriate access and cleaning.

(5) The installation of nonflammable medical gas and air systems shall comply with the requirements of NFPA 99. Rooms with station outlets shall comply with Appendix B. When any piping or supply of medical gases are installed, altered, or augmented, the altered zone shall be tested and certified as required by NFPA 99.

(6) Clinical vacuum system installations shall be in accordance with NFPA 99. Rooms that require station outlets are specified in Appendix B. Cautionary comments of NFPA 99 may be especially applicable when a vacuum system is being considered for scavenging of anesthetizing gases.

(7) All piping, except control-line tubing, shall be identified. All valves shall be tagged, and a valve schedule provided to the facility owner for permanent record and reference.

(8) Where the functional program includes hemodialysis, continuously circulated filtered cold water shall be provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-32. Electrical systems**

(a) **General.**

(1) All material and equipment, including conductors, controls, and signaling devices, shall be installed in compliance with applicable sections of NFPA 70 and NFPA 99. All materials shall be listed as complying with approved established standards.

(2) The electrical installations, including alarm, nurse call and communication systems, shall be tested to demonstrate that equipment installation and operation is appropriate and functional. A written record of performance tests on special electrical systems and equipment shall show compliance with applicable codes and standards. Grounding continuity shall be tested as described in NFPA 99.

(3) Shielded isolation transformers, voltage regulators, filters, surge suppressors, or other safeguards shall be provided as required where power line disturbances are likely to affect data processing and/or automated laboratories or diagnostic equipment.

(4) Design of the electrical systems shall provide for avoiding power-factor deviations below established norms.

(b) **Switchboards and power panels.** Switchboards and power panels shall comply with NFPA 70. The main switchboard shall be located in an area separate from plumbing and mechanical equipment and shall be accessible to authorized persons only. The switchboards shall be convenient for use, readily accessible for maintenance, away from traffic flow, and located in a dry, ventilated space free of corrosive or explosive fumes, gases, or any flammable material. Overload protection devices shall operate properly at ambient room temperatures.

(c) **Panelboards.** Panelboards serving normal lighting and appliance circuits shall be located on the same floor as the circuits they serve. Panelboards serving critical branch emergency circuits shall be located on each floor that has major users such as operating rooms, delivery suite, and intensive care. Panelboards serving life safety emergency circuits may also serve floors above and/or below for secondary users such as general patient areas, administration, laboratory, and x-ray.

(d) **Lighting.**

(1) Three (3) types of interior lighting systems are available and shall be maximized when designing lighting; e.g., direct, indirect, and task lighting. Site lighting, a specialty, requires design skill to create an efficient system. In general, the use of light colors and reflective surfaces can affect lighting efficiency.

(A) Direct lighting has been the standard design for years and shall remain so for some time. Its performance has been dramatically increased in recent years through the improvement of luminaries and the use of more efficient light sources.

(B) Indirect lighting uses the reflectance characteristics of the ceiling and walls to disperse the light, resulting in less glare and higher visual comfort. Calculations are best accomplished by computers. The most popular sources for indirect lighting are metal halide and high-pressure sodium.

(C) Task lighting reduces general area lighting needs by applying light to a specific task. This system of lighting results in the greatest energy savings by focusing light only in required spaces. Emphasis shall be given to task lighting design that is independently controlled for use on an as needed basis.

(D) Site lighting shall be high and/or low pressure sodium or metal halides. Calculations of footcandles and layouts are best accomplished by computer for maximization of light efficiency.

(2) Approaches to buildings and parking lots, and all occupied spaces within buildings shall have lighting fixtures.

(3) Patient rooms shall have general lighting and night lighting. A reading light shall be provided for each patient. Flexible light arms, if used, shall be mechanically controlled to prevent the bulb from contacting the bed linen. At least one (1) night light fixture in each patient room shall be controlled at the room entrance. All light controls in patient areas shall be quiet-operating. Lighting for intensive care bed areas shall permit staff observation of the patient but minimize glare.

(4) Operating and delivery rooms shall have general lighting in addition to special lighting units provided at surgical and obstetrical tables. General lighting and special lighting shall be on separate circuits.

(5) Nursing unit corridors shall have general illumination with provisions for reducing light levels at night.

(6) Light intensity for staff and patient needs shall generally comply with health care guidelines set forth in the Illuminating Engineering Society of North America (IES) publications. Consideration shall be given to controlling intensity to prevent harm to the patient's eyes, i.e., retina damage in premature infants and cataracts due to ultraviolet light. Many procedures are available to satisfy requirements, but the design shall consider light quality as well as quantity for effectiveness and efficiency. While light levels in the IES publication are referenced, those publications include other useful guidance and recommendations that the designer is encouraged to follow.

(7) Light intensity of required emergency lighting shall generally comply with standards in the IES publication, Lighting for Health Care Facilities.

(e) **Receptacles (convenience outlets).**

(1) Receptacles for pediatric and psychiatric units shall be in accordance with NFPA 70.

(2) Each operating room and delivery room shall have at least six (6) receptacles at anesthetizing locations. Where mobile x-ray equipment requiring special electrical considerations is used, additional receptacles distinctively marked for x-ray use shall be provided. Design shall comply with NFPA 70, article 517 for receptacle requirements when capacitive discharge or battery--operated, mobile x-ray units are used. Each operating room shall have at least sixteen (16) simplex or eight (8) duplex receptacles at the height of thirty-six (36) inches (0.91 meter). In addition, special receptacles for x-ray, laser or other equipment requiring special plugs or voltage shall be provided in accordance with the functional plan.

(3) Each patient room shall have duplex-grounded receptacles. There shall be one (1) at each side of the head of each bed; one for television, if used; and one on every other wall. Receptacles may be omitted from exterior walls where construction makes installation

impractical. Nurseries shall have at least two (2) duplex-grounded receptacles for each bassinet. Critical care areas as defined in NFPA 70, article 517, including pediatric and newborn intensive care, shall have at least seven (7) duplex outlets at the head of each bed, crib, or bassinet. Trauma and resuscitation rooms shall have eight (8) duplex outlets located convenient to head of each bed. Emergency department examination and treatment rooms shall have at least six (6) duplex outlets located convenient to the head of each bed. Approximately fifty (50) percent of critical and emergency care outlets shall be connected to emergency system power and be so labeled.

(4) Duplex-grounded receptacles for general use shall be installed approximately fifty (50) feet (15.24 meters) apart in all corridors and within twenty-five (25) feet (7.62 meters) of corridor ends. Receptacles in pediatric unit corridors shall be of the tamper-resistant type or protected by five (5) milliampere ground-fault circuit interrupters (GFCI). Single-polarized receptacles marked for use of x-ray only shall be installed in corridors of patient areas so that mobile equipment may be used anywhere within a patient room using a cord length of fifty (50) feet (15.24 meters) or less. If the same mobile x-ray unit is used in operating rooms and in nursing areas, receptacles for x-ray use shall permit the use of one plug in all locations. Where capacitive discharge or battery-powered x-ray units are used, separate polarized receptacles shall not be required.

(5) Electrical receptacle coverplates or electrical receptacles supplied from the emergency system shall be distinctively colored or marked for identification. If color is used for identification purposes, the same color shall be used throughout the facility.

(f) **Equipment installation in special areas.**

(1) At inhalation anesthetizing locations, all electrical equipment and devices, receptacles, and wiring shall comply with applicable sections of NFPA 99 and NFPA 70.

(2) Fixed and mobile x-ray equipment installations shall conform to articles 517 and 660 of NFPA 70.

(3) The x-ray film illuminator unit or units for displaying at least four (2) films simultaneously shall be installed in each specified emergency treatment rooms x-ray viewing room of the radiology department. All illuminator units within one (1) space or room shall have lighting of uniform intensity and color value.

(4) Ground-fault circuit interrupters shall comply with NFPA 70. When ground-fault circuit interrupters (GFCI) are used in critical areas, provisions shall be made to insure that other essential equipment is not affected by activation of one interrupter.

(5) In areas such as critical care units and special nurseries where a patient may be treated with an internal probe or catheter connected to the heart, the ground system shall comply with applicable sections of NFPA 99 and NFPA 70.

(g) **Nurse call system.**

(1) In patient areas, each patient room shall be served by at least one (1) call station for two-way voice communication. Each bed shall be provided with a call device. Two (2) call devices serving

adjacent beds may be served by one (1) call station. Calls shall activate a visible signal in the corridor at the patient's door, in the clean workroom, in the soiled workroom, and at the nursing station of the nursing unit. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two (2) or more call stations, indicating lights shall be provided at each station. The nurses call system at each call station shall be equipped with an indicating light that remains lighted as long as the voice circuit is operating.

(2) A nurse emergency call system shall be provided at each inpatient toilet, bath, sitz bath, and shower room. This system shall be accessible to a collapsed patient lying on the floor. Inclusion of a pull cord shall satisfy this requirement. The emergency call system shall be designed so that a signal activated at a patient's calling station initiates a visible and audible signal distinct from the regular nurse calling system that can be turned off only at the patient calling station. The signal shall activate an enumerator panel at the nurse station, a visible signal in the corridor at the patient's door, and at other areas defined by the functional program. Provisions for emergency calls shall also be needed in outpatient and treatment areas where patients may be subject to incapacitation.

(3) In areas such as critical care where patients are under constant visual surveillance, the nurse call system may be limited to a bedside button or station that activates a signal readily seen at the control station.

(4) An emergency assistance system for staff to summon additional assistance shall be provided in each operating, delivery, recovery, emergency examination and/or treatment area, and in critical care units, nurseries, special procedure rooms, stress-test areas, triage, outpatient surgery, admission and discharge areas, and areas for psychiatric patients including seclusion and security rooms, anterooms and toilet rooms serving them, communal toilet and bathing facility rooms, dining, activity, therapy, exam, and treatment rooms. This system shall annunciate at the nurse station with back-up to another staffed area from which assistance shall be summoned.

(h) **Emergency electric service.**

(1) An emergency electrical source shall be provided and connected to certain circuits to provide lighting and power during an interruption of the normal electric supply. Where stored fuel is required, storage capacity shall permit continuous operation for at least twenty-four (24) hours. Fuel storage for electricity generation shall be separate from heating fuels. If the use of heating fuel for diesel engines is considered after the required twenty-four (24) hour supply has been exhausted, positive valving and filtration shall be provided to avoid entry of water and/or contaminants. In areas where the electrical service is found to be unreliable, consideration should be given to the use of dual-fuel generator units.

(2) The source(s) of this emergency electric service shall be:

(A) An emergency generating set for facilities whose normal

service is supplied by one (1) or more central station transmission lines.

(B) An emergency generating set or a central station transmission line for facilities whose normal electrical supply is generated on the premises.

(3) The required emergency generating set, including the prime mover and generator, shall be located on the premises and shall conform to NFPA 99 and NFPA 110.

(4) As required in NFPA 99 and NFPA 70, emergency electric service shall be provided to all services that must continue to function during any failure of the normal power source including the fire pump, if installed. Each patient bed and treatment space shall have access to a receptacle on the critical branch of the emergency power system. Where access is by an extension cord, the required length shall not exceed fifty (50) feet (15.24 meters).

(5) Local codes and regulations may have additional requirements.

(6) Exhaust systems, including locations, mufflers, and vibration isolators, for internal combustion engines shall be designed and installed to minimize objectionable noise. Where a generator is routinely used to reduce peak loads, protection of patient areas from excessive noise shall be accomplished.

(7) An emergency generator set shall have adequate clearances for access and maintenance and shall be provided with appropriate ventilation for cooling and elimination of fumes. Mechanisms for intake air shall be arranged to resist entry of rain and/or snow.

(i) **Fire alarm system.** The fire alarm and detector system shall be in compliance with NFPA 101 and NFPA 72.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-33. Skilled nursing unit - distinct part**

(a) **General conditions.**

(1) **Applicability.** This section covers a distinct part of a general medical surgical hospital and represents minimum requirements for new construction. Requirements shall not be applied to existing units unless major construction renovations are undertaken.

(2) **Ancillary services.** Since the nursing unit is part of a general hospital, services such as dietary, storage, pharmacy, and laundry may be shared. In some cases, all ancillary service requirements can be met by the hospital although modifications may be necessary within the nursing unit. In some cases, the functional program and requirements may dictate separate services.

(3) **Environment of care.** Nursing facilities shall be designed to provide flexibility in order to meet the changing physical, medical, and psychological needs of the residents. The facility design shall produce a supportive environment to enhance and extend quality of life for residents and facilitate wayfinding while promoting privacy, dignity, and self-determination. The architectural design, through the organization of functional space, the specification of ergonomically appropriate and arranged furniture and equipment, and

the selection of details and finishes, shall eliminate as many barriers as possible to effect access and use by residents of all space, services, equipment, and utilities appropriate for daily living.

(4) **Hospital conversions.** While there are similarities in the spatial arrangement of a hospital and nursing facility, the service requirements of long-term care residents require special design considerations. When a section of a general medical surgical hospital is converted, it may be necessary to reduce the number of beds to provide space for long-term care services. The design shall maximize opportunities for ambulation and self-care, and minimize the negative aspects of institutionalization.

(5) **Services.** Each unit shall contain the elements described, however, when the project calls for the sharing or purchase of services, appropriate modifications or deletions in space requirements may be made.

(b) **Resident Unit.** Each resident unit shall contain the following:

(1) Resident units are groups of resident rooms, staff work areas, service areas and resident support areas, whose size and configuration are based upon organizational patterns of staffing, functional operations and communications, as provided in the functional program for the facility.

(2) Unit size

(A) Maximum sixty (60) beds, or

(B) Maximum one hundred fifty (150) feet travel distance between nurse’s station and resident room.

(3) Arranging groups of resident rooms adjacent to decentralized service areas, optional satellite staff work areas, and optional decentralized resident support areas is acceptable.

(4) In new construction, resident units shall be arranged to avoid unrelated traffic through the unit.

(5) Each resident room shall meet the following requirements:

(A) Maximum room occupancy in renovations, less than fifty (50) percent change, shall be four (4) residents.

(B) Maximum room occupancy for new construction shall be two (2) occupants.

(C) Based upon the function program for the facility, provisions shall be made for individual occupancy when medically or behaviorally indicated.

(D) In new construction, room areas exclusive of toilets, closets, lockers, wardrobes, alcoves, or vestibules, shall be at least one hundred-twenty (120) square feet (11.15 square meters) in single bed rooms and one hundred (100) square feet (9.29 square meters) per bed in multiple-bed rooms. In renovations, room areas exclusive of toilets, closets, lockers, wardrobes, alcoves, or vestibules, shall be at least one hundred (100) square feet (9.29 square meters) in single bed rooms and eighty (80) square feet (7.43 square meters) per bed in multiple-bed rooms. In multiple-bed rooms, clearance shall allow for the movement of beds and equipment without disturbing residents. The dimensions and arrangement of rooms shall be such that there is at least three (3) feet (0.91 meter) between the sides and foot of the bed and

any wall, other fixed obstruction, or bed. If function is not impaired, minor encroachments such as columns, lavatories, and door swings may be ignored in determining space requirements.

(E) Each room shall have a window that meets the requirements at OAC 310:667-49-28(b)(1)(J).

(F) A nurse call system shall be provided. Each bed shall be provided with a call device. Two (2) call devices serving adjacent beds may be served by one (1) call station. Calls shall activate a visible signal in the corridor at the resident's door or other appropriate location. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. A nurse emergency call system shall be provided at each inpatient toilet, bath, sitz bath, and shower room. This system shall be accessible to a collapsed resident lying on the floor. Inclusion of a pull cord satisfies this requirement. The emergency call system shall be designed so that a signal activated at a resident's calling station initiates a visible and audible signal distinct from the regular nurse call system that can be turned off only at the resident call station. The signal shall activate an annunciator panel at the nurses station or other appropriate location, a visible signal in the corridor at the resident's door, and at other areas defined by the functional program.

(G) Handwashing stations shall be provided in each resident room. They may be omitted from single-bed or two (2) bed rooms when such is located in an adjoining toilet room serving that room only.

(H) Each resident shall have access to a toilet room without having to enter the corridor area. One (1) toilet room shall serve no more than four (4) beds and no more than two (2) resident rooms in renovation projects and no more than two residents in new construction.

(I) The toilet room shall contain a water closet, a handwashing station, and a horizontal surface for the personal effects of each resident. Doors to toilet rooms shall comply with the requirements of NFPA 101, 2000 edition, with provisions made to ensure acoustical privacy and resident safety. Toilets utilized by residents shall be accessible as required at OAC 310:667-41-3.

(J) Each resident bedroom shall have a wardrobe, locker, or closet with clear dimensions of at least one (1) foot ten (10) inches (55.88 centimeters) depth by one (1) foot eight (8) inches (50.80 centimeters); with a shelf and clothes rod provided at heights accessible to the resident. Accommodations shall be made for the storage of full-length garments. The shelf may be omitted if the unit provides at least two (2) drawers and capacity for storing extra blankets, pillows, etc.

(K) Visual privacy shall be provided for each resident in multiple-bed rooms. Design for privacy shall not restrict resident access to the toilet, lavatory, room entrance, window, or other shared common areas within the resident’s room.

(L) Beds shall be no more than two (2) deep from windows in new construction and three (3) deep from windows in renovated construction.

(6) The size and features of each service area shall depend upon the number and types of residents served. Although identifiable spaces are required for each indicated function, consideration shall be given to multiple-use designs that provide equal, though unspecified, areas. Service areas may be arranged and located to serve more than one (1) nursing unit, but at least one (1) such service area shall be provided on each nursing floor unless noted otherwise. Except where the words room or office are used, service may be provided in a multipurpose area. The following service areas shall be located in or be readily accessible to each nursing unit:

(A) Nurses station. This shall have space for charting, storage, and administrative activities.

(B) Toilet room(s). Toilets with handwashing stations for staff shall be provided and may be unisex.

(C) Lockable closets, drawers, or compartments shall be provided for safekeeping of staff personal effects such as handbags.

(D) Staff lounge area(s) shall be provided and may be shared by more than one (1) nursing unit or service.

(E) Clean utility room. If the room is used for work, it shall contain a counter, handwashing station, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile materials, the work counter and handwashing station may be omitted.

(F) Soiled utility or soiled holding room. This shall contain a clinical sink or equivalent flushing-rim fixture with a rinsing hose or a bed pan sanitizer, handwashing station, soiled linen receptacles, and waste receptacles in the number and type as required in the functional program for the facility.

(G) Medication station. Provision shall be made for twenty-four (24) hour distribution of medications. A medicine preparation room, a self-contained medicine dispensing unit, or other system may be used for this purpose. The medicine preparation room, if used, shall be visually controlled from the nurses station. It shall contain a work counter, sink, refrigerator, and locked storage for controlled drugs. It shall have an area of at least fifty (50) square feet (4.65 square meters). A self contained medicine dispensing unit, if used, may be located at the nurses station, in the clean workroom, in an alcove, or in other space convenient for staff control. The standard cup sinks provided in many self contained units are not adequate for handwashing.

(H) Clean linen storage. A separate closet or designated area shall be provided. If a closed-cart system is used, storage may be in an alcove where staff control can be assured.

(I) Nourishment station. This shall contain a work counter, refrigerator, storage cabinets, and a sink for serving nourishments between meals. Ice for residents consumption shall be provided by icemaker units which may serve more than one (1) nourishment station. Where accessible to resident and the public, ice-maker units shall be self-dispensing. Ice-makers shall be located, designed, and installed to minimize noise. The nourishment station shall include space for trays and dishes used

for nonscheduled meal service. Handwashing facilities shall be in or immediately accessible from the nourishment station.

(J) Storage space for wheelchairs that shall be located away from normal traffic flow.

(K) Resident bathing facilities. At least one (1) bathtub or shower shall be provided for every twenty (20) beds or major fraction thereof not otherwise served by bathing facilities in resident rooms. Residents shall have access to at least one bathtub per floor or unit, sized to permit assisted bathing in a tub or shower. The bathtub in this room shall be accessible to residents in wheelchairs and the shower shall accommodate a shower gurney with fitting for a resident in a recumbent position. Other showers and tubs shall be in individual room(s) or enclosure(s) with space for private use of the bathing fixture, for drying and dressing and access to a grooming location containing a sink, mirror and counter or shelf.

(L) A separate toilet shall be provided that is directly accessible to each multifixture central bathing area without requiring entry into the general corridor. This may also serve as the required toilet training facility.

(c) **Resident support areas.**

(1) **Area need.** In new construction, the total area set aside for dining, resident lounges, and recreation areas shall be at least thirty-five (35) square feet (3.25 square meters) per bed with a total area of at least two hundred twenty-five (225) square feet (20.90 square meters). At least twenty (20) square feet (1.86 square meters) per bed shall be available for dining. Additional space may be required for outpatient day care programs. For renovations, at least fourteen (14) square feet (1.30 square meters) per bed shall be available for dining. Additional space may be required for outpatient day care programs.

(2) **Storage.** Storage space(s) for supplies, resident needs, and recreation shall be provided. This area shall be on-site but not necessarily in the same building as the resident room, provided access is convenient.

(d) **Activities.** If included in the functional program, the minimum requirements for new construction shall include:

(1) Area shall be available for storage of large items used for large group activities. This storage shall be accessible to the area served (point of use).

(2) A space for small group and "one-on-one" activities shall be readily accessible to the residents.

(3) Space and equipment shall be readily accessible for carrying out each of the activities defined in the functional program.

(4) Resident toilet rooms shall be convenient to the area.

(e) **Rehabilitation therapy.** Each skilled nursing unit that provides physical and/or occupational therapy services for rehabilitating long--term care residents shall have areas and equipment that conform to program intent. Where the nursing facility is part of a general hospital or other facility, services may be shared as appropriate. The following shall be located on-site and convenient for use:

(1) Space for files, records, and administrative activities.

(2) Provisions for wheelchair residents.
(3) Storage for supplies and equipment.
(4) Handwashing facilities within the therapy unit.
(5) Space and equipment for carrying out each of the types of therapy that may be prescribed.
(6) Provisions for resident privacy.
(7) Housekeeping rooms, in or near unit.
(8) Resident toilet room(s), usable by wheelchair residents.
(9) Additional outpatient requirements:
(A) Convenient facility access for the disabled.
(B) Lockers for storing patients' clothing and personal effects.
(A) Outpatient facilities for dressing.
(D) Shower(s) for patient use.

(f) **Barber/beauty area.** Facilities and equipment for resident hair care and grooming shall be provided separate from the resident rooms. These may be unisex and can be located adjacent to central resident activity areas, provided that location and scheduling preserve patient dignity. Resident toilets shall be readily accessible to the hair and grooming area(s).

(g) **Alzheimer's and other dementia units.**
(1) Areas or pieces of furniture that could be hazardous to residents should be eliminated or designed to minimize possible accidents.
(2) All locking arrangements shall comply with the requirements contained in the NFPA 101, 2000 edition. All secured units shall, at a minimum, contain appropriate activity areas, dining, bathing, soiled linen/utility, and staff work area.
(3) Secured outdoor areas shall be made available to residents.
(4) Activity space for resident use in dementia programs shall be provided.

(h) **General services.** The following services shall be provided:
(1) Dietary facilities. Food service facilities and equipment shall conform with requirements of this Chapter and other appropriate codes and shall provide food service for residents, staff, and visitors of the unit.
(A) Food receiving, storage, and preparation areas shall facilitate quality control. Provision shall be made for the transport of hot and cold foods, as required by the functional program. Separate dining areas shall be provided for staff and for residents. The design and location of dining facilities shall encourage resident use.
(B) Facilities shall be furnished to provide nourishments and snacks between scheduled meals.
(C) The dietary facility shall be easily cleaned and maintained in a sanitary condition.
(D) Functional elements. If the dietary facility is on-site, the following facilities, in the size and number appropriate for the type of food service selected, shall be provided:
(i) A control station for receiving and controlling food supplies.
(ii) Storage space, including cold storage, for at least a four-day supply of food. Facilities in more remote areas may

require proportionally more food storage facilities.

(iii) Food preparation facilities. Conventional food service systems require space and equipment for preparing, cooking, and baking. Convenience food service systems using frozen prepared meals, bulk packaged entrees, individual packaged portions, or those using contractual commissary services, require space and equipment for thawing, portioning, cooking, and/or baking.

(iv) Handwashing stations located in the food preparation area.

(v) Facilities for assembly and distribution to patient rooms.

(vi) Separate dining facilities for residents and staff.

(vii) Warewashing space located in a room or an alcove separate from the food preparation and servicing area. Commercial-type warewashing equipment shall be provided. Space shall also be provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using areas. Convenient handwashing stations shall be provided.

(viii) Potwashing facilities.

(ix) Storage areas and sanitizing facilities for cans, carts, and mobile tray conveyors.

(x) Waste, storage, and recycling facilities located in a separate room easily accessible to the outside for direct disposal or pick-up.

(xi) Office(s) or desk spaces for dietician(s) and/or dietary service manager.

(xii) Toilet for dietary staff convenient to the kitchen area.

(xiii) A housekeeping room located within the dietary department. This shall include a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(xiv) Ice-making facilities located in the food preparation area or in a separate room. It shall be easily cleaned and convenient to the dietary department.

(2) Administrative areas and public areas. The following shall be provided and may be common with the general medical surgical hospital:

(A) Entrance. This shall be at grade level, sheltered from inclement weather, and accessible to the handicapped.

(B) Administrative/lobby area. This shall include:

(i) A counter or desk for reception and information.

(ii) Public waiting area(s).

(iii) Public toilet facilities.

(iv) Public telephone(s).

(v) Drinking fountain(s).

(3) General or individual office(s). These shall be provided for business transactions, admissions, social services, medical and financial records, and administrative and professional staff. There shall be provisions for private interviews.

(4) Multipurpose room(s). There shall be a multipurpose room for conferences, meetings, and health education purposes as required by the functional program; it shall include provisions for the use of visual aids. One (1) multipurpose room may be shared by several services.

(5) Storage for office equipment and supplies.

(6) Clerical files and staff office space shall be provided as needed.

(i) **Linen services.**

(1) Each facility shall have provisions for storing and processing of clean and soiled linen for appropriate resident care. Processing may be done within the facility, in a separate building or off-site, or in a commercial or shared laundry. At least, the following elements shall be included:

(A) A separate room for receiving and holding soiled linen until ready for pickup or processing. Such room shall have proper ventilation and exhaust.

(B) A central, clean linen storage and issuing room(s), in addition to the linen storage required at individual resident units.

(C) Provisions shall be made for parking of clean and soiled linen carts separately and out of traffic.

(D) Handwashing stations in each area where unbagged, soiled linen is handled.

(2) If linen is processed off-site, provisions shall also be made for:

(A) A service entrance, protected from inclement weather, for loading and unloading of linen.

(A) Control station for pickup and receiving.

(3) If linen is processed in a laundry facility within the facility, the following shall be provided:

(A) A receiving, holding, and sorting room for control and distribution of soiled linen. Discharge from soiled linen chutes may be received within the room or a separate room adjacent to it.

(B) Washers/extractors may be located between the soiled linen receiving and clean processing areas. Personal laundry, if decentralized, may be handled within one room or rooms, so long as there are separate, defined areas for handling clean and soiled laundry.

(C) Storage for laundry supplies.

(D) Linen inspection and mending area.

(E) Arrangement of equipment that will permit orderly flow and minimize cross-traffic that might mix clean and soiled operations.

(j) **Housekeeping rooms.** Housekeeping rooms shall be provided throughout the unit as required to maintain a clean and sanitary environment. Each shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. There shall not at least one (1) housekeeping room for each floor of the unit.

(k) **Engineering service and engineering areas.** The following shall be provided as necessary for effective service and maintenance functions:

(1) Room(s) or separate building(s) for boilers, mechanical, and electrical equipment.

(2) Provisions for protected storage of facility drawings, records, manuals, etc.

(3) General maintenance area for repair and maintenance.

(4) Storage for solvents and flammable liquids shall comply with applicable NFPA codes.

(5) Yard equipment and supply storage areas shall be located so that

equipment may be moved directly to the exterior.

(6) Loading dock, receiving and breakout area(s), if required by the functional program. These may be shared with other services.

(7) General storage spaces shall be provided for furniture and equipment such as intravenous stands, inhalators, air mattresses, walkers, etc., medical supplies, housekeeping supplies, and equipment.

(l) **Details and finishes.** Nursing facilities require features that encourage ambulation of long-term residents. Potential hazards to the infirm, such as sharp corners, highly polished floors, and loose carpets, shall be avoided.

(1) **Details.**

(A) The placement of drinking fountains, public telephones, and vending machines shall not restrict corridor traffic or reduce the corridor width below the minimum stipulated in NFPA 101.

(B) Doors to all rooms containing bathtubs, sitz baths, showers, and water closets for resident use shall be hinged, sliding, or folding.

(C) Windows and outer doors that may be left open shall have insect screens.

(D) Resident rooms or suites in new construction shall have windows. Operable windows or vents that open from the inside shall be restricted to inhibit possible resident escape or suicide. Windows shall have sills located above grade, but no higher than 36 inches (914.4 millimeters) above the finished floor.

(E) Doors, sidelights, borrowed lights, and windows glazed to within eighteen (18) inches (45.72 centimeters) of the floor shall be constructed of safety glass, wire glass, tempered glass, or plastic glazing material that resists breaking and creates no dangerous cutting edges when broken. Similar materials shall be used in wall openings in activity areas, such as recreation rooms and exercise rooms, unless fire safety codes require otherwise. Glazing for shower doors and tub enclosures shall be safety glass or plastic.

(F) Thresholds and expansion joint covers shall be designed to facilitate use of wheelchairs and carts and to prevent tripping.

(G) Grab bars shall be installed in all resident toilets, showers, tubs, and sitz baths. For wallmounted grab bars, a one and one-half (1 1/2) inch (3.81 centimeter) clearance from walls is required. Bars, including those which are part of fixtures such as soap dishes, shall have the strength to sustain a concentrated load of at least two hundred fifty (250) pounds (113.4 kilograms).

(H) Handrails shall be provided on both sides of all corridors normally used by residents. A clearance of one and one-half (1 1/2) inches (3.81 centimeters) shall be provided between the handrail and the wall. Rail ends shall be finished to minimize potential for personal injury.

(I) Handwashing stations shall be constructed with sufficient clearance for blade-type operating handles as may be required.

(J) Lavatories and handwashing stations shall be securely anchored.

(K) Each resident handwashing station shall have a mirror. Mirror placement shall allow for convenient use by both wheelchair occupants and/or ambulatory persons. Tops and bottoms may be at levels usable by individuals either sitting or standing, or additional mirrors may be provided for wheelchair occupants. One (1) separate full-length mirror may serve for wheelchair occupants.

(L) Provisions for hand drying shall be included at all handwashing stations. These shall be paper or cloth towels enclosed to protect against dust or soil and to insure single-unit dispensing.

(M) Ceiling height shall be at least seven (7) feet ten (10) inches (2.39 meters) with the following exceptions:

(i) Rooms containing ceiling-mounted equipment shall have the required ceiling height to ensure proper functioning of that equipment.

(ii) Ceilings in corridors, storage rooms, and toilet rooms shall be at least seven (7) feet eight (8) inches (2.34 meters). Ceilings in normally unoccupied spaces may be reduced to seven (7) feet (2.13 meters).

(iii) Building components and suspended tracks, rails, and pipes located along the path of normal traffic shall be at least seven (7) feet (2.13 meters) above the floor.

(iv) Boiler rooms shall have ceiling clearances of at least 2 feet 6 inches (762 millimeters) above the main boiler and connecting pipe.

(v) In buildings being renovated, it is desirable to maintain the minimum ceiling heights required at OAC 310:667-49-33(j)(1)(M). However, in no case shall ceiling heights be reduced more than 4 inches (25.4 millimeters) below the minimum requirement for new construction.

(vi) Architecturally framed and trimmed openings in corridors and rooms shall be permitted, provided that a minimum clear opening height of 7 feet (2.13 meters) is maintained.

(N) Rooms containing heat-producing equipment, such as boiler rooms, heater rooms, and laundries shall be insulated and ventilated to prevent the floors of occupied areas overhead and the adjacent walls from exceeding a temperature of ten (10) degrees F (6 degrees C) above the ambient room temperature of such occupied areas.

(2) **Finishes.**

(A) Cubicle curtains and draperies shall be noncombustible or flame-retardant as prescribed in both the large- and small-scale tests in NFPA 701.

(B) Materials provided by the facility for finishes and furnishings, including mattresses and upholstery, shall comply with NFPA 101.

(C) Floor materials shall be easily cleanable and appropriate for the location. Floors in areas used for food preparation and assembly shall be water resistant. Floor surfaces, including tile joints, shall be resistant to food acids. In all areas subject to frequent wet-cleaning methods, floor materials shall not be

physically affected by germicidal cleaning solutions. Floors subject to traffic while wet, such as shower and bath areas, kitchens, and similar work areas, shall have a non skid surface. Carpet and padding in resident areas shall be stretched taut and free of loose edges or wrinkles that might create hazards or interfere with the operation of wheelchairs, walkers or wheeled carts.

(D) Wall bases in areas subject to routine wet cleaning shall be covered, integrated with the floor, and tightly sealed.

(E) Wall finishes shall be washable and, if near plumbing fixtures, shall be smooth and moisture free.

(F) The finishes of all exposed ceilings and ceiling structures in resident rooms and staff work areas shall be readily cleanable with routine housekeeping equipment. Finished ceilings shall be provided in dietary and other areas where dust fallout might create a problem.

(3) **Construction features.** All parts of the skilled nursing unit shall be designed and constructed to sustain dead and live loads in accordance with local and national building codes and accepted engineering practices and standards, including requirements for NFPA 101. Since these units are located within a hospital; general medical surgical hospital mechanical, electrical, plumbing and ventilation requirements shall be met.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-34. Outpatient services**

(a) **General.** This section applies to the outpatient services, which may be within, or apart from, a general medical surgical hospital. Outpatient facilities, operated by the hospital but not located at the address of the hospital, may voluntarily meet these requirements and be considered part of the licensed hospital. Outpatient services located at the same address as the licensed hospital are required to meet these requirements.

(b) **Life safety code.** An outpatient facility not located within a hospital shall comply with "Ambulatory Health Care Centers" section of NFPA 101, in addition to requirements of this section if patients receive inhalation anesthesia or are incapable of selfpreservation. The "Business Occupancy" section of NFPA 101 shall apply to other types of outpatient facilities. Outpatient units that are part of a hospital may be subject to the additional hospital occupancy requirements depending on the location within the building.

(c) **Facility access.** Where the outpatient service is part of a hospital, access shall be maintained as described in NFPA 101. Building entrances used to reach the outpatient service shall be at grade level, clearly marked, and located so that patients need not go through other activity areas. Lobbies of multi-occupancy buildings may be shared. Design shall preclude unrelated traffic within the service.

(d) **Parking.** In the absence of a formal parking study, parking for outpatient services shall accommodate the projected needs of the

patients, personnel and the public.

(e) **Privacy for patients.** Facility design shall ensure patient audible and visual privacy and dignity during interviews, examinations, treatment, and recovery.

(f) **Administration and public areas.**

(1) The entrance shall be located at grade level and able to accommodate wheelchairs.

(2) Public services shall include:

(A) Convenient and accessible wheelchair storage.

(B) A reception and information counter or desk.

(C) Waiting space(s). Where an organized pediatric service is part of the outpatient service, provisions shall be made for separating pediatric and adult patients.

(D) Convenient and accessible public toilets.

(E) Convenient and accessible public telephone(s).

(F) Convenient and accessible drinking fountain(s).

(3) Interview space for private interviews related to social service, and business transactions shall be provided.

(4) General or individual office(s) for business transactions, records, administrative, and professional staffs shall be provided.

(5) Clerical space or rooms for clerical activities, separated from public areas for confidentiality, shall be provided.

(6) Multipurpose room(s) equipped for visual aids shall be provided as necessary for conferences, meetings, and health education purposes.

(7) Special storage for staff personal effects with locking drawers or cabinets shall be provided. Such storage shall be near individual workstations and be staff controlled.

(8) General storage facilities for supplies and equipment shall be provided as needed for continuing operation.

(9) In new construction and renovations where hemodialysis or hemoperfusion are routinely performed, there shall be a separate water supply and a drainage facility that do not interfere with handwashing.

(g) **Clinical facilities.** As needed, the following elements shall be provided for clinical services:

(1) **General-purpose examination room(s).** For medical, obstetrical, and similar examinations, rooms shall have a floor area of at least eighty (80) square feet (7.43 square meters), excluding vestibules, toilets, and closets. Room arrangement shall permit at least two (2) feet eight (8) inches (81.28 centimeters) clearance at each side and at the foot of the examination table. A handwashing station and a counter or shelf space for writing shall be provided.

(2) **Special-purpose examination rooms.** Rooms for special clinics such as eye, ear, nose, and throat examinations, if provided, shall accommodate procedures and the equipment used. A handwashing station and a counter or shelf space for writing shall be provided.

(3) **Treatment room(s).** Rooms for minor surgical and cast procedures, if provided, shall have floor area of at least one hundred-twenty (120) square feet (11.15 square meters), excluding vestibule, toilet, and closets. The room dimension shall be at least ten (10) feet (3.05 meters). A handwashing station and a counter or

shelf for writing shall be provided.

(4) **Observation room(s).** Observation rooms for the isolation of suspect or disturbed patients on an outpatient basis shall have a floor area of at least eighty (80) square feet (7.43 square meters) and shall be convenient to a nurse or control station. This shall allow close observation of patients and shall minimize the possibility of patient hiding, escape, injury, or suicide. An examination room may be modified to accommodate this function. A toilet room with lavatory shall be immediately accessible.

(5) **Nurses station(s).** A work counter, communication system, space for supplies, and provisions for charting shall be provided.

(6) **Drug distribution station.** This may be a part of the nurses station and shall include a work counter, sink, refrigerator, and locked storage for biologicals and drugs.

(7) **Clean storage.** A separate room or closet for storing clean and sterile supplies shall be provided. This storage shall be in addition to that of cabinets and shelves.

(8) **Soiled holding.** Provisions shall be made for separate collection, storage, and disposal of soiled materials.

(9) **Sterilizing facilities.** A system for sterilizing equipment and supplies shall be provided. Sterilizing procedures may be done on or off-site, or disposables may be used to satisfy functional needs.

(10) **Wheelchair storage space.** Such storage shall be out of the direct traffic flow.

(11) **Airborne infection isolation rooms.** The need for and number of required airborne infection isolation rooms shall be determined by an ICRA. When required, the airborne infection isolation room(s) shall comply with OAC 310:667-49-2(a)(3) except that a shower or tub is not required.

(h) **Radiology.** Basic diagnostic procedures shall be available to the service on-site or by referral. If services are provided on-site in the service area the following elements shall be provided:

(1) Radiographic room(s).

(2) Film processing facilities.

(3) Viewing and administrative areas(s).

(4) Storage facilities for exposed film.

(5) Toilet rooms with handwashing stations accessible to fluoroscopy room(s), if fluoroscopic procedures are part of the program.

(6) Dressing rooms or booths, as required by the services provided, with convenient toilet access.

(i) **Laboratory.** Facilities shall be provided as needed for required diagnostic laboratory services. The following shall be provided for specimen processing:

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

(2) Lavatory or counter sink equipped for handwashing.

(3) Storage cabinet or closet.

(4) Specimen collection facilities with a water closet and lavatory. Blood collection facilities shall have seating space, a work counter, and handwashing station.

(j) **Housekeeping room.** There shall be at least one (1) housekeeping room per floor. It shall contain a service sink and storage for

housekeeping supplies and equipment.

(k) **Staff facilities.** Staff locker rooms and toilets shall be provided.

(l) **Engineering service and equipment areas.** The following shall be provided; these may be shared with other services provided capacity is appropriate for overall use:

(1) Equipment room(s) for boilers, mechanical equipment, and electrical equipment.

(2) Storage room(s) for supplies and equipment.

(3) Waste processing services:

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

(B) If incinerators and/or trash chutes are used, they shall comply with NFPA 82.

(C) Incinerators, if used, shall also conform to all Federal, State and local air pollution regulations.

(m) **Details and finishes.**

(1) Details shall comply with the following standards:

(A) Public corridor width shall be at least five (5) feet (1.52 meters). Work corridors that are less than six (6) feet (1.83 meters) long may be four (4) feet (1.22 meters) wide.

(B) Each building shall have at least two (2) exits that are remote from each other. Other details relating to exits and fire safety shall comply with NFPA 101 and the requirements outlined herein.

(C) Items such as drinking fountains, telephone booths, and vending machines, shall not restrict corridor traffic or reduce the corridor width below the required minimum. Out-of-traffic storage space for portable equipment shall be provided.

(D) The door width for patient use shall be at least 36 inches (0.91 meter). If the outpatient facility services hospital inpatients, the width of doors to rooms used by hospital inpatients transported in beds shall be at least three (3) feet (8) inches (1.12 meters).

(E) Doors, sidelights, borrowed lights, and windows glazed to within eighteen (18) inches (45.72 centimeters) of the floor shall be constructed of safety glass, wired glass, or plastic glazing material that resists breakage and creates no dangerous cutting edges when broken. Similar materials shall be used in wall openings of playrooms and exercise rooms unless otherwise required for fire safety. Glazing materials used for shower doors and bath enclosures shall be safety glass or plastic.

(F) Threshold and expansion joint covers shall be flush with the floor surface to facilitate use of wheelchairs and carts.

(G) Handwashing stations shall be located and arranged to permit proper use and operation. Particular care shall be taken to provide the required clearance for blade-type handle operation.

(H) Provisions for hand drying shall be included at all handwashing stations except scrub sinks.

(I) The ceiling height shall be at least seven (7) feet ten (10) inches (2.39 meters) with the following exceptions:

(i) Boiler rooms shall have ceiling clearances at least two

(2) feet six (6) inches (76.20 centimeters) above the main boiler header and connecting piping.

(ii) Radiographic and other rooms containing ceiling-mounted equipment shall have ceilings of sufficient height to accommodate the equipment and/or fixtures.

(iii) Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms shall be at least seven (7) feet eight (8) inches (2.34 meters).

(iv) Tracks, rails, and pipes suspended along the path of normal traffic shall be at least six (6) feet eight (8) inches (2.03 meters) above the floor.

(J) Rooms containing heat-producing equipment, such as boiler or heater rooms, shall be insulated and ventilated to prevent occupied adjacent floor or wall surfaces from exceeding a temperature ten (10) degrees above the ambient room temperature.

(2) Finishes shall comply with the following standards: Cubicle curtains and draperies shall be noncombustible or flame-retardant and shall pass both the large and small scale tests required by NFPA 701.

(3) The flame-spread and smoke-developed ratings of finishes shall comply with OAC 310:667-49-29. Where possible, the use of materials known to produce large amounts of noxious gases shall be avoided.

(4) Floor materials shall be easily cleaned and appropriately wear-resistant. In all areas subject to wet cleaning, floor materials shall not be physically affected by liquid germicidal and cleaning solutions. Floors subject to traffic while wet, including showers and bath areas, shall have a nonslip surface.

(5) Wall finishes shall be washable and, in the proximity of plumbing fixtures, shall be smooth and moisture resistant.

(6) Wall bases in areas that are frequently subject to wet cleaning shall be monolithic and coved with the floor; tightly sealed to the wall; and constructed without voids.

(7) Floor and wall areas penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

(n) **Design and construction, including fire-resistive standards.**

(1) Construction and structural elements of freestanding outpatient facilities shall comply with recognized model-building-code requirements for offices and these requirements. Outpatient services that are an integral part of the hospital or that share common areas and functions shall comply with the construction standards for general medical surgical hospitals.

(2) Interior finish materials shall have flamespread and smoke-production limitations as described in NFPA 101. Wall finishes less than four (4) mil thick applied over a noncombustible material are not subject to flame-spread rating requirements.

(3) Building insulation materials, unless sealed on all sides and edges, shall have a flame-spread rating of twenty-five (25) or less and a smoke-developed rating of one hundred-fifty (150) or less when tested in accordance with NFPA 255.

(o) **Provision for disasters.** Seismic-force resistance of new construction for outpatient facilities shall comply with OAC 310:667-41-4. Where the outpatient facility is part of an existing building, that

facility shall comply with applicable local codes.

(p) **Elevators.**

(1) All buildings with patient or service areas on other than the grade-level main entrance floor shall have electric or hydraulic elevators. Installation and testing of elevators shall comply with ANSI A 117.1 and the following:

(A) Cars shall have an inside floor dimension of at least five (5) feet (1.52 meters).

(B) Elevators shall be equipped with an automatic two-way leveling device with an accuracy of + one-half (1/2) inch (+ 1.27 centimeters).

(C) Elevator controls, alarm buttons, and telephones shall be accessible to wheelchair occupants and usable by the blind.

(D) Heat-sensitive call buttons shall not be used. Where light beams are used to activate safety stops, these shall be in addition to door-edge stops and shall be deactivated by smoke detectors located at each landing.

(2) Elevator inspections and tests shall be made. The owner shall be furnished with written certification that the installation meets all applicable safety regulations and these requirements.

(q) **Mechanical systems.** The following requirements shall apply to outpatient facilities that are freestanding; or within a nonmedical facility; or part of a health maintenance organization or other health service; or physically attached to a general medical surgical hospital but independent of hospital areas, services, or equipment:

(1) Where general medical surgical hospital areas, services, and/or equipment are shared with the outpatient facility, the mechanical systems of OAC 310:667-49-31 shall apply only to the specific areas, services, and/or equipment being shared, i.e., operating room and recovery room.

(2) General mechanical systems standards are as follows:

(A) The mechanical system shall be subject to general review for overall efficiency and lifecycle cost. Recognized engineering procedures shall be followed for the most economical and effective results. In no case shall patient care or safety be sacrificed for conservation.

(B) Remodeling and work in existing facilities may present special problems. As practicality and funding permit, existing insulation and weather stripping, shall be brought up to standard for maximum economy and efficiency. Consideration shall be given to additional work that may be needed to achieve this goal.

(C) Facility design considerations shall include site, building mass, orientation, configuration, fenestration, and other features relative to passive and active energy systems.

(D) Insofar as practical, the facility shall include provisions for recovery of waste cooling and heating energy, e.g., ventilation, exhaust, water and steam discharge, cooling towers and incinerators.

(E) Facility design shall include consideration of recognized procedures such as variable-air-volume systems, load shedding, programmed controls for unoccupied periods, and use of natural ventilation, site and climatic conditions permitting. Systems with

excessive operational and/or maintenance costs that negate long-range energy savings shall be avoided.

(F) Controls for air-handling systems shall be designed with an economizer cycle to use outside air for cooling and/or heating. Use of mechanically circulated outside air does not reduce need for filtration. It may be practical in many areas to reduce or shut down mechanical ventilation during appropriate climatic and patient-care conditions and to use open windows for ventilation.

(G) Ventilation standards permit maximum use of simplified systems including those for variable-air-volume (VAV) supply. However, care shall be taken in design to avoid possibility of large temperature differentials, high-velocity supply, excessive noise, and air stagnation. Air supply and exhaust in rooms for which no minimum air change rate is noted may vary down to zero in response to room load. Temperature control shall also comply with these requirements. To maintain asepsis control, airflow supply and exhaust shall generally be controlled to insure movement of air from "clean" to "less clean" areas.

(H) Prior to acceptance of the facility, all mechanical systems shall be tested, balanced, and operated to demonstrate to the design engineer or the engineer's representative that the installation and performance of these systems conform to design intent. Test results shall be documented for maintenance files.

(I) Upon completion of the equipment installation contract, the owner shall be furnished with a complete set of manufacturers operating, maintenance, and preventive maintenance instructions, a parts list, and complete procurement information including equipment numbers and descriptions. Operating staff shall also be provided with instructions for properly operating systems and equipment. Required information shall include energy ratings needed for future conservation calculations.

(3) Thermal and acoustical insulation shall meet the following standards:

(A) Insulation within the building shall be provided to conserve energy, protect personnel, prevent vapor condensation, and reduce noise and vibration.

(B) Insulation on cold surfaces shall include an exterior vapor barrier. Material that does not absorb or transmit moisture need not have a separate vapor barrier.

(C) Insulation, including finishes and adhesives on the exterior surfaces of ducts and equipment, 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 NFPA 255. The smoke-development rating for pipe insulation shall not exceed one hundred-fifty (150). This includes mechanical refrigeration and distribution equipment and hot water distribution equipment such as valves, pumps, chillers, etc.

(D) If duct linings are used, they shall meet the erosion test method described in ASTM C 1071. These linings including coatings, adhesives, and exterior surface insulation of pipes and ducts in 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 NFPA 255. Duct lining shall not be installed downstream of humidifiers.

(E) Duct lining exposed to air movement shall not be used in ducts serving operating rooms, delivery rooms, LDR rooms, and intensive care units. Where its use cannot be avoided, terminal filters of at least ninety (90) percent efficiency shall be installed downstream of all lining material. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such linings.

(F) Asbestos insulation shall not be used in hospitals.

(G) Existing accessible insulation within areas of facilities to be modernized shall be inspected, repaired, and/or replaced, as appropriate.

(4) Mechanical standards for steam and hot water systems are as follows:

(A) Boilers shall have the capacity, based upon the net ratings published by the Hydronics Institute or another acceptable national standard, to supply the normal heating, hot water, and steam requirements of all systems and equipment.

(B) Boiler accessories including feed pumps/heating circulating pumps, condensate return pumps, fuel oil pumps, and waste heat boilers shall be connected and installed to provide both normal and standby service.

(C) Supply and return mains and risers for cooling, heating, and steam systems shall be equipped with valves to isolate the various sections of each system. Each piece of the equipment shall have valves at the supply and return ends. However, vacuum condensate returns need not be valved at each piece of equipment.

(5) Air conditioning, heating, and ventilating systems shall comply with the following standards:

(A) The ventilation rates shown in Appendix A shall be used only as model standards; they do not preclude the use of higher, more appropriate rates. All rooms and areas in the facility shall have provisions for ventilation. Though natural window ventilation for noncritical areas may be employed, weather permitting, mechanical ventilation shall be considered for use in interior areas and during periods of temperature extremes. Fans serving exhaust systems shall be located at the discharge end and shall be readily serviceable. Exhaust systems may be combined to enhance the efficiency of recovery devices required for energy conservation.

(B) Facility design shall utilize energy conserving mechanisms including recovery devices, variable air volume, load shedding, and systems to shut down or reduce ventilation of unoccupied areas, insofar as patient care is not compromised. When appropriate, mechanical ventilation shall employ an economizer cycle that uses outside air to reduce heating- and cooling-system loads. Filtering requirements shall be met when outside air is used as part of the mechanical ventilation system.

(C) Fresh air intakes shall be located at least twenty-five (25) feet (7.62 meters) from exhaust outlets of ventilating systems,

combustion equipment stacks, medical-surgical vacuum systems, plumbing vents, or areas that may collect vehicular exhaust or other noxious fumes. Prevailing winds and/or proximity to other structures may require greater clearances. Plumbing and vacuum vents that terminate at a level above the top of the air intake may be located as close as ten (10) feet (3.05 meters). The bottom of outdoor air intakes serving central systems shall be as high as practical, but at least six (6) feet (1.83 meters) above ground level, or, if installed above the roof, at least three (3) feet (91.44 centimeters) above the roof level. Exhaust outlets from areas that may be contaminated shall be above roof level and arranged to minimize recirculation of exhaust air into the building.

(D) The ventilation systems shall be designed and balanced to provide directional flow as shown in Appendix A.

(E) The bottoms of ventilation (supply/return) openings shall be at least three (3) inches (7.62 centimeters) above the floor.

(F) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies equal to, or greater than, those specified in Appendix D. Where two (2) filter beds are used, filter bed one (1) shall be located upstream of the air conditioning equipment and filter bed two (2) shall be downstream of any fan or blower. Where only one (1) filter bed is required, it shall be located upstream of the air conditioning equipment, unless an additional prefilter is used. In this case, the prefilter shall be upstream of the equipment and the main filter may be located further downstream. Filter efficiencies, tested in accordance with ASHRAE 52-76, shall be average, except as noted otherwise. Filter frames shall be durable and proportioned to provide an airtight fit with the enclosing ductwork. All joints between filter segments and enclosing ductwork shall have gaskets or seals to provide a positive seal against air leakage. A manometer shall be installed across each filter bed having a required efficiency of seventy-five (75) percent or more, including hoods requiring HEPA filters. Reservoir-type sprays shall not be used.

(G) Air-handling duct systems shall meet the requirements of NFPA 90A in addition to these requirements.

(H) Ducts that penetrate construction intended for x-ray or other gamma-ray protection shall not impair the effectiveness of the protection.

(I) Fire and smoke dampers shall be constructed, located, and installed in accordance with the requirements of NFPA 101 and 90A. Fans, dampers, and detectors shall be interconnected so that damper activation shall not damage the ducts. Maintenance access shall be provided at all dampers. All damper locations shall be shown on drawings. Dampers shall be activated by all phases of the smoke and fire alarms, not by fan cutoff alone. Switching systems for restarting fans shall be installed for fire department use in venting smoke after a fire has been controlled. However, provisions shall be made to avoid possible damage to the system due to closed dampers. When smoke partitions are required,

heating, ventilating, and air conditioning zones shall be coordinated with compartmentation insofar as practical to minimize the need to penetrate fire smoke partitions.

(J) If air change standards in Appendix A do not provide sufficient air for use by hoods and safety cabinets, makeup air shall be provided to maintain the required airflow direction and to avoid dependence upon infiltration from outdoor or contaminated areas.

(K) Laboratory hoods shall have an average face-velocity of at least seventy-five (75) feet per minute (0.38 meters per second). They shall be connected to an outside-vented exhaust system separate from the building exhaust system and have an exhaust fan located at the discharge end. In addition, they shall have an exhaust duct system made of noncombustible corrosion-resistant material designed to accommodate the planned usage of the hood.

(L) Laboratory hoods used to process infectious or radioactive materials shall meet special standards. In new construction and major renovation work, each hood used to process infectious or radioactive materials shall have a face velocity of at least one hundred-fifty (150) feet per minute (0.76 meters per second) with suitable static pressure operated dampers and alarms to alert staff of fan shutdown. Each shall also have filters with a 99.97 percent efficiency based on the DOP, dioctyl-phthalate test method, in the exhaust stream, and be designed and equipped to permit the safe removal, disposal, and replacement of contaminated filters. Filters shall be as close to the hood as practical to minimize duct contamination. Hoods that process radioactive materials shall meet requirements of the Nuclear Regulatory Commission and the Oklahoma Department of Environmental Quality. Radioactive isotopes used for injections, etc., without probability of airborne particulates or gases, may be processed in a clean workbench-type hood in keeping with standards acceptable to the Nuclear Regulatory Commission. Ducts serving hoods for radioactive material shall be constructed of acid-resistant stainless steel overall and have a minimum number of joints. Duct systems serving hoods in which strong oxidizing agents, e.g., perchloric acid, are used shall be constructed of acid-resistant stainless steel for at least ten (10) feet (3.05 meters) from the hood and shall be equipped with washdown facilities. Provisions shall be made for safe removal of filters during washdown operations.

(M) The ventilation system for anesthesia storage rooms shall conform to the requirements of NFPA 99.

(N) Where ethylene oxide is used for sterilization, provisions shall be made for complete exhaust of gases to the exterior. Provisions shall be made to ensure that when the sterilizer door is open, gases are pulled away from the operator. Provisions shall also be made for appropriate aeration of supplies. Aeration cabinets shall be vented to the outside. Where aeration cabinets are not used in ethylene oxide processing, an isolated area for mechanically venting gases to the outside shall be provided.

(O) Boiler rooms shall be provided with sufficient outdoor

airflow to maintain equipment combustion rates and to limit workstation temperatures.

(P) Gravity exhaust may be used, conditions permitting, for non-patient areas such as boiler rooms and central storage.

(Q) The energy-saving potential of variable air-volume systems is recognized, and these requirements are intended to maximize appropriate use of such systems. Any ventilation system used for occupied areas shall include provisions to avoid air stagnation in interior spaces where thermostat demands are met by temperatures of surrounding areas.

(r) **Plumbing and other piping systems.** Unless otherwise specified all plumbing systems shall be designed and installed in accordance with the plumbing code adopted by the Department for medical care facility plumbing equipment.

(1) The following standards shall apply to plumbing fixtures:

(A) The material used for plumbing fixtures shall be nonabsorptive and acid-resistant.

(B) Handwashing facilities for staff in patient care areas shall be trimmed with valves that can be operated without hands, a single-lever device may be used, subject to above. Where blade handles are used, they shall not exceed four and one-half (4 1/2) inches (11.43 centimeters) in length, except that handles on clinical sinks shall be at least than six (6) inches (15.24 centimeters) long.

(2) The following standards shall apply to water systems:

(A) Systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand.

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

(C) Backflow preventers or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached.

(3) The following standards shall apply to drainage systems: Building sewers shall discharge into a community sewage system. Where such a system is not available, sewage treatment shall conform to applicable local and state regulations.

(4) All piping in the HVAC and service-water systems shall be color coded or otherwise marked for easy identification.

(5) In any outpatient facility where general anesthesia is used, piped-in oxygen, vacuum, and medical air shall be provided in accordance with NFPA-99 and Appendix B.

(s) **Electrical systems.**

(1) All material and equipment, including conductors, controls, and signaling devices, shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the electrical systems as indicated on plans and in the functional program. All materials shall be listed as complying with available standards of Underwriters' Laboratories, Inc., or other similar established standards. All electrical installations and systems shall be tested to show that the equipment operates in accordance with design intent. Installation shall be in accordance with

applicable sections of NFPA 70.

(2) Circuit breakers or fused switches that provide electrical disconnection and overcurrent protection for switchboard and panelboard conductors shall be enclosed or guarded to provide a dead-front assembly. The main switchboard shall be readily accessible for use and maintenance, set apart from traffic lanes, and located in a dry, ventilated space, free of corrosive fumes or gases. Overload protective devices shall operate properly in ambient temperature conditions.

(3) Panelboards serving lighting and appliance circuits shall be on the same floor and in the same facility area as the circuits they serve.

(4) The following standards for lighting shall apply:

(A) All spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots shall have lighting.

(B) A portable or fixed examination light shall be provided for examination and treatment.

(5) Duplex grounded-type receptacles, e.g., convenience outlets, shall be installed in all areas in sufficient quantities for tasks to be performed as needed. Each examination and work table shall have access to at least two (2) duplex receptacles.

(6) Automatic emergency lighting in accordance with NFPA 99 shall be provided for safe egress from the building in the event of power failure.

(7) A manually operated, electrically supervised fire alarm system shall be installed in each facility. The fire alarm system shall be as described in NFPA 101.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-49-35. Endoscopy suite**

(a) This section applies to construction requirements for an endoscopy suite. These procedures may be performed within the general medical surgical hospital or at an outpatient facility licensed as part of the hospital. It both instances, the following requirements shall be met:

(b) **Procedure room(s).**

(1) Each procedure room shall have a clear area of at least two hundred (200) square feet (15 square meters) exclusive of fixed cabinets and built-in shelves.

(2) A freestanding handwashing fixture with hands-free controls shall be available in the suite.

(3) Station outlets for oxygen, vacuum (suction), and medical air specified in Appendix B shall be met.

(4) Floor covering shall be monolithic and joint free.

(5) A system for emergency communication shall be provided.

(c) **Instrument processing room(s).**

(1) Dedicated processing room(s) for cleaning and disinfecting instrumentation shall be provided. In an optimal situation, cleaning room(s) shall be located between two (2) procedure rooms. However,

one (1) processing room may serve multiple procedure rooms. Size of the cleaning room(s) shall be dictated by the amount of equipment to be processed. Cleaning rooms shall allow for flow of instrumentation from the contaminated area to the clean area and, finally, to storage. The clean equipment rooms, including storage, shall protect the equipment from contamination.

(2) The decontamination room shall be equipped with the following:

(A) At least two (2) utility sinks remote from each other.

(B) At least one (1) freestanding handwashing fixture.

(C) Work counter space(s).

(D) Space and plumbing fixtures for automatic endoscope cleaners, sonic processor, and flash sterilizers where required.

(E) Ventilation system. Negative pressure shall be maintained and at least ten (10) air changes per hour shall be maintained. A hood shall be provided over the work counter. All air shall be exhausted to the outside to avoid recirculation within the facility.

(F) Outlets for vacuum and compressed air.

(G) Floor covering that shall be monolithic and joint free.

(d) **Patient holding/prep/recovery area.** The following elements shall be provided in this area:

(1) Each patient cubicle shall be equipped with oxygen and suction outlets.

(2) Cubicle curtains for patient privacy.

(3) Medication preparation and storage with hand-washing facilities.

(4) Toilet facilities that may be accessible from patient holding or directly from procedure room(s) or both.

(5) Change areas and storage for the patient's personal effects.

(6) Nurses reception and charting area with visualization of patients.

(7) Clean utility room or area.

(8) Janitor/housekeeping closet.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-49-36. Renal dialysis unit (acute and chronic)**

(a) **General.** The number of dialysis stations shall be based upon the expected workload and may include several work shifts per day.

(1) The location shall offer convenient access for outpatients. Accessibility to the unit from parking and public transportation shall be a consideration.

(2) Space and equipment shall be provided as necessary to accommodate the functional programs which may include acute(inpatient services) and chronic cases, home treatment and kidney reuse facilities. Inpatient services (acute) may be performed in critical care units and designated areas in the hospital, with appropriate utility.

(b) **Treatment.**

(1) The treatment area shall be separate from administrative waiting

areas.
(2) Nurse's station(s) shall be located within the dialysis treatment area and designed to provide visual observation of all patient stations.
(3) Individual patient treatment areas shall contain at least 80 square feet (7.44 square meters). There shall be at least a 4-foot (1.22 square meters) space between beds and/or lounge chairs.
(4) Handwashing stations shall be convenient to the nurses station and patient treatment areas. There shall be at least one handwashing station serving no more than four stations. These shall be uniformly distributed to provide equal access from each patient station.
(5) The open unit shall be designed to provide privacy for each patient.
(6) The number of and need for required airborne infection isolation rooms shall be determined by an ICRA. When required, the airborne infection isolation room(s) shall comply with the requirements of OAC 310:667-49-2(a)(3).
(7) If required by the functional program, there shall be a medication dispensing station for the dialysis center. A work counter and handwashing stations shall be included in this area. Provisions shall be made for the controlled storage, preparation and distribution and refrigeration of medications.
(8) If home training is provided in the unit, a private treatment area of at least 120 square feet (11.15 square meters) shall be provided for patients who are being trained to use dialysis equipment at home. This room shall contain counter, handwashing stations, and a separate drain for fluid disposal.
(9) An examination room with handwashing stations and writing surface shall be provided with at least 100 square feet (9.29 square meters).
(10) A clean workroom shall be provided. If the room is used for preparing patient care items, it shall contain a work counter, a handwashing station, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile materials, the work counter and handwashing station may be omitted. Soiled and clean workrooms or holding rooms shall be separated and have no direct connection.
(11) A soiled workroom shall be provided and contain a flushing-rim sink, handwashing station, work counter, storage cabinets, waste receptacles, and a soiled linen receptacle.
(12) If dialyzers are reused, a reprocessing room is required and sized to perform the functions and include one-way flow of materials from soiled to clean with provisions for refrigeration (temporary storage of dialyzers) decontamination/cleaning areas, sinks, processors, computer processors and label printers, packaging area and dialyzer storage cabinets.
(13) If a nourishment station for the dialysis service is provided, the nourishment station shall contain a sink, a work counter, a refrigerator, storage cabinets and equipment for serving nourishments as required.
(14) An environmental services closet shall be provided adjacent to

and for the exclusive use of the unit. The closet shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment.

(15) If required by the functional program, an equipment repair and breakdown room shall be equipped with a handwashing station, deep service sink, work counter and storage cabinet.

(16) Supply areas and supply carts shall be provided.

(17) Storage space shall be available for wheelchairs and stretchers, if stretchers are provided, out of direct line of traffic.

(18) A clean linen storage area shall be provided. This may be within the clean workroom, a separate closet, or an approved distribution system. If a closed cart system is used, storage may be in an alcove. It must be out of the path of normal traffic and under staff control.

(19) Each facility using a central batch delivery system shall provide, either on the premises or through written arrangements, individual delivery systems for the treatment of any patient requiring special dialysis solutions. The mixing room should also include a sink, storage space and holding tanks.

(20) The water treatment equipment shall be located in an enclosed room.

(21) A patient toilet and handwashing station shall be provided.

(22) All installed reverse osmosis water and dialysis solution piping shall be accessible.

(c) **Ancillary facilities.**

(1) Appropriate areas shall be available for male and female personnel for staff clothing change area and lounge. The areas shall contain lockers, shower, toilet, and handwashing stations.

(2) Storage for patient belongings shall be provided.

(3) A waiting room, toilet room with handwashing stations, drinking fountain, public telephone, and seating accommodations for waiting periods shall be available or accessible to the dialysis unit.

(4) Office and clinical workspace shall be available for administrative services.

**[Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 51. REHABILITATION HOSPITAL AND REHABILITATION UNIT CONSTRUCTION REQUIREMENTS

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### 310:667-51-1. General considerations

(a) A rehabilitation hospital and a rehabilitation unit of general medical surgical hospital shall be designed to serve either single- or multiple-disability categories of illness including but not limited to: cerebrovascular, head trauma, spinal cord injury, amputees, complicated fractures, arthritis, neurological degeneration, genetic abnormalities, and cardiac rehabilitation. In general, rehabilitation hospitals and units shall have larger space requirements than general medical surgical hospitals, have longer lengths of stay, and have less institutional and more residential environments.

(b) **Functional units and service areas.** Functional units and service areas shall include:

(1) **Required units.** Each rehabilitation hospital or unit shall contain a medical evaluation unit and at least one (1) of the following units:

(A) Psychological services unit.

(B) Social services unit.

(C) Vocational services.

(2) **Required service areas.** Each rehabilitation hospital or unit shall provide the following service areas, if they are not otherwise conveniently accessible to the facility and appropriate to program functions:

(A) Patient dining, recreation, and day spaces.
(B) Dietary unit.
(C) Personal care facilities.
(D) Unit for teaching activities of daily living.
(E) Administration department.
(F) Engineering service and equipment areas.
(G) Linen service.
(H) Housekeeping rooms.
(I) Employee facilities.
(J) Nursing unit.

(3) **Optional units.** The following special services areas, if required by the functional program, shall be provided as outlined in these sections. The size of the various departments depends upon the requirements of the service to be provided:

(A) Sterilizing facilities.
(B) Physical therapy unit.
(C) Occupational therapy unit.
(D) Prosthetics and orthotics unit.
(E) Speech and hearing unit.
(F) Dental unit.
(G) Radiology unit.
(H) Pharmacy unit.
(I) Laboratory facilities.
(J) Home health service.
(K) Outpatient services.
(L) Therapeutic pool.
(M) Convenience store, i.e., expanded gift shop, with toiletries and other items needed by patients during extended lengths of stay.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-2. Evaluation unit**

(a) **Personnel offices.** Offices for personnel shall be provided.

(b) **Examination room(s).** Examination rooms shall have a clear floor area of at least one hundred-forty (140) square feet (13.01 square meters), excluding such spaces as the vestibule, toilet, closet, and work counter whether fixed or movable. The room dimension shall be at least ten (10) feet (3.05 meters). The room shall contain a handwashing station, a work counter, and storage facilities, and a desk, counter, or shelf space for writing.

(c) **Evaluation room(s).** Evaluation room areas shall be arranged to permit appropriate evaluation of patient needs and progress and to determine specific programs of rehabilitation. Rooms shall include a desk and work area for the evaluators; writing and workspace for patients; and storage for supplies. Where the facility is small and

workload light, evaluation may be done in the examination room(s).

(d) **Laboratory facilities.** Facilities shall be provided within the rehabilitation department or through contract arrangement with a nearby hospital or laboratory service for hematology, clinical chemistry, urinalysis, cytology, pathology, and bacteriology. If these services are provided through contract, at least the following laboratory facilities shall be provided in the rehabilitation facility:

(1) Laboratory work counter(s) with a sink, and gas and electric service.

(2) Handwashing stations.

(3) Storage cabinet(s) or closet(s).

(4) Specimen collection facilities. Urine collection rooms shall be equipped with a water closet and lavatory. Blood collection facilities shall have space for a chair and work counter.

(e) **Imaging facilities.** The following special service areas, if required by the functional program, shall be provided as outlined in OAC 310:667-49-10 and OAC 310:667-49-11. The sizes of the various departments will depend upon the requirements of the service to be provided:

(1) Electromyographic

(2) CAT scan

(3) MRI

(4) Nuclear medicine

(5) Radiographic

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-3. Psychological services unit**

The psychological services unit shall include office(s) and workspace for testing, evaluation, and counseling.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-4. Social services unit**

The social services unit shall include office space(s) for private interviewing and counseling.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-5. Vocational services unit**

The vocational services unit shall include office(s) and workspace for vocational training, counseling, and placement.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-6. Dining, recreation, and day spaces**

The following requirements shall be met for patient dining, recreation, and day spaces, and may be in separate or adjoining spaces:

(1) **Inpatients and residents.** There shall be at least fifty-five (55) square feet (5.11 square meters) per bed for dining, recreation and day spaces.

(2) **Outpatients.** If dining is part of the day care program, a total of fifty-five (55) square feet (5.11 square meters) per person shall be provided. If dining is not part of the program, there shall be at least thirty-five (35) square feet (3.25 square meters) per person for recreation and day spaces.

(3) **Storage.** Storage spaces shall be provided for recreational equipment and supplies.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-7. Dietary facility services**

(a) Construction, equipment, and installation of food service facilities shall meet the requirements of the functional program. Services may consist of an on-site conventional food preparation system, a convenience food service system, or combination thereof. On-site facilities shall be provided for emergency food preparation and refrigeration.

(b) The following facilities shall be provided as required to implement the food service selected:

(1) A control station for receiving food supplies.

(2) Food preparation facilities. For conventional food preparation systems, space and equipment for preparing, cooking, and baking shall be provided. For convenience food service systems such as frozen prepared meals, bulk packaged entrees, individually packaged portions, and contractual commissary services required space and equipment for thawing, portioning, cooking, and/or baking adequate space and equipment shall be provided.

(3) Handwashing stations located in the food preparation area.

(4) Patient meal service facilities for tray assembly and distribution.

(5) Separate dining space shall be provided for staff.

(6) Warewashing space. This shall be located in a room or an alcove separate from the food preparation and serving area. Commercial dishwashing equipment shall be provided. Space shall also be provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using areas. A lavatory shall be convenient and available.

(7) Potwashing facilities.

(8) Storage areas for cans, carts, and mobile tray conveyors.

(9) Waste storage facilities. These shall be located in a separate room easily accessible to the outside for direct waste pickup or disposal.

(10) Office(s) or desk spaces for the dietitian or the dietary

service manager.
(11) Toilets for dietary staff. Handwashing stations shall be immediately available.
(12) Housekeeping room. This shall be located within the dietary department and shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.
(13) Self-dispensing icemaking facilities. This may be in an area or room separate from the food preparation area but shall be easily cleaned and convenient to dietary facilities.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-8. Personal care unit for inpatients**

A separate room with appropriate fixtures and utilities shall be provided for patient grooming.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-9. Activities for daily living unit**

A unit for teaching daily living activities shall be provided. It shall include a bedroom, bath, kitchen, and space for training stairs. Equipment shall be functional. The bathroom shall be in addition to other toilet and bathing requirements. The facilities shall be similar to a residential environment so that the patient may learn to use them at home.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-10. Administration and public areas**

(a) **Entrance.** A grade-level entrance, sheltered from the weather and able to accommodate wheelchairs, shall be provided.
(b) **Lobby.** The lobby shall include:
(1) Wheelchair storage space(s).
(2) A reception and information counter or desk.
(3) Waiting space(s).
(4) Public toilet facilities.
(5) Public telephone(s).
(6) Drinking fountain(s).
(7) Convenience store as described at OAC 310:667-51-1(b)(3)(M).
(c) **Interview space(s).** Space for private interviews relating to social service, business transactions, and admissions shall be provided if not provided for under OAC 310:667-51-1(b)(1).
(d) **General or individual office(s).** General or individual offices for business transactions, records, and administrative and professional staffs shall be provided if not provided for under OAC 310:667-51-1(b)(2).

(e) **Multipurpose room(s).** Multipurpose room(s) for conferences, meetings, health education, and library services shall be provided.
(f) **Patient storage.** Rehabilitation patients shall be provided more space for storage of personal effects.
(g) **General storage.** Separate space for office supplies, sterile supplies, pharmaceutical supplies, splints and other orthopedic supplies, and housekeeping supplies and equipment shall be provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-11. Engineering service and equipment areas**
(a) **Equipment rooms.** Rooms for boilers, mechanical equipment, and electrical equipment shall be provided.
(b) **Storage room(s).** Storage rooms for building maintenance supplies and yard equipment shall be provided.
(c) **Waste processing services.**
(1) Space and facilities shall be provided for the sanitary storage and disposal of waste.
(2) If provided, design and construction of incinerators and trash chutes shall be in accordance with NFPA 82 and shall also conform to the requirements prescribed by federal and state environmental regulations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-12. Linen services**
(a) **On-site processing.** If linen is to be processed on site, the following shall be provided:
(1) Laundry processing room with commercial equipment that shall be able to process at least seven (7) days' laundry within a regularly scheduled forty (40) hour workweek. Handwashing stations shall be provided.
(2) Soiled linen receiving, holding, and sorting room with handwashing station and cart-washing facilities.
(3) Storage for laundry supplies.
(4) Clean linen storage, issuing, and holding room or area.
(5) Housekeeping room containing a floor receptor or service sink and storage space for housekeeping equipment and supplies.
(b) **Off-site processing.** If linen is processed off site, the following shall be provided:
(1) Soiled linen holding room.
(2) Clean linen receiving, holding, inspection, and storage room(s).

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-13. Housekeeping room(s)**

In addition to the housekeeping rooms called for in certain departments, housekeeping rooms shall be provided throughout the facility as required to maintain a clean and sanitary environment. Each shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-14. Employee facilities**

In addition to the employee facilities such as locker rooms, lounges, toilets, or showers called for in certain departments, a sufficient number of such facilities to accommodate the needs of all personnel and volunteers shall be provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-15. Nursing unit (for inpatients)**

Where inpatients are part of the facility, each nursing unit shall provide the following:

(1) **Patient rooms.** Each patient room shall meet the following requirements:

(A) The maximum room occupancy shall be four (4) patients. Larger units may be provided if justified by the functional program. At least two (2) single-bed rooms with private toilet rooms shall be provided for each nursing unit.

(B) The room areas exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules shall be at least one hundred-forty (140) square feet (13.01 square meters) in single-bed rooms and at least one hundred twenty-five (125) square feet (11.61 square meters) per bed in multi-bed rooms. In multi-bed rooms, a clearance of three (3) feet eight (8) inches (1.12 meters) shall be maintained at the foot of each bed to permit the passage of equipment and beds.

(C) Each patient sleeping room shall have a window as required in OAC 310:667-49-28(b)(1)(J).

(D) A nurse call system as required at OAC 310:667-49-32(g) shall be provided.

(E) In new construction, handwashing facilities shall be provided in each patient room. A handwashing station shall be located in the toilet room. In new construction, a handwashing station or a dispenser containing a hand degerming agent that does not require water for use, such as an alcohol based foam, rinse, or gel, shall be provided in the patient room in addition to the handwashing station in the toilet room. This handwashing station or dispenser shall be located outside the patient’s cubicle curtain so that it is accessible to staff. In renovation projects, the handwashing fixture may be omitted from the bedroom where a water closet and handwashing fixture are provided in a

toilet room designed to serve a single-bed room or one two (2) -bed room. This exception does not apply to postpartum rooms.

(F) Each patient shall have access to a toilet room without having to enter the general corridor area. One (1) toilet room shall serve no more than four (4) beds and no more than two (2) patient rooms. The toilet room shall contain a water closet and a handwashing station. The handwashing station may be omitted from a toilet room that serves single-bed and two (2) bed rooms if each such patient's room contains a handwashing station. Each toilet room shall be of sufficient size to ensure that wheelchair users may access the room.

(G) Each patient shall have a wardrobe, closet, or locker with clear dimensions of at least one (1) foot ten (10) inches (55.88 centimeters) by one (1) foot eight (8) inches (50.80 centimeters). A clothes rod and adjustable shelf shall be provided.

(H) Visual privacy shall be provided for each patient in multibed rooms.

(2) **Service areas.** The service areas noted below shall be in, or readily available to, each nursing unit. The size and disposition of each service area shall depend upon the number and types of disabilities for which care shall be provided. Although identifiable spaces shall be required for each indicated function, consideration shall be given to alternative designs that accommodate some functions without designating specific areas or rooms. Such proposals shall be submitted for prior approval. Each service area may be arranged and located to serve more than one (1) nursing unit, but at least one (1) such service area shall be provided on each nursing floor. The following service areas shall be provided:

(A) Administrative center or nurse station.

(B) Nursing office.

(C) Storage for administrative supplies.

(D) Handwashing stations located near the nurse station and the drug distribution station. One (1) station may serve both areas.

(E) Charting facilities for nurses and doctors.

(F) Lounge and toilet room(s) for staff.

(G) Individual closets or compartments for safekeeping personal effects of nursing personnel, located convenient to the duty station or in a central location.

(H) Room for examination and treatment of patients. This room may be omitted if all patient rooms are single-bed rooms. It shall have a floor area of at least one hundred-twenty (120) square feet (11.15 square meters), excluding space for vestibules, toilet, closets, and work counters whether fixed or movable. The room dimension shall be at least ten (10) feet (3.05 meters). The room shall contain a handwashing station, work counter, storage facilities, and a desk, counter, or shelf space for writing. The examination room in the evaluation unit may be used if it is conveniently located.

(I) Clean workroom or clean holding room.

(J) Soiled workroom or soiled holding room.

(K) Medication station. Provisions shall be made for convenient

and prompt twenty-four (24) hour distribution of medicine to patients. Distribution may be from a medicine preparation room, a self-contained medicine dispensing unit, or through another approved system. If used, a medicine preparation room shall be under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for biologicals and drugs. A medicine dispensing unit may be located at a nurse station, in the clean workroom, or in an alcove or other space under direct control of nursing or pharmacy staff.

(L) Clean linen storage. A separate closet or an area within the clean workroom shall be provided for this purpose. If a closed-cart system is used, storage may be in an alcove.

(M) Nourishment station. This shall be accessible to patients and contain a handwashing station, equipment for serving nourishment between scheduled meals, a refrigerator, storage cabinets, and icemaker-dispenser units to provide for patient service and treatment.

(N) Equipment storage room. This shall be for equipment such as IV stands, inhalators, air mattresses, and walkers.

(O) Parking for stretchers and wheelchairs. This shall be located out of the path of normal traffic flow.

(P) Multipurpose dayroom. Due to patients' length of stay, a dayroom shall be provided for patients to socialize on the unit.

(3) **Patient bathing facilities.** Bathtubs or showers shall be provided at a ratio of at least one (1) bathing facility for each eight (8) beds not otherwise served by bathing facilities within patient rooms. Each tub or shower shall be in an individual room or privacy enclosure that provides space for the private use of bathing fixtures, for drying and dressing, and for a wheelchair and an assistant. Showers in central bathing facilities shall be at least four (4) feet (1.22 meters) square, curb-free, and designed for use by a wheelchair patient.

(4) **Patient toilet facilities.**

(A) A toilet room that does not require travel through the general corridor shall be accessible to each central bathing area.

(B) Doors to toilet rooms shall have a width of at least two (2) feet ten (10) inches (86.36 centimeters) to admit a wheelchair. The doors shall permit access from the outside in case of an emergency.

(C) A handwashing facility shall be provided for each water closet in each multifixture toilet room.

(5) **Airborne infection isolation rooms.** The need for and number of required airborne infection isolation rooms in the rehabilitation facility shall be determined by an ICRA. When required, the airborne infection isolation room(s) shall comply with the general requirements listed in OAC 310:667-49-2(a)(3). These may be located within individual nursing units and used for normal patient care when not required for isolation cases, or they may be grouped as a separate isolation unit.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 21 Ok Reg 2785, eff 7-12-2004]

**310:667-51-16. Sterilizing facilities**

Where required by the functional program, a system for sterilizing equipment and supplies shall be provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-17. Physical therapy unit**

The following elements shall be provided:

(1) Office space.

(2) Waiting space.

(3) Treatment area(s) for thermotherapy, diathermy, ultrasonics, and hydrotherapy; cubicle curtains around each individual treatment area shall be provided. Handwashingstations shall be provided. One (1) station may serve more than one (1) cubicle. Facilities for collection of wet and soiled linen and other material shall be provided. As a minimum, one treatment area shall be enclosed with walls and have a door for access. This treatment area shall be at least 80 square feet (7.44 square meters). Curtained treatment areas shall have a minimum size of 70 square feet (6.51 square meters).

(4) An exercise area. Space requirements shall be designed to permit access to all equipment and be sized to accommodate equipment for physical therapy.

(5) Storage for clean linen, supplies, and equipment.

(6) Patient dressing areas, showers, lockers, and toilet rooms shall be provided as required by the functional program.

(7) Wheelchair and stretcher storage.

(8) Paragraphs (1), (2), (5), (6) and (7) may be planned and arranged for shared use by occupational therapy patients and staff if the functional program reflects this concept.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-18. Occupational therapy unit**

The following elements shall be provided in the occupational therapy unit:

(1) Office space.

(2) Waiting space.

(3) Activity areas. Provisions shall be made for a sink or lavatory and for the collection of waste products prior to disposal.

(4) Storage for supplies and equipment.

(5) Patient dressing areas, showers, lockers, and toilet rooms shall be provided as required by the functional program.

(6) Items (1), (2), (4), and (5) may be planned and arranged for shared use by physical therapy patients and staff if the functional program reflects this concept.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-19. Prosthetics and orthotics unit**

The following elements shall be provided in the prosthetics and orthotics unit:

(1) Workspace for technician(s).

(2) Space for evaluation and fitting including provision for privacy.

(3) Space for equipment, supplies, and storage.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-20. Speech and hearing unit**

The speech and hearing unit shall include:

(1) Office(s) for therapists.

(2) Space for evaluation and treatment.

(3) Space for equipment and storage.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-21. Dental unit**

The following elements shall be provided in the dental unit:

(1) Operatory including a handwashing station.

(2) Laboratory and film processing facilities.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-22. Imaging suite**

The imaging suite shall be provided as required by the functional program. Rooms shall comply with requirements specified in 310-667-49-10.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-23. Pharmacy or drug room**

(a) The size and type of services to be provided in the pharmacy or drug room depends on the selected drug distribution system and whether the facility provides, purchases, or shares pharmacy services. The selected service shall be described in the functional program.

(b) Provisions shall be made for the following areas:

(1) A dispensing area with a handwashing station.

(2) An editing or order review area.

(3) An area for compounding.

(4) Administrative areas.

(5) Storage areas.

(6) A drug information area.

(7) A packaging area
(8) A quality-control area.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-24. Details and finishes**

Patients in a rehabilitation hospital or unit shall be disabled to differing degrees. Therefore, high standards of safety for the patients shall be provided to minimize accidents. All details and finishes for renovation projects as well as for new construction shall comply with the following elements insofar as they affect patient services:

(1) **Details.**

(A) Compartmentation, exits, automatic extinguishing systems, and other details relating to fire prevention and fire protection in inpatient rehabilitation facilities shall comply with requirements listed in NFPA 101, and these requirements. In freestanding outpatient rehabilitation facilities, details relating to exits and fire safety shall comply with the appropriate occupancy chapter of NFPA 101 and the requirements contained herein.

(B) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall not restrict traffic flow or reduce the corridor width below the required minimum.

(C) Rooms containing bathtubs, sitz baths, showers, and water closets subject to patient use shall be equipped with doors and hardware that permits access from the outside in an emergency. When such rooms have only one (1) opening or are small, the doors shall open outward or be otherwise designed to open without pressing against a patient who may have collapsed within the room.

(D) Doors to rooms needing access for beds shall be at least three (3) feet eight (8) inches (1.12 meters). Doors to rooms requiring access for stretchers and doors to patient toilet rooms and other rooms needing access for wheelchairs shall have a width of at least two (2) feet ten (10) inches (86.36 centimeters). Where the functional program states that the sleeping facility shall be for residential use and therefore not subject to in-bed patient transport, patient room doors may be three (3) feet (0.91 meter) wide if approved by the Department. This exception shall be noted in submitted drawings.

(E) Doors between corridors and rooms or those leading into spaces subject to occupancy, except elevator doors, shall be swing-type. Openings to showers, baths, patient toilets, and other small, wet-type areas not subject to fire hazards are exempt from this requirement.

(F) Doors, except those to spaces such as small closets not subject to occupancy, shall not swing into corridors in a manner that obstructs traffic flow or reduces the required corridor width.

(G) Windows shall be designed to prevent accidental falls when open, or shall be provided with security screens as deemed necessary by the functional program.

(H) Windows and outer doors that may be frequently left open shall be provided with insect screens.
(I) Patient rooms intended for twenty-four (24) hour occupancy shall have windows that operate without the use of tools and shall have sills no more than three (3) feet (0.9 meter) above the floor.
(J) Doors, sidelights, borrowed lights, and windows glazed to within eighteen (18) inches (45.72 centimeters) of the floor shall be constructed of safety glass, wired glass, or plastic glazing material that resists breaking or creates no dangerous cutting edges when broken. Similar materials shall be used in wall openings of playrooms and exercise rooms. Safety glass or plastic glazing material shall be used for shower doors and bath enclosures.
(K) Linen and refuse chutes shall comply with NFPA 101.
(L) Thresholds and expansion joint covers shall be flush with the floor surface to facilitate use of wheelchairs and carts in new facilities.
(M) Grab bars shall be provided at all patient toilets, bathtubs, showers, and sitz baths. The bars shall have one and one-half (1 & 1/2) inches (3.81 centimeters) clearance to walls and shall be sufficiently anchored to sustain a concentrated load of at least two hundred-fifty (250) pounds (113.4 kilograms). Special consideration shall be given to shower curtain rods that may be momentarily used for support.
(N) Recessed soap dishes shall be provided in showers and bathrooms.
(O) Handrails shall be provided on both sides of corridors used by patients. A clear distance of one and one-half (1 & 1/2) inches (3.81 centimeters) shall be provided between the handrail and the wall, and the top of the rail shall be approximately thirty-two (32) inches (81.28 centimeters) above the floor, except for special care areas such as those serving children.
(P) Ends of handrails and grab bars shall be constructed to prevent snagging the clothes of patients.
(Q) Location and arrangement of handwashing stations shall permit proper use and operation. Particular care shall be given to clearance required for blade-type operating handles. Lavatories intended for use by handicapped patients shall be installed to permit wheelchairs to slide under them.
(R) Mirrors shall be arranged for convenient use by wheelchair patients as well as by patients in a standing position.
(S) Provisions for hand drying shall be included at all handwashing stations.
(T) Lavatories and handwashing stations shall be securely anchored to withstand an applied vertical load of at least two hundred-fifty (250) pounds (113.4 kilograms) on the front of the fixture.
(U) Radiation protection requirements of x-ray and gamma ray installations shall conform to necessary Department, federal, state and local requirements. Provisions shall be made for testing the completed installation before use. Any defect shall

be corrected before acceptance.

(V) The ceiling height shall be at least seven (7) feet ten (10) inches (2.39 meters) with the following exceptions:

(i) Boiler rooms shall have a ceiling clearance of at least two (2) feet six (6) inches (76.20 centimeters) above the main boiler header and connecting piping.

(ii) Ceilings of radiographic and other rooms containing ceiling-mounted equipment, including those with ceiling-mounted surgical light fixtures, shall have sufficient height to accommodate the equipment and/or fixtures.

(iii) Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms shall be at least seven (7) feet eight (8) inches (2.34 meters).

(iv) Suspended tracks, rails, and pipes located in the path of normal traffic flow shall be at least six (6) feet eight (8) inches (2.03 meters) above the floor.

(W) Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed areas unless special provisions are made to minimize such noise.

(X) Rooms containing heat-producing equipment such as boiler or heater rooms and laundries shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature ten degrees (10) F (6 degrees C) above the ambient room temperature.

(Y) Sound transmission limitations shown in Appendix C shall apply to partition, floor, and ceiling construction in patient areas.

(2) **Finishes.**

(A) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant and shall pass both the large and small scale tests in NFPA 701.

(B) Floor materials shall be easily cleaned and appropriately wear-resistant for the location. Floor surfaces in patient areas shall be smooth, without irregular surfaces to prevent tripping by patients using orthotic devices. Floors in food preparation or assembly areas shall be water-resistant. Joints in tile and similar material in such areas shall also be resistant to food acids. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. Floors subject to traffic while wet, such as shower and bath areas, kitchens, and similar work areas, shall have a nonslip surface.

(C) Wall bases in kitchens, soiled workrooms and other areas that are frequently subject to wet cleaning methods shall be monolithic and coved with the floor, tightly sealed within the wall, and constructed without voids that can harbor insects.

(D) Wall finishes shall be washable and, in the proximity of plumbing fixtures, shall be smooth and moisture-resistant. Finish, trim, and floor and wall construction in dietary and food preparation areas shall be free from spaces that can harbor pests.

(E) Floor and wall areas penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of pests. Joints of

structural elements shall be similarly sealed.

(F) Ceilings throughout shall be readily cleanable. All overhead piping and ductwork in the dietary and food preparation area shall be concealed behind a finished ceiling. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

(G) Acoustical ceilings shall be provided for corridors in patient areas, nurse stations, day rooms, recreational rooms, dining areas, and waiting areas.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-25. Design and construction, including fire-resistive standards**

(a) **Design.** Except as noted below, construction of freestanding outpatient rehabilitation facilities shall adhere to recognized national model building codes and/or to NFPA 101 and these requirements. Rehabilitation hospitals and units that accommodate inpatients shall comply with the construction requirements for general medical surgical hospitals as indicated in 310:667-49-29.

(b) **Interior finishes.** Interior finish materials for inpatient facilities shall comply with the flame-spread limitations and the smoke-production limitations set forth in NFPA 101.

(c) **Insulation Materials.** Building insulation materials, unless sealed on all sides and edges, shall have a flame-spread rating of twenty-five (25) or less and a smoke-developed rating of one hundred fifty (150) or less when tested in accordance with NFPA 255-1984.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-26. Special systems**

Rehabilitation hospitals and units shall comply with OAC 310:667-49-30.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-27. Mechanical systems**

Rehabilitation hospitals and units shall comply with 310:667-49-31.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-51-28. Electrical systems**

Rehabilitation hospitals and units shall comply with 310:667-49-32.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-51-29. Outpatient services**

Outpatient services may be provided within, or apart from a rehabilitation hospital. Outpatient facilities, operated by the licensed hospital but not located at the address of the hospital, may voluntarily meet the requirements specified at 310:667-49-34 and be considered to part of the licensed hospital. Outpatient facilities located at the same address as the licensed hospital shall comply with requirements of 310:667-49-34.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 53. PSYCHIATRIC HOSPITAL CONSTRUCTION REQUIREMENTS

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310:667-53-27. Outpatient services

### 310:667-53-1. General conditions

(a) **Applicability.** This Subchapter provides construction requirements for psychiatric hospitals intended for the care and treatment of inpatients and outpatients who do not require acute general medical surgical care services.

(b) **Parking.** In the absence of a formal parking study, the psychiatric hospital shall provide at least one (1) space for each employee normally present during one (1) weekday shift plus one (1) space for every five (5) beds or a total of one and one half (1 & 1/2) per patient. This ratio may be reduced when justified by availability of convenient public transportation and public parking. Additional parking may be required for outpatients or other services.

(c) **Swing Beds.** Occupancy of a group of rooms within the facility may be changed to accommodate different patient groups based on age, sex, security level, or treatment programs.

(d) **Services.** When the psychiatric hospital is a distinct part of another facility, services such as dietary, storage, pharmacy, and laundry may be shared insofar as practical. In some cases, all ancillary service requirements may be met by the principal facility. In other cases, programmatic concerns and requirements may require separate

services.

(e) **Environment.** The psychiatric hospital shall provide a therapeutic environment appropriate for the planned treatment programs. Security appropriate for the planned treatment programs shall be provided. The unit shall be characterized by a feeling of openness, with emphasis on natural light and exterior view. Interior finishes, lighting, and furnishings shall suggest a residential rather than an institutional setting. These shall, however, conform with applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients. Design, finishes, and furnishings shall minimize the opportunity for residents to cause injury to themselves or others. Special design considerations for injury and suicide prevention shall be given to the following elements:

(1) Visual control of nursing units and passive activity areas such as dayrooms and outdoor areas.

(2) Hidden alcoves or enclosed spaces.

(3) Areas secured from patients such as staff areas and mechanical space.

(4) Door closers, latch handles, and hinges.

(5) Door swings to private patient bathrooms.

(6) Shower, bath, toilet, and sink plumbing fixtures, hardware and accessories including grab bars and toilet paper holders.

(7) Windows including interior and exterior glazing.

(8) Light fixtures, electrical outlets, electrical appliances, nurse call systems, and staff emergency assistance systems.

(9) Ceilings, ventilation grilles, and access panels in patient bedrooms and bathrooms.

(10) Sprinkler heads and other protrusions.

(11) Fire extinguisher cabinets and fire alarm pull stations.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-53-2. General psychiatric nursing unit**

Each nursing unit shall include the following:

(1) **Patient rooms.** Each patient room shall meet the following standards:

(A) The maximum room capacity shall be two (2) patients.

(B) Patient room areas, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules, shall be at least one hundred (100) square feet (9.29 square meters) for single-bed rooms and at least eighty (80) square feet (7.43 square meters) per bed for multiple-bed rooms. Minor encroachments, including columns and lavatories, that do not interfere with functions may be ignored when determining space requirements for patient rooms. These areas are intended as minimums and do not prohibit use of larger rooms required for needs and functions.

(C) Security rooms may be included if required by the treatment program. These rooms shall be single bed rooms designed to minimize potential for escape, hiding, injury to self or others, or suicide. Access to toilets, showers, and wardrobes shall be

restricted. Security rooms may be centralized on one (1) unit or decentralized among units.

(D) Windows or vents in psychiatric units shall be arranged and located so that they can be opened from the inside to permit venting of combustion products and to permit any occupant direct access to fresh air in emergencies. The operation of operable windows shall be restricted. Where windows or vents require the use of tools or keys for operation, the tools or keys shall be located on the same floor in a prominent location accessible to staff. Windows in buildings designed with approved, engineered smoke-control systems may be fixed construction. Security glazing and/or other appropriate security features shall be used at all windows of the nursing unit and other patient activity and treatment areas to reduce the possibility of patient injury or escape.

(E) Each patient shall have access to a toilet room without having to enter the general corridor area. This direct access requirement may be disregarded if it conflicts with the supervision of patients as required by the treatment program.

(F) One (1) toilet room shall serve no more than four (4) beds and no more than two (2) patient rooms. The toilet room shall contain a water closet and a handwashing station and the door shall swing outward or be double acting.

(G) Each patient shall have within the room a separate wardrobe, locker, or closet suitable for hanging full-length garments and for storing personal effects. Adequate storage shall be available for a daily change of clothes for seven days. If the treatment program indicates, shelves for folded garments may be used instead of hanging garments.

(H) There shall be a desk or writing surface in each room for patient use.

(2) **Service areas.** Provisions for the services noted below shall be located in, or be readily available to, each nursing unit. Each service area may be arranged and located to serve more than one (1) nursing unit but, unless noted otherwise, at least one (1) such service area shall be provided on each nursing floor. Where the words room or office are used, a separate, enclosed space for the one named function shall be provided; otherwise, the described area may be a specific space in another room or common area.

(A) Administrative center or nurse station.

(B) Office(s) for staff.

(C) Administrative supplies storage.

(D) Handwashing stations.

(E) A separate charting area shall be provided with provisions for acoustical and patient file privacy.

(F) Toilet room(s) for staff.

(G) Staff lounge facilities.

(H) Securable closets or cabinet compartments for the personal effects of nursing personnel, conveniently located to the duty station. These shall be large enough for purses and billfolds.

(I) Clean workroom or clean holding room as required at OAC 310:667-49-2(a)(2)(K).

(J) Soiled workroom as required in OAC 310:667-49-2(a)(2)(L).

(K) Medication distribution station as required at OAC 310:667-49-2(a)(2)(M).

(L) Clean linen storage as required at OAC 310:667-49-2(a)(2)(N).

(M) Food service within the unit may be one or a combination, of the following:

(i) A nourishment station.

(ii) A kitchenette designed for patient use with staff control of heating and cooking devices.

(iii) A kitchen service within the unit including a handwashing station, storage space, refrigerator, and facilities for meal preparation.

(N) Ice machine as required at OAC 310:667-49-2(a)(2)(P).

(O) A bathtub or shower shall be provided for at least each six (6) beds not otherwise served by bathing facilities within the patient rooms. Bathing facilities shall be designed and located for patient convenience and privacy.

(P) At least two (2) separate social spaces, one (1) appropriate for noisy activities and one (1) for quiet activities, shall be provided. The combined area shall be at least twenty-five (25) square feet (2.32 square meters) per patient with at least one hundred-twenty (120) square feet (11.15 square meters) for each of the two (2) spaces. This space may be shared by dining activities if an additional fifteen (15) square feet (1.39 square meters) per patient is added; otherwise, at least twenty (20) square feet (1.86 square meters) per patient for dining shall be provided. Dining facilities may be located off the nursing unit in a central area.

(Q) Space for group therapy shall be provided. This may be combined with the quiet space noted above when the unit accommodates no more than twelve (12) patients and when at least two hundred twenty-five (225) square feet (20.90 square meters) of enclosed private space is available for group therapy activities.

(R) Patient laundry facilities with an automatic washer and dryer shall be provided.

(S) A secured storage area for patients' effects determined potentially harmful such as razors, nail files, or cigarette lighters. This area shall be controlled by staff.

(3) **Additional service areas.** The following elements shall also be provided, but may be either within a unit or immediately accessible to it unless otherwise dictated by the program:

(A) Equipment storage room.

(B) Storage space for wheelchairs which may be outside the psychiatric unit, provided that provisions are made for convenient access as needed for handicapped patients.

(C) Examination and treatment room(s). The examination and treatment room(s) may serve several nursing units and may be on a different floor if conveniently located for routine use. An examination room shall have at least one hundred-twenty (120) square feet (11.15 square meters) of floor area excluding space for vestibule, toilets, and closets. The room shall contain a lavatory or sink equipped for handwashing; storage facilities; and

a desk, counter, or shelf space for writing.

(D) Emergency equipment storage. Space shall be provided for emergency equipment that is under direct control of the nursing staff, such as a CPR cart. This space shall be in close proximity to a nurse station; it may serve more than one (1) unit.

(E) Housekeeping room as required at OAC 310:667-49-2(a)(2)(V).

(F) A visitor room for patients to meet with friends or family with a at least one hundred (100) square feet (9.29 square meters) of floor space.

(G) A quiet room for a patient who needs to be alone for a short period of time but does not require a seclusion room that is at least eighty (80) square feet (7.43 square meters) of floor space. The visitor room may serve this purpose.

(H) Separate consultation room(s) with at least one hundred (100) square feet (9.29 square meters) each provided at a room-to-bed ratio of one (1) consultation room for each twelve (12) psychiatric beds or major fraction thereof. The room(s) shall be designed for acoustical and visual privacy and constructed to achieve a level of voice privacy of fifty (50) STC, which in terms of vocal privacy means that some loud or raised speech is heard only by straining, but is not intelligible. The visitor room may serve as a consultation room.

(I) A conference and treatment planning room for use by the psychiatric unit. This room may be combined with the charting room.

(4) **Seclusion treatment room.** There shall be at least one (1) seclusion room for up to twenty-four (24) beds or a major fraction thereof. The seclusion treatment room shall be for short-term occupancy by violent or suicidal patients. Within the psychiatric nursing unit, this space provides for patients requiring security and protection. The room(s) shall be located for direct nursing staff supervision. Each room shall be for only one (1) patient and shall not be considered a licensed census bed. It shall have at least sixty (60) square feet (5.6 square meters) and shall be constructed to prevent patient hiding, escape, injury, or suicide. Where restraint beds are required by the functional program, at least eighty (80) square feet (7.43 square meters) shall be required. If a facility has more than one (1) psychiatric nursing unit, the number of seclusion rooms shall be a function of the total number of psychiatric beds in the facility. Seclusion rooms may be grouped together. Special fixtures and hardware for electrical circuits shall be used. Doors shall be three at least (3) feet eight (8) inches (1.12 meters) wide and shall permit staff observation of the patient while also maintaining provisions for patient privacy. The ceiling height shall be at least nine (9) feet (274.32 centimeters). Seclusion treatment rooms shall be accessed by an anteroom or vestibule that also provides direct access to a toilet room. The toilet room and anteroom shall be large enough to safely manage the patient. The seclusion room door shall swing out. Where the interior of the seclusion treatment room is padded with combustible materials, these materials shall be of a type acceptable to the local authority having jurisdiction. The room area, including floor,

walls, ceilings, and all openings shall be protected with not less than one-hour-rated construction.

(5) **Airborne infection isolation room.** The need for and number of required airborne infection isolation rooms in the psychiatric hospital shall be determined by an ICRA. When required, the airborne infectious isolation room(s) shall comply with the general requirements of OAC 310:667-49-2(a)(3).

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-53-3. Child psychiatric unit**

The standards of OAC 310:667-53-2 shall apply to child units with the following exceptions.

(1) **Patient rooms.**

(A) The maximum room capacity shall be four (4) children.

(B) A patient room with beds or cribs shall be at least one hundred (100) square feet (9.29 square meters) for single bedrooms; and at least eighty (80) square feet (7.43 square meters) per bed and (sixty) (60) square feet (5.57 square meters) per crib in multiple-bed rooms.

(C) Storage space shall be provided for toys, equipment, extra cribs and beds, and cots or recliners for parents.

(2) **Service areas.** The combined area for social activities shall be at least thirty-five (35) square feet (3.25 square meters) per patient.

(3) **Outdoor areas.** Protected outdoor areas shall be provided for play and therapy in facilities where the length of stay exceeds two (2) weeks.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-53-4. Geriatric, alzheimer's and other dementia unit**

The standards of 310:667-53-2 shall apply to these units with the following exceptions.

(1) **Patient rooms.**

(A) The patient room area shall be at least one hundred twenty 120 square feet (11.15 square meters) in single-bed rooms and at least two-hundred (200) square feet (18.58 square meters) in multiplebed rooms.

(B) A nurse call system shall be provided in accordance with 310:667-49-32(g). Provisions shall be made for easy removal or for covering call button outlets.

(C) Each patient bedroom shall have storage for extra blankets, pillows, and linen.

(D) The door to a patient room shall be at least three (3) feet eight (8) inches wide (1.12 meters).

(2) **Service areas.**

(A) Patients shall have access to at least one (1) bathtub in

each nursing unit.

(B) The standards 310:667-53-2(a)(2)(P) shall apply for social spaces except that the combined area for social activities shall be at least thirty (30) square feet (2.79 square meters) per patient.

(C) Storage space for wheelchairs shall be provided in the nursing unit.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-5. Forensic psychiatric unit**

The standards at 310:667-53-2 shall be applied to forensic psychiatric units. Forensic units shall have security vestibules or sally ports at the unit entrance. Specialized program requirements may indicate the need for additional treatment areas, police and courtroom space, and security considerations. Children, juveniles, and adolescents shall be separated from the adult areas.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-6. Imaging suite**

Imaging services are not required to be provided within a psychiatric hospital. If they are provided within the hospital, the imaging suite shall comply with 310:667-49-10.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-7. Nuclear medicine**

Nuclear medicine services are not required to be provided within a psychiatric hospital. If they are provided within the hospital, the nuclear medicine area shall comply with 310:667-49-11.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-8. Laboratory suite**

Required clinical laboratory services may be performed on-site or provided through a contractual arrangement with a clinical laboratory service. Provisions shall be made for specimen collection and processing. Minimum facilities on-site shall include a defined area with a laboratory counter, sink with water, refrigerated storage, storage for equipment and supplies, clerical area, and record storage.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-9. Rehabilitation therapy services**

(a) **General.** If a formal rehabilitative therapy service is included in a project, the facilities and equipment shall be as necessary for the effective function of the program. Where two (2) or more rehabilitative services are included, items may be shared, as appropriate.

(b) **Common elements.** Each rehabilitative therapy department shall include the following, which may be shared or provided as separate units for each service.

(1) Office and clerical space with provision for filing and retrieval of patient records.

(2) Where reception and control station(s) are required by the program, provision shall be made for visual control of waiting and activity areas. This may be combined with office and clerical space.

(3) Patient waiting area(s) out of the traffic flow, with provision for wheelchairs. Patient waiting time for rehabilitation therapy shall be minimized in a psychiatric hospital. The waiting area may be omitted if not required by the program.

(4) Patient toilets with handwashing stations accessible to wheelchair patients.

(5) A conveniently accessible housekeeping room and service sink for housekeeping use.

(6) A secured area or cabinet within the vicinity of each work area for securing staff personal effects.

(7) Convenient access to toilets and lockers.

(8) Access to a demonstration-conference room.

(c) **Physical therapy.** If physical therapy is provided, the following, at least, shall be included.

(1) Individual treatment area(s) with privacy screens or curtains. Each such space shall have at least sixty (60) square feet (5.57 square meters) of clear floor area.

(2) Handwashing stations for staff either within or at each treatment space. One (1) handwashing station may serve several treatment stations.

(3) Exercise area and facilities.

(4) Clean linen and towel storage.

(5) Storage for equipment and supplies.

(6) Separate storage for soiled linen, towels, and supplies.

(7) Dressing areas, showers, and lockers for outpatients to be treated.

(8) Provisions shall be made for thermotherapy, diathermy, ultrasonics, and hydrotherapy when required by the functional program.

(d) **Occupational therapy.** If occupational therapy is provided, the following, at least, shall be included:

(1) Work areas and counters suitable for wheelchair access.

(2) Handwashing stations.

(3) Storage for supplies and equipment.

(4) Secured storage for supplies and equipment potentially harmful.

(5) A separate room or alcove for a kiln.

(6) Remote electrical switching for equipment potentially harmful.

(7) Work areas shall be sized for one (1) therapy group at a time.
(8) Display areas for patients' work such as shelves or wall surfaces shall be provided.

(e) **Vocational therapy.** If vocational therapy is provided, the following, at least, shall be included:
(l) Work areas suitable for wheelchair access.
(2) Handwashing stations if required by the program.
(3) Storage for supplies and equipment.
(4) Secured storage for supplies and equipment potentially harmful.
(5) Remote electrical switching for equipment potentially harmful.
(6) Group work areas should be sized for one (1) therapy group at a time.

(f) **Recreation therapy.** If recreation therapy is provided, the following, at least, shall be included:
(1) Activity areas suitable for wheelchair access.
(2) Handwashing stations if required by the program.
(3) Storage for supplies and equipment.
(4) Secured storage for supplies and equipment potentially harmful.
(5) Remote electrical switching for equipment potentially harmful.

(g) **Education therapy.** If education therapy is provided, the following, at least, shall be included.
(1) Classroom with student desks with at least thirty (30) square feet (2.79 square meters) per desk with at least one hundred-fifty (150) square feet (13.94 square meters) per classroom.
(2) Desk and lockable storage for the teacher.
(3) Storage for supplies, equipment, and books.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-53-10. Pharmacy or drug room**

As described in the functional program, the size and type of services to be provided in the pharmacy or drug room depends on the type of patients and illnesses treated, type of drug distribution system used, number of patients to be served, and extent of shared or purchased services. This shall be described in the functional program. The pharmacy or drug room shall be located for convenient access, staff control, and security. Facilities and equipment shall be as necessary to accommodate the program and shall include provisions for procurement, storage, distribution, and recording of drugs and other pharmacy products. Satellite facilities, if provided, shall include those items required by the program.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-11. Dietary service facilities**

Construction of this area shall comply with 310:667-49-17.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-12. Administration and public areas**

Construction of this area shall comply with 310:667-49-18.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-13. Medical records**

Construction of this area shall comply with 310:667-49-19.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-14. Central services**

If only primary medical care is provided, central services may not be required or may be provided by countertop sterilizing/cleaning equipment. If decontamination and sterilization are required on-site, full central services shall be provided as specified at 310:667-49-20.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-15. General storage**

General storage room(s) with a total area of at least four (4) square feet (0.37 square meters) per inpatient bed shall be provided. Storage may be in separate, concentrated areas within the institution or in one (1) or more individual buildings on-site. A portion of this storage may be provided off-site.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-16. Linen services**

Construction of this area shall comply with 310:667-49-22.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-17. Facilities for cleaning and sanitizing carts**

Facilities shall be provided as specified at 310:667-49-23.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-18. Employee facilities**

Employee facilities shall be provided as specified at 310:667-49-24.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-19. Housekeeping room(s)**

Housekeeping rooms shall be provided as specified at 310:667-49-25.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-20. Engineering service and equipment area**

Facilities shall be provided as specified at 310:667-49-26.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-21. Waste processing services**

Services shall be provided as specified at 310:667-49-27.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-22. General standards for details and finishes**

The standards at 310:667-49-28 shall be required with the following exceptions.

(1) The door width for patient use access in new work shall be at least three (3) feet (.91 meters).

(2) Where grab bars are provided the space between the bar and the wall shall be filled to prevent a cord being tied around it for hanging. Bars, including those which are part of such fixtures as soap dishes, shall be sufficiently anchored to sustain a concentrated load of at least two-hundred (250) pounds (113.4 kilograms).

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-23. Design and construction, including fire-resistive standards**

Requirements at 310:667-49-29 shall be met.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-24. Special systems**

The standards at OAC 310:667-49-30 shall be met.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-53-25. Mechanical systems**

Medical systems shall comply with 310:667-49-31.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-26. Electrical systems**

Electrical standards shall comply with 310:667-49-32 with the following exception: a nurse call system is not required, but if it is included, provisions shall be made for easy removal, or covering call button outlets. If a call system is provided, installation shall comply with 310:667-49-32(g).

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

**310:667-53-27. Outpatient services**

Outpatient services may be within, or apart from, a psychiatric hospital. Outpatient facilities operated by the hospital but not located at the address of the hospital, may voluntarily meet the requirements at 310:667-49-34 and be considered part of the licensed hospital. Outpatient facilities located at the same address as the licensed hospital shall comply with requirements at 310:667-49-34.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95]

## SUBCHAPTER 55. CONSTRUCTION REQUIREMENTS FOR CRITICAL ACCESS HOSPITALS

310:667-55-1. General requirements
310:667-55-2. Existing facilities

### 310:667-55-1. General requirements

A critical access hospital shall generally comply with construction requirements specified for general medical surgical hospitals as specified at 310:667-49. The critical access hospital shall not be required to meet construction standards for services not required or provided.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 2992, eff 7-13-00]

### 310:667-55-2. Existing facilities

A general medical surgical hospital that converts to a critical access hospital shall be considered an existing facility and shall comply with the construction standards and codes that existed at the time of their construction. If the critical access hospital renovates, all new work shall comply, insofar as practical, as specified at 310:667-49.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 17 Ok Reg 2992, eff 7-13-00]

## SUBCHAPTER 56. CONSTRUCTION REQUIREMENTS FOR EMERGENCY HOSPITALS

310:667-56-1. General requirements
310:667-56-2. Existing facilities

### 310:667-56-1. General requirements

An emergency hospital shall generally comply with construction requirements specified for general medical surgical hospitals as specified at OAC 310:667-49. The emergency hospital shall not be required to meet construction standards for services not required, allowed, or provided.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

### 310:667-56-2. Existing facilities

A general medical surgical hospital or critical access hospital that converts to an emergency hospital shall be considered an existing facility and shall comply with the construction standards and codes that existed at the time of their construction. If the emergency hospital renovates, all new work shall comply, insofar as practical, as specified at OAC 310:667-49.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-2003]

## SUBCHAPTER 57. DAY TREATMENT PROGRAM STANDARDS

Section
310:667-57-1. Definitions
310:667-57-2. General
310:667-57-3. Services

### 310:667-57-1. Definitions

When used in this Subchapter, the following words and terms shall have the following meaning, unless the context clearly indicates otherwise:

**"Day treatment program"** means *nonresidential, partial hospitalization programs, day treatment programs, and day hospital programs in which children and adolescents are placed for psychiatric or psychological treatment* {10 O.S. Supp. 1998, Section 175.20.A}.

[**Source:** Added at 16 Ok Reg 684, eff 1-5-99 (emergency); Added at 16 Ok Reg 1411, eff 5-27-99]

### 310:667-57-2. General

(a) In addition to meeting requirements listed for general medical surgical hospitals in OAC 310:667-1 through OAC 310:667-31, any general hospital or psychiatric hospital offering a day treatment program shall comply with the requirements of OAC 310:667-57.

(b) The day treatment program may be operated as a distinct unit within the hospital or as part of the hospital campus. Whether located within or apart from the hospital, the site for the day treatment program shall comply with the construction requirements in OAC 310:667-41 through OAC 310:667-49 as applicable based on the facility's functional program.

[**Source:** Added at 16 Ok Reg 684, eff 1-5-99 (emergency); Added at 16 Ok Reg 1411, eff 5-27-99]

### 310:667-57-3. Services

(a) Each day treatment program shall have the capability to provide or arrange services as required under 10 O.S. Supp. 1998, Section 175.20.

(b) Each day treatment program serving school-age patients shall have policies to ensure appropriate educational exposure for such patients.

(c) Each day treatment program providing outpatient hospital day treatment services under OAC 317:30-5-42 shall demonstrate compliance with the requirements of OAC 317:30-5-42.

[**Source:** Added at 16 Ok Reg 684, eff 1-5-99 (emergency); Added at 16 Ok Reg 1411, eff 5-27-99]

## SUBCHAPTER 59. CLASSIFICATION OF HOSPITAL EMERGENCY SERVICES

Section
310:667-59-1. General
310:667-59-3. Inspections and deemed status
310:667-59-5. Notification
310:667-59-7. Clinical categories of emergency medical services
310:667-59-9. Classification of trauma and emergency operative services
310:667-59-11. Classification of emergency cardiology services
310:667-59-13. Classification of emergency pediatric medicine and trauma
310:667-59-15. Classification of emergency dental services
310:667-59-17. Classification of emergency obstetrics and gynecologic services
310:667-59-19. Classification of emergency ophthalmology services
310:667-59-20. Classification of emergency stroke services
310:667-59-21. Classification of emergency neurology services
310:667-59-20. Classification of emergency stroke services
310:667-59-23. Classification of emergency psychiatric services
310:667-59-25. Classification of emergency general medicine services

### 310:667-59-1. General

(a) All hospitals that treat emergency patients shall identify the extent of the stabilizing and definitive emergency services they provide. For each of the clinical areas listed in OAC 310:667-59-7 for which a hospital provides emergency services, the hospital shall designate which classification level of service it provides.

(b) All hospitals shall participate in the state-wide trauma and stroke registries and shall submit data on stroke and trauma related injury and illness to the Department as required. Hospitals shall submit data on the other emergency medical services they provide as required by the Department as the data collection tools to capture this information become available.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 25 Ok Reg 2785, eff 7-17-2008 (emergency)]

### 310:667-59-2. [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

### 310:667-59-3. Inspections and deemed status

(a) All hospitals required to have a license are subject to inspection by Department staff in accordance with OAC 310:667-1-4.

(b) The Commissioner shall designate representatives to verify a hospital's emergency services are accurately classified for trauma and emergency operative services Levels II, III and IV, and all other classified emergency services. Survey teams for facilities providing

trauma and emergency operative services at Levels II and III shall include a physician. If it is determined a hospital does not meet the requirements for a service to be classified at the Level reported on the Emergency Medical Services Classification Report (ODH Form 911), the Department shall classify that service at the next lowest Level where all requirements are met.

(c) Hospitals holding current verification as a Level I or Level II trauma center issued after an on-site review of their trauma services by a verification team from the American College of Surgeons Committee on Trauma (ACS COT) shall be deemed to meet the classification requirements for Trauma and Emergency Operative Services listed in OAC 310:667-59-9(c) or OAC 310:667-59-9(d). Such hospitals shall be classified by the Department as providing definitive trauma and emergency operative services at either classification Level I or Level II as reported by the ACS based on the provisions of this Subchapter.

(d) The services provided by hospitals classified at Level II for Trauma and Emergency Operative Services may be verified by either ACS COT surveyors or other representatives deemed qualified by the Commissioner.

(e) Only hospitals holding current verification as a Level I trauma center after an on-site review of their trauma services by a verification team from the ACS COT according to the standards at OAC 310:667-59-9(d) shall be classified at Level I for trauma and emergency operative services.

(f) The Department may grant Primary Stroke Center classification to hospitals holding current verification as a Primary Stroke Center issued after an on-site review of their emergency stroke services by a verification team from The Joint Commission. Such classification shall also be granted to hospitals that meet the requirements of a Primary Stroke Center as specified at OAC 310:667-59-20 (relating to the classification of emergency stroke services) and verified by Department staff.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 21 Ok Reg 573, eff 1-12-2004 (emergency); Amended at 21 Ok Reg 2785, eff 7-12-2004; Amended at 25 Ok Reg 2785, eff 7-17-2008 (emergency)]

**310:667-59-4.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-5. Notification**

(a) Each hospital shall notify the regional emergency medical services system control when treatment services are at maximum capacity and that emergency patients should be diverted to another hospital (divert status). If the hospital is located in an area in which no regional emergency medical services system control is active, the hospital shall notify each entity providing emergency medical services, such as ambulance services, in their catchment area. Each hospital shall

maintain written records documenting the date and time of the start and end of each interval of divert status.
(b) Each hospital shall develop and maintain written criteria that describe the conditions under which any one or all of the hospital's emergency services are deemed to be at maximum capacity.
(c) A hospital classified at Level I or Level II for Trauma and Emergency Operative Services or as a Primary Stroke Center shall notify the Department in writing or by facsimile or other electronic means within twenty-four (24) hours of the complete loss of verified status as a Level I or Level II trauma center by ACS COT, or as a Primary Stroke Center by the Joint Commission.
(d) A hospital shall notify the Department in writing or by facsimile or other electronic means within twenty-four hours (24) if it is unable to provide any classified emergency medical service at the current classified level, such as through the unavailability of professional personnel or required equipment which is beyond the scope of the facility's normal divert protocols. If such an interruption of service is expected to be brief and the hospital notifies the Department promptly, at the discretion of the Commissioner, it may not be necessary to permanently reclassify the service to a lower Level.
(e) A hospital may request a permanent change in classification for any classified emergency medical service by notifying the Department in writing and submitting a new Emergency Medical Services Classification Report (ODH Form 911) at least thirty (30) days prior to the effective date of the change.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 25 Ok Reg 2785, eff 7-17-2008 (emergency)]

**310:667-59-6.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-7. Clinical categories of emergency medical services**

The level of stabilizing and definitive emergency medical services provided by each hospital shall be identified for each of the following clinical categories according to the classification criteria in 310:667-59-9 through 310:667-59-25.

(1) Trauma and emergency operative services;
(2) Cardiology;
(3) Pediatric medicine and trauma;
(4) Dental;
(5) Obstetrics/Gynecology;
(6) Ophthalmology;
(7) Neurology;
(8) Psychiatry; and
(9) General Medicine.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-8.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-9. Classification of trauma and emergency operative services**

(a) **Level IV.** A Level IV facility shall provide emergency medical services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level IV for trauma and emergency operative services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** The hospital shall have equipment for use in the resuscitation of patients of all ages on site, functional, and immediately available, including at least the following:

(A) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen;

(B) Suction devices;

(C) Electrocardiograph-oscilloscope-defibrillator-pacer;

(D) Standard intravenous fluids and administration devices, including large-bore intravenous catheters;

(E) Sterile surgical sets for:

(i) Airway control/cricothyrotomy;
(ii) Vascular access; and
(iii) Chest decompression.

(F) Equipment for gastric decompression;
(G) Drugs necessary for emergency care;
(H) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4); and
(I) Thermal control equipment for patients.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a transfer agreement with a hospital capable of providing trauma care for severely injured patients. This agreement shall include reciprocal provisions requiring the facility to accept return transfers of patients at such time as the facility has the capability and capacity to provide needed care. Reciprocal agreements shall not incorporate financial provisions for transfers.

(C) The facility shall have transfer agreements with a hospital capable of providing burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(D) The facility shall have transfer agreements with a hospital capable of providing acute spinal cord and head injury management and rehabilitation.

(E) The facility shall have transfer agreements with a hospital capable of providing rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(5) **Quality Improvement.**

(A) For a hospital licensed as a general medical surgical hospital, in addition to the requirements of OAC 310:667-11-1 through OAC 310:667-11-5, the quality improvement programs shall include:

(i) Trauma registry;
(ii) Audit for all trauma deaths to include prehospital care and care received at a transferring facility;
(iii) Morbidity and mortality review;
(iv) Medical nursing audit, utilization review, tissue review; and
(v) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(B) For a hospital licensed as a critical access hospital, in addition to the requirements of OAC 310:667-39-7, the quality improvement programs shall include:

(i) A trauma registry;
(ii) Audit for all trauma deaths to include prehospital care

and care received at a transferring facility;

(iii) Morbidity and mortality review;

(iv) Medical nursing audit, utilization review, tissue review; and

(v) The availability and response times of on call staff specialists shall be continuously monitored and documented.

(C) For a facility licensed as a birthing center, in addition to the requirements of OAC 310:667-616-5-2, the quality improvement programs shall include:

(i) Trauma registry;

(ii) Audit for all trauma deaths to include prehospital care and care received at a transferring facility;

(iii) Morbidity and mortality review;

(iv) Medical nursing audit, utilization review, tissue review; and

(v) The availability and response times of on call staff specialists shall be continuously monitored and documented.

(b) **Level III.** A Level III facility shall provide emergency medical services with an organized trauma service and emergency department. A physician and nursing staff with special capability in trauma care shall be on site twenty-four (24) hours a day. General surgery and anesthesiology services shall be available either on duty or on call. A hospital shall be classified at Level III for trauma and emergency operative services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Trauma service.** A trauma service shall be established by the medical staff and shall be responsible for coordinating the care of injured patients, the training of personnel, and trauma quality improvement. Privileges for physicians participating in the trauma service shall be determined by the medical staff credentialing process. All patients with multiple-system or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the admitted patient shall be identified.

(B) **Emergency services.** A physician deemed competent in the care of the critically injured and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in trauma care shall be on site twenty-four (24) hours a day. The emergency service may also serve as the trauma service.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(C) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(D) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(E) **Internal medicine.** A physician board certified, board eligible, or residency trained in internal medicine shall be on call twenty-four (24) hours a day and promptly available in the emergency department.

(F) **Orthopedic Surgery.** A physician board certified, board eligible, or residency trained in orthopedics and deemed competent in the care of orthopedic emergencies shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. In the absence of the orthopedic surgeon, a physician designated by the trauma director and credentialed to provide stabilizing emergency orthopedic treatment may provide care prior to transfer.

(G) **Operating suite.** An operating suite with thermal control equipment for patients and infusion of blood and fluids shall be available twenty-four (24) hours a day.

(H) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(I) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program.

(J) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(i) For hospitals licensed as general medical surgical hospitals or specialty hospitals, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For hospitals licensed as critical access hospitals, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(K) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored.

The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis;

(v) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Drug and alcohol screening.

(vii) For hospitals licensed as general medical surgical hospitals or specialty hospitals, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(viii) For hospitals licensed as critical access hospitals, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(L) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(M) **Burn Care.** If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(O)(i) it shall have a transfer agreement with a hospital capable of providing burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(N) **Spinal cord and head injury management.** If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(P)(i) it shall have a transfer agreement with a hospital capable of providing acute spinal cord and head injury management and rehabilitation.

(O) **Rehabilitation services.** If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(Q)(i) it shall have a transfer agreement with a hospital which meets the requirements of Subchapter 35 of this Chapter and is capable of providing rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(2) **Personnel.**

(A) **Trauma service director.** The medical staff shall designate a surgeon as trauma service director. Through the quality improvement process, the director shall have responsibility for all trauma patients and administrative authority for the hospital's trauma program. The director shall be responsible for recommending appointment to and removal from the trauma service.

(B) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medial care as emergency services director. The emergency services director may serve as the trauma service director.

(C) **Surgical director.** The medical staff shall designate a surgeon credentialed by the hospital to be the director of care for surgical and critical care for trauma patients.

(3) **Supplies and equipment.**

(A) **Emergency department.** The emergency department shall have equipment for use in the resuscitation of patients of all ages on site, functional, and available in the emergency department, including at least the following:

(i) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen;

(ii) Pulse oximetry;

(iii) Suction devices;

(iv) Electrocardiograph-oscilloscope-defibrillator-pacer;

(v) Apparatus to establish central venous pressure monitoring;

(vi) Standard intravenous fluids and administration devices, including large-bore intravenous catheters;

(vii) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and

(IV) Chest decompression.

(viii) Equipment for gastric decompression;

(ix) Drugs necessary for emergency care;

(x) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4);

(xi) Skeletal traction devices including cervical immobilization device; and

(xii) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(B) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Pulse oximetry;

(iii) End-tidal $CO_2$ determination; and

(iv) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(C) **Intensive care unit.** The intensive care unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Cardiopulmonary resuscitation cart;

(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;

(iv) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and

(IV) Chest decompression.

(4) **Policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who

require stabilizing treatment and transfer to another facility.

(B) The facility shall have a transfer agreement with a hospital capable of providing trauma care for severely injured patients. This agreement shall include reciprocal provisions requiring the facility to accept return transfers of patients at such time as the facility has the capability and capacity to provide needed care. Reciprocal agreements shall not incorporate financial provisions for transfers.

(5) **Quality Improvement.** In addition to any other requirements of this Chapter, the hospital quality improvement program shall include:

(A) Trauma registry;

(B) Audit for all trauma deaths to include prehospital care and care received at a transferring facility;

(C) Morbidity and mortality review;

(D) Medical nursing audit, utilization review, tissue review;

(E) Multidisciplinary peer review of trauma and emergency services;

(F) Published on call schedules for surgeons, neurosurgeons, and orthopedic surgeons;

(G) Review of the times and reasons for trauma-related bypass; and

(H) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(6) **Continuing education.** The hospital shall provide and document formal continuing education programs for physicians, nurses, and allied health personnel.

(7) **Organ Procurement.** The hospital, in association with an organ procurement organization certified by the CMS, shall develop policies and procedures to identify and refer potential organ donors.

(c) **Level II.** A Level II facility shall provide emergency medical services with an organized trauma service and emergency department. A physician and nursing staff with special capability in trauma care shall be on site twenty-four (24) hours a day. General surgery, anesthesiology, and neurosurgery services shall be available on site or on call twenty-four (24) hours a day. Services from an extensive group of clinical specialties including cardiology, internal medicine, orthopedics, and obstetrics/gynecology shall be promptly available on call. A hospital shall be classified at Level II for trauma and emergency operative services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Trauma service.** A trauma service shall be established by the medical staff and shall be responsible for coordinating the care of injured patients, the training of personnel, and trauma quality improvement. Privileges for physicians participating in the trauma service will be determined by the medical staff credentialing process. All patients with multiple-system or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the admitted patient shall be identified.

(B) **Emergency services.** A physician deemed competent in the care of the critically injured and credentialed by the hospital to

provide emergency medical services and nursing personnel with special capability in trauma care shall be on site twenty-four (24) hours a day. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(C) **General surgery.** A general surgeon or senior surgical resident deemed competent and appropriately credentialed by the hospital shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. A stated goal of the general surgery service shall be to have the attending trauma surgeon authorized and designated by the trauma service director present in the emergency room at the time of the severely injured patient's arrival. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(D) **Anesthesia.** A board certified, board eligible, or residency trained anesthesiologist shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. If the anesthesiologist is not present in the facility, prior to the physician's arrival, anesthesia services may be provided by a certified registered nurse anesthetist (CRNA). The CRNA shall be deemed competent in the assessment of emergent situations in trauma patients and of initiating and providing any indicated treatment. All anesthesia shall be administered as required in OAC 310:667-25-2.

(E) **Neurologic surgery.** A board certified, board eligible, or residency trained neurosurgeon or other physician deemed competent in the care of patients with neurotrauma and appropriately credentialed shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. If care is initiated by a physician other than a neurosurgeon, the neurosurgeon on call shall respond as required by the hospital's policy.

(F) **Other specialties.** The hospital shall also have services from the following specialties on call and promptly available:

(i) Cardiac surgery;
(ii) Cardiology;
(iii) Internal medicine;
(iv) Obstetric/gynecologic surgery;
(v) Ophthalmic surgery;
(vi) Oral/maxillofacial surgery;
(vii) Orthopedic surgery;
(viii) Otolaryngology;
(ix) Pediatrics;
(x) Plastic surgery;
(xi) Clinical licensed psychologist or psychiatrist;
(xii) Pulmonary medicine;
(xiii) Radiology;
(xiv) Thoracic surgery; and
(xv) Urology and urologic surgery.

(G) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained.

(H) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(I) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall continuously monitor compliance with these requirements through the quality improvement program. A registered nurse shall be on call and immediately available when no patients are in the unit. A physician with privileges in critical care shall be on duty in the unit or immediately available in the hospital twenty-four (24) hours a day.

(J) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;

(ii) Ultrasonography;

(iii) Computed tomography;

(iv) Magnetic resonance imaging;

(v) Neuroradiology; and

(vi) Nuclear medicine imaging.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(K) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a

community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis;

(v) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Drug and alcohol screening.

(vii) For a hospital licensed as general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(L) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(M) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(N) **Burn Care.** If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(O)(i) it shall have a transfer agreement with a hospital capable of providing burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(O) **Spinal cord and head injury management.** The hospital shall provide acute spinal cord and head injury management including at least the ability to initiate rehabilitative care prior to transfer and shall have a transfer agreement with a hospital that meets the requirements at OAC 310:667-59-9(d)(1)(P)(i) if comprehensive rehabilitation services are not available within the facility.

(P) **Rehabilitation services.** If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(Q)(i) it shall have a transfer agreement with a hospital which meets the requirements of Subchapter 35 of this Chapter and is capable of providing rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(2) **Personnel.**

(A) **Trauma service director.** The medical staff shall designate a surgeon as trauma service director. Through the quality improvement process, the director shall have responsibility for all trauma patients and administrative authority for the hospital's trauma program. The trauma service director shall be responsible for recommending appointment to and removal from the trauma service.

(B) **Trauma coordinator.** The hospital shall have a designated trauma coordinator who may also serve as the prevention coordinator. Under the supervision of the trauma service director, the trauma coordinator is responsible for organizing the

services and systems of the trauma service to ensure there is a multidisciplinary approach throughout the continuum of trauma care. The trauma coordinator shall have an active role in the following:

(i) Clinical activities such as design of clinical protocols, monitoring care, and assisting the staff in problem solving;

(ii) Educational activities such as professional staff development, case reviews, continuing education, and community trauma education and prevention programs;

(iii) Quality improvement activities such as development of quality monitors, audits, and case reviews in all phases of trauma care;

(iv) Administrative tasks for the trauma service such as those related to services' organization, personnel, budget preparation, and accountability;

(v) Trauma registry data collection, coding, scoring, and validation; and

(vi) Consultation and liaison to the medical staff, prehospital emergency medical service agencies, patient families, and the community at large.

(C) **Prevention coordinator.** The hospital shall have a designated prevention coordinator who may also serve as the trauma coordinator. Under the supervision of the trauma director, the prevention coordinator is responsible for the organization and management of the hospital's outreach, prevention, and public education activities.

(D) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(E) **Surgical director.** The medical staff shall designate a surgeon credentialed by the hospital to be the director of care for surgical and critical care for trauma patients.

(3) **Supplies and equipment.**

(A) **Emergency department.** The emergency department shall have equipment for use in the resuscitation of patients of all ages on site, functional, and available in the emergency department, including at least the following:

(i) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen;

(ii) Pulse oximetry;

(iii) End-tidal $CO_2$ determination;

(iv) Suction devices;

(v) Electrocardiograph-oscilloscope-defibrillator-pacer;

(vi) Apparatus to establish central venous pressure monitoring;

(vii) Standard intravenous fluids and administration devices, including large-bore intravenous catheters;

(viii) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and
(IV) Chest decompression.
(ix) Equipment for gastric decompression;
(x) Drugs necessary for emergency care;
(xi) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4);
(xii) Skeletal traction devices including cervical immobilization device;
(xiii) Arterial catheters; and
(xiv) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(B) **Operating suite.** The operating suite shall have the following supplies and equipment on site, functional and available for use:
(i) Thermal control equipment for patients and infusion of blood, blood products, and other fluids;
(ii) X-ray capability including c-arm intensifier;
(iii) Endoscopes;
(iv) Craniotomy instruments; and
(v) Equipment appropriate for fixation of long-bone and pelvic fractures.

(C) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;
(ii) Equipment for the continuous monitoring of intracranial pressure;
(iii) Pulse oximetry;
(iv) End-tidal $CO_2$ determination; and
(v) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(D) **Intensive care unit.** The intensive care unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;
(ii) Cardiopulmonary resuscitation cart;
(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;
(iv) Sterile surgical sets for:
(I) Airway control/cricothyrotomy;
(II) Thoracotomy;
(III) Vascular access; and
(IV) Chest decompression.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Quality Improvement.** The hospital shall establish a multidisciplinary trauma committee composed of the trauma service director, emergency services director, trauma coordinator, and other

members of the medical and nursing staff that treat trauma and emergency operative patients. The trauma committee shall meet regularly to review and evaluate patient outcomes and the quality of care provided by the trauma service. In addition to any other requirements of this Chapter, the hospital quality improvement program shall include:

(A) Trauma registry;

(B) Audit for all trauma deaths to include prehospital care and care received at a transferring facility;

(C) Morbidity and mortality review;

(D) Medical nursing audit, utilization review, tissue review;

(E) Regularly scheduled multidisciplinary trauma and emergency operative services review conferences;

(F) Published on call schedules for surgeons, neurosurgeons, and orthopedic surgeons;

(G) Review of the times and reasons for trauma-related bypass;

(H) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored; and

(I) Quality improvement staff with time dedicated to and specific for trauma and emergency operative services.

(6) **Continuing education.** The hospital shall provide and document formal continuing education programs for physicians, nurses, allied health personnel, and community physicians. Continuing education programs shall be available to all state physicians, nurses, allied health personnel, and emergency medical service providers.

(7) **Organ Procurement.** The hospital, in association with an organ procurement organization certified by CMS, shall develop policies and procedures to identify and refer potential organ donors.

(8) **Outreach programs.** The hospital shall have organized outreach programs under the direction of a designated prevention coordinator.

(A) **Consultation.** The hospital shall provide on-site and/or electronic consultations with community health care providers and those in outlying areas as requested and appropriate.

(B) **Prevention and public education programs.** The hospital shall serve as a public information resource and collaborate with other institutions and national, regional, and state programs in research and data collection projects in epidemiology, surveillance, and injury prevention, and other areas.

(d) **Level I.** A Level one facility shall provide emergency medical services with an organized trauma service and emergency department. A physician and nursing staff with special capability in trauma care shall be on site twenty-four (24) hours a day. General surgery, anesthesiology, and neurosurgery services shall be available on site or on call twenty-four (24) hours a day. Additional clinical services and specialties such as nuclear diagnostic imaging, cardiac surgery, hand surgery, and infectious disease specialists shall also be promptly available. A Level I facility shall also have an organized trauma research program with a designated director.

(1) **Clinical services and resources.**

(A) **Trauma service.** A trauma service shall be established by the medical staff and shall be responsible for coordinating the care

of injured patients, the training of personnel, and trauma quality improvement. Privileges for physicians participating in the trauma service will be determined by the medical staff credentialing process. All patients with multiple-system or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the admitted patient shall be identified.

(B) **Emergency services.** A physician deemed competent in the care of the critically injured and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in trauma care shall be on site twenty-four (24) hours a day. For a hospital licensed as a general medical surgical hospital or a specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(C) **General surgery.** A general surgeon or senior surgical resident deemed competent and appropriately credentialed by the hospital shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. A stated goal of the general surgery service shall be to have the attending trauma surgeon authorized and designated by the trauma service director present in the emergency room at the time of the severely injured patient's arrival. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(D) **Anesthesia.** A board certified, board eligible, or residency trained anesthesiologist shall be on site or on call twenty-four (24) hours a day and promptly available. All anesthesia shall be administered as required in OAC 310:667-25-2.

(E) **Neurologic surgery.** A board certified, board eligible, or residency trained neurosurgeon or other physician deemed competent in the care of patients with neurotrauma and appropriately credentialed shall be on site twenty-four (24) hours a day and promptly available in the emergency department. If care is initiated by a physician other than a neurosurgeon, the neurosurgeon on call shall respond as required by the hospital's policy.

(F) **Other specialties.** The hospital shall also have services from the following specialties on call and promptly available:

(i) Cardiac surgery;
(ii) Cardiology;
(iii) Hand surgery;
(iv) Infectious disease;
(v) Internal medicine;
(vi) Microvascular surgery;
(vii) Obstetric/gynecologic surgery;
(viii) Ophthalmic surgery;
(ix) Oral/maxillofacial surgery;
(x) Orthopedic surgery;
(xi) Otolaryngology;
(xii) Pediatric surgery;

(xiii) Pediatrics;
(xiv) Plastic surgery;
(xv) Clinical licensed psychologist or psychiatrist;
(xvi) Pulmonary medicine;
(xvii) Radiology;
(xviii) Thoracic surgery; and
(xvix) Urology and urologic surgery.

(G) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained.

(H) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(I) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall continuously monitor compliance with these requirements through the quality improvement program. A registered nurse shall be on call and immediately available when no patients are in the unit. A physician with privileges in critical care shall be on duty in the unit or immediately available in the hospital twenty-four (24) hours a day.

(J) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;
(ii) Ultrasonography;
(iii) Computed tomography;
(iv) Magnetic resonance imaging;
(v) Neuroradiology; and
(vi) Nuclear medicine imaging.
(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(K) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these

services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis;

(v) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Drug and alcohol screening.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(L) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(M) **Acute hemodialysis.** The hospital shall have the capability to provide acute hemodialysis services twenty-four (24) hours a day. All staff providing hemodialysis patient care shall have documented hemodialysis training and experience.

(N) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(O) **Burn Care.**

(i) The hospital shall provide burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient; or

(ii) If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(O)(i), it shall have a transfer agreement with a hospital capable of providing burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(P) **Spinal cord and head injury management.** The hospital shall provide acute spinal cord and head injury management including at least the ability to initiate rehabilitative care prior to transfer and shall have a transfer agreement with a hospital that meets the requirements at OAC 310:667-59-9(d)(1)(P)(i) if comprehensive rehabilitation services are not available within the facility.

(Q) **Rehabilitation services.**

(i) The hospital shall provide rehabilitation services in a rehabilitation center with a staff of personnel trained in

rehabilitation care and equipped properly for acute care of the critically injured patient; or

(ii) If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(Q)(i) it shall have a transfer agreement with a hospital which meets the requirements of Subchapter 35 of this Chapter and is capable of providing rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(2) **Personnel.**

(A) **Trauma service director.** The medical staff shall designate a surgeon as trauma service director. Through the quality improvement process, the director shall have responsibility for all trauma patients and administrative authority for the hospital's trauma program. The trauma service director shall be responsible for recommending appointment to and removal from the trauma service.

(B) **Trauma coordinator.** The hospital shall have a designated trauma coordinator who may also serve as the prevention coordinator. Under the supervision of the trauma service director, the trauma coordinator is responsible for organizing the services and systems of the trauma service to ensure there is a multidisciplinary approach throughout the continuum of trauma care. The trauma coordinator shall have an active role in the following:

(i) Clinical activities such as design of clinical protocols, monitoring care, and assisting the staff in problem solving;

(ii) Educational activities such as professional staff development, case reviews, continuing education, and community trauma education and prevention programs;

(iii) Quality improvement activities such as development of quality monitors, audits, and case reviews in all phases of trauma care;

(iv) Administrative tasks for the trauma service such as those related to services' organization, personnel, budget preparation, and accountability;

(v) Trauma registry data collection, coding, scoring, and validation; and

(vi) Consultation and liaison to the medical staff, prehospital emergency medical service agencies, patient families, and the community at large.

(C) **Prevention coordinator.** The hospital shall have a designated prevention coordinator who may also serve as the trauma coordinator. Under the supervision of the trauma director, the prevention coordinator is responsible for the organization and management of the hospital's outreach, prevention, and public education activities.

(D) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medial care as emergency services director.

(E) **Surgical director.** The medical staff shall designate a surgeon credentialed by the hospital to be the director of care

for surgical and critical care for trauma patients.

(F) **Research director.** The medical staff shall designate a physician as research director who may also serve as the trauma service director. The research director is responsible for the organization and management of the hospital's trauma and emergency operative research activities.

(3) **Supplies and equipment.**

(A) **Emergency department.** The emergency department shall have equipment for use in the resuscitation of patients of all ages on site, functional, and available in the emergency department, including at least the following:

(i) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen;

(ii) Pulse oximetry;

(iii) End-tidal $CO_2$ determination;

(iv) Suction devices;

(v) Electrocardiograph-oscilloscope-defibrillator-pacer;

(vi) Apparatus to establish central venous pressure monitoring;

(vii) Standard intravenous fluids and administration devices, including large-bore intravenous catheters;

(viii) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and

(IV) Chest decompression.

(ix) Equipment for gastric decompression;

(x) Drugs necessary for emergency care;

(xi) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4);

(xii) Skeletal traction devices including cervical immobilization device;

(xiii) Arterial catheters; and

(xiv) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(B) **Operating suite.** The operating suite shall have the following supplies and equipment on site, functional and available for use:

(i) Cardiopulmonary bypass capability;

(ii) Operating microscope;

(iii) Thermal control equipment for patients and infusion of blood, blood products, and other fluids;

(iv) X-ray capability including c-arm intensifier;

(v) Endoscopes;

(vi) Craniotomy instruments; and

(vii) Equipment appropriate for fixation of long-bone and pelvic fractures.

(C) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature,

hemodynamics, and gas exchange;

(ii) Equipment for the continuous monitoring of intracranial pressure;

(iii) Pulse oximetry;

(iv) End-tidal $CO_2$ determination; and

(v) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(D) **Intensive care unit.** The intensive care unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Cardiopulmonary resuscitation cart;

(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;

(iv) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and

(IV) Chest decompression.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Quality Improvement.** The hospital shall establish a multidisciplinary trauma committee composed of the trauma service director, emergency services director, trauma coordinator, and other members of the medical and nursing staff that treat trauma and emergency operative patients. The trauma committee shall meet regularly to review and evaluate patient outcomes and the quality of care provided by the trauma service. In addition to any other requirements of this Chapter, the hospital quality improvement program shall include:

(A) Trauma registry;

(B) Audit for all trauma deaths to include prehospital care and care received at a transferring facility;

(C) Morbidity and mortality review;

(D) Medical nursing audit, utilization review, tissue review;

(E) Regularly scheduled multidisciplinary trauma and emergency operative services review conference;

(F) Published on call schedules for surgeons, neurosurgeons, and orthopedic surgeons;

(G) Review of the times and reasons for trauma-related bypass; and

(H) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(I) Quality improvement staff with time dedicated to and specific for trauma and emergency operative services.

(6) **Continuing education.** The hospital shall provide and document formal continuing education programs for physicians, nurses, allied health personnel, and community physicians. Continuing education

programs shall be available to all state physicians, nurses, allied health personnel, and emergency medical service providers.

(7) **Organ Procurement.** The hospital, in association with an organ procurement organization certified by CMS, shall develop policies and procedures to identify and refer potential organ donors.

(8) **Outreach programs.** The hospital shall have organized outreach programs under the direction of a designated prevention coordinator.

(A) **Consultation.** The hospital shall provide on-site and/or electronic consultations with community health care providers and those in outlying areas as requested and appropriate.

(B) **Prevention and public education programs.** The hospital shall serve as a public information resource and collaborate with other institutions and national, regional, and state programs in research and data collection projects in epidemiology, surveillance, and injury prevention, and other areas.

(9) **Research programs.** The hospital shall have an organized trauma and emergency operative services research program under the direction of a designated research director. Research groups shall meet regularly and all research proposals shall be approved by an Institutional Review Board (IRB) prior to launch. The research director shall maintain evidence of the productivity of the research program through documentation of presentations and copies of published articles.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-2000; Amended at 17 Ok Reg 3450, eff 8-29-2000 (emergency); Amended at 18 Ok Reg 2032, eff 6/11/2001; Amended at 20 Ok Reg 1664, eff 6-12-2003; Amended at 21 Ok Reg 573, eff 1-12-2004 (emergency); Amended at 21 Ok Reg 2785, eff 7-12-2004]

**310:667-59-10.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-2000]

**310:667-59-11. Classification of emergency cardiology services**

(a) **Level III.** A Level III facility shall provide Advanced Cardiac Life Support (ACLS) services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level III for emergency cardiology services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Electrocardiogram.** The hospital shall have the immediate availability of a 12-lead electrocardiogram.

(B) **Thrombolytic therapy.** Thrombolytic medications shall be immediately available in the emergency room to provide reperfusion therapy when appropriate. No other diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner,

registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Oxygen and oxygen delivery equipment;

(B) Equipment to perform a 12-lead electrocardiogram (ECG)with ECG monitor and printout;

(C)Equipment for the electronic or facsimile transmission of ECG readings to an expert for interpretation;

(D) Transcutaneous pacing capability; and

(E) ACLS medications including at least:

(i) Aspirin;

(ii) Antianginal agents such as sublingual nitroglycerin;

(iii) Medications to provide adequate analgesia such as morphine and meperidine;

(iv) Sympathomimetics such as epinephrine, norepinephrine, dopamine, etc;

(v) Sympatholytics such as ß-adrenoceptor blocking agents;

(vi) Angiotensin converting enzyme (ACE) inhibitors;

(vii) Antidysrythmics including:

(I) Rhythm control agents such as lidocaine, procainamide, bretylium tosylate and magnesium sulfate; and

(II) Rate control agents such as atropine, adenosine, verapamil, and digitalis.

(viii) Diuretics such as furosemide; and

(ix) Antihypertensives such as sodium nitroprusside.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients

which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained cardiologist, or group of cardiologists to provide immediate consultative services for cardiac patients twenty-four (24) hours a day. Such services shall include the immediate interpretation of ECG results and providing instructions for the initiation of appropriate therapy and/or patient transfer.

(b) **Level II.** A Level II facility shall provide emergency medical services with an organized emergency department. A physician and nursing staff with special capability in cardiac care shall be on site twenty-four (24) hours a day. A hospital shall be classified at Level II for emergency cardiology services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent cardiac patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in cardiac care shall be on site twenty-four (24) hours a day. Nursing personnel shall have completed the Advanced Cardiac Life Support Program offered through the American Heart Association or have equivalent training.

(i) For a hospital licensed as a general medical surgical hospital or a specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **Thrombolytic therapy.** Thrombolytic medications shall be immediately available in the emergency room to provide reperfusion therapy when appropriate.

(C) **Intensive care unit.** The hospital shall have an intensive care unit and/or cardiac care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the unit whenever the unit has a patient(s). A registered nurse be on call an immediately available when no patients are in the unit. Nursing personnel shall have completed the Advanced Cardiac Life Support Program offered through the American Heart Association or have equivalent training.

(D) **Continuous electrocardiographic monitoring**. The emergency room and intensive/cardiac care unit shall have the capability to continuously monitor patients electrocardiographically when necessary. While a patient is continuously monitored, there shall be adequate human surveillance of the monitors twenty-four (24) hours a day by medical, nursing, or paramedical personnel trained and qualified in the ECG recognition of clinically significant cardiac rhythm disturbances.

(E) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or a specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(F) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(ii) Coagulation studies;

(iii) Blood gas/pH analysis; and

(iv) Rapid determination of cardiac serum markers such as creatine kinase (CK), CK-MB isoform(s), and/or cardiac specific troponins T and I.

(v) For a hospital licensed as a general medical surgical hospital or a specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(vi) For a hospital licensed as a critical access hospitals, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(G) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Cardiologist.** A physician board certified, board eligible, or residency trained in cardiovascular diseases shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(C) **Training.** Emergency room and intensive care/cardiac care unit nursing personnel shall have completed the Advanced Cardiac Life Support Program offered through the American Heart Association or have equivalent training.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Oxygen and oxygen delivery equipment including:

(i) Continuous positive-pressure breathing; and

(ii) Mechanical ventilation.

(B) Equipment to perform a 12-lead electrocardiogram (ECG) with ECG monitor and printout;

(C) Equipment for the electronic or facsimile transmission of ECG readings to an expert for interpretation;

(D) Pacing equipment including at least:

(i) Transcutaneous pacing capability; and
(ii) Transvenous pacing electrodes.
(E) ACLS medications including at least:
(i) Aspirin;
(ii) Antianginal agents such as sublingual nitroglycerin;
(iii) Medications to provide adequate analgesia such as morphine and meperidine;
(iv) Sympathomimetics such as epinephrine, norepinephrine, dopamine, etc;
(v) Sympatholytics such as ß-adrenoceptor blocking agents;
(vi) Angiotensin converting enzyme (ACE) inhibitors;
(vii) Antidysrythmics including:
(I) Rhythm control agents such as lidocaine, procainamide, bretylium tosylate and magnesium sulfate; and
(II) Rate control agents such as atropine, adenosine, verapamil, and digitalis.
(viii) Diuretics such as furosemide; and
(ix) Antihypertensives such as sodium nitroprusside.

(4) **Agreements and policies on transfers.**
(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.
(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained cardiologist, or group of cardiologists to provide immediate consultative services for cardiac patients twenty-four (24) hours a day. Such services shall include the immediate interpretation of ECG results and providing instructions for the initiation of appropriate therapy and/or patient transfer.

(c) **Level I.** A Level I facility shall provide emergency medical services with organized emergency and cardiology departments. A physician and nursing staff with special capability in cardiac care shall be on site twenty-four (24) hours a day. The facility shall have the capability to provide immediate diagnostic angiography and emergency reperfusion therapy by thrombolysis, primary percutaneous transluminal coronary angioplasty (PTCA), and coronary artery bypass graft (CABG) twenty-four (24) hours a day. A hospital shall be classified at Level I for emergency cardiology services if it meets the following requirements:

(1) **Clinical services and resources.**
(A) **Emergency services.** A physician deemed competent in the care of the emergent cardiac patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in cardiac care shall be on site twenty-four (24) hours a day. Nursing personnel shall have completed the Advanced Cardiac Life Support Program (ACLS) offered through the American Heart Association or have equivalent training. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.
(B) **Thrombolytic therapy.** Thrombolytic medications shall be

immediately available in the emergency room to provide reperfusion therapy when appropriate.

(C) **Cardiology and cardiovascular surgery.** The facility shall have an organized cardiology and cardiovascular surgery service with appropriately credentialed physicians experienced in percutaneous and surgical revascularization immediately available twenty-four (24) hours a day. Physician members of the cardiology service shall be board certified, board eligible, or residency trained in cardiovascular diseases or be board certified, board eligible, or residency trained in cardiovascular and/or vascular surgery. On call physicians shall respond as required by the hospital's policy.

(D) **Cardiac catheterization laboratory**. The facility shall have a full-service cardiac catheterization laboratory or laboratories capable of providing both diagnostic and therapeutic procedures on the heart and great vessels for a wide variety of cardiovascular diseases. Diagnostic, therapeutic, and electrophysiology laboratories shall be supervised by physicians with appropriate training and expertise in the procedures performed and who are properly credentialed by the medical staff. When primary PTCA is performed, prompt access to emergency CABG surgery shall also be available.

(E) **Anesthesia.** A board certified, board eligible, or residency trained anesthesiologist shall be on site or on call twenty-four (24) hours a day and promptly available. All anesthesia shall be administered as required in OAC 310:667-25-2.

(F) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained. The operating suite shall have cardiopulmonary bypass capability.

(G) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(H) **Cardiac care unit.** The hospital shall have a cardiac care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the unit whenever the unit has a patient(s). The hospital shall define and document in writing the minimum staffing requirements for the cardiac care unit. A registered nurse shall be on call and immediately available when no patients are in the unit. A physician with privileges in cardiac care or cardiovascular surgery shall be on duty in the unit or immediately available in the hospital twenty-four (24) hours a day.

(I) **Continuous electrocardiographic monitoring**. The emergency room, cardiac catheterization laboratory(s), and cardiac care unit shall have the capability to continuously monitor patients electrocardiographically when necessary. While a patient is continuously monitored, there shall be adequate human surveillance of the monitors twenty-four (24) hours a day by medical, nursing,

or paramedical personnel trained and qualified in the ECG recognition of clinically significant cardiac rhythm disturbances.

(J) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray, computed tomography, and ultrasonography services available twenty-four (24) hours a day. A radiologic technologist, computerized tomography technologist, and staff designated as qualified to perform ultrasonography shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;

(ii) Ultrasonography including echocardiography;

(iii) Computed tomography;

(iv) Magnetic resonance imaging; and

(v) Nuclear medicine imaging.

(vi) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(K) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis;

(v) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Rapid determination of cardiac serum markers such as creatine kinase (CK), CK-MB isoform(s), and/or cardiac specific troponins T and I.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(L) **Respiratory therapy service.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply

with OAC 310:667-23-6.

(M) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(N) **Cardiac rehabilitation service.** The hospital shall have available a formal program for rehabilitation of the cardiac patient. An individualized rehabilitation program shall be designed for each patient, and when appropriate, the program shall combine prescriptive exercise training with education about coronary risk factor modification techniques. Rehabilitation services shall also comply with the requirements of Subchapter 35 of this Chapter.

(O) **Post-cardiac event evaluation.** Through the use of exercise or pharmacologic ECG stress testing, exercise stress echocardiography, exercise or stress nuclear perfusion scintigraphy or other procedures as appropriate, the hospital shall have the capability of evaluating patients after a cardiac event to:

(i) Assess functional capacity and the patient's ability to perform tasks at home and at work.

(ii) Evaluate the efficacy of the patient's current medical regimen; and

(iii) Risk-stratify the post-MI patient according to the likelihood of a subsequent cardiac event.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Cardiology services director.** The medical staff shall designate a physician credentialed to provide medical and/or surgical cardiac care as cardiology services director.

(C) **Physician qualifications.** Physician members of the cardiology service shall be board certified, board eligible, or residency trained in cardiovascular diseases or be board certified, board eligible, or residency trained in cardiothoracic and/or vascular surgery.

(D) **Training.** Emergency room, intensive care/cardiac care unit, and cardiac catheterization laboratory nursing personnel shall have completed the Advanced Cardiac Life Support Program (ACLS) offered through the American Heart Association or have equivalent training.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-11(b)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) The hospital shall have the equipment and personnel to monitor the hemodynamic stability of cardiac patients with balloon flotation catheters when appropriate;

(B) The hospital shall have the equipment and personnel to monitor intra-arterial pressure when appropriate; and

(C) The hospital shall have the equipment and personnel to provide intra-aortic balloon counterpulsation therapy when appropriate.

(4) **Policies on transfers.** The hospital shall have written

policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-59-12.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-13. Classification of emergency pediatric medicine and trauma services**

(a) **Level IV.** A Level IV facility shall provide emergency pediatric medicine and trauma services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. The hospital shall be capable of identifying critically ill or injured pediatric patients and providing stabilizing treatment to manage airway, breathing, and circulation prior to patient transfer. A hospital shall be classified at Level IV for emergency pediatric medicine and trauma services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required. The facility shall have access by telephone or other electronic means to a regional poison control center.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is

licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** The hospital shall have equipment for use in the resuscitation of pediatric patients on site, functional, and immediately available, including at least the following:

(A) Spine board (child/adult) for cardiopulmonary resuscitation and papoose board for immobilization of infants and toddlers;

(B) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, oxygen, and oxygen delivery equipment. Masks and cannula shall be available in infant, child, and adult sizes;

(C) Pulse oximeter with adult and pediatric probes;

(D) Infant, child, adult, and thigh blood pressure cuffs;

(E) Rectal thermometer probe;

(F) Suction devices suitable for infants, children, and adults;

(G) Electrocardiograph-oscilloscope-defibrillator-pacer with pediatric capability;

(H) Standard intravenous fluids and administration devices suitable for infants, children, and adults including large-bore intravenous catheters;

(I) Specialized pediatric procedure trays for:

(i) Lumbar puncture;

(ii) Urinary catheterization;

(iii) Umbilical vessel cannulation; and

(iv) Airway control/cricothyrotomy;

(v) Vascular access; and

(vi) Chest decompression.

(J) Equipment for gastric decompression;

(K) Magill forceps (pediatric and adult);

(L) Equipment for gastric decompression;

(M) Fracture management devices including:

(i) Skeletal traction devices including cervical immobilization device suitable for pediatric patients;

(ii) Extremity splints; and

(iii) Child and adult femur splints.

(N) Drugs necessary for pediatric emergency care with printed pediatric doses and pediatric reference materials such as precalculated drug sheets or length-based tape;

(O) Infant scale;

(P) Thermal control equipment for patients including a heat source or procedure for infant warming; and

(Q) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4).

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have transfer agreements with a hospital capable of providing burn care in a physician-directed, organized

burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(C) The facility shall have transfer agreements with a hospital capable of providing acute spinal cord and head injury management and rehabilitation.

(D) The facility shall have transfer agreements with a hospital capable of providing rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(5) **Quality Improvement.**

(A) For a hospital licensed as a general medical surgical hospital, in addition to the requirements of OAC 310:667-11-1 through OAC 310:667-11-5, the quality improvement programs shall include:

(i) Trauma registry;

(ii) Audit for all pediatric deaths to include prehospital care and care received at a transferring facility;

(iii) Incident reports related to pediatric patients;

(iv) Pediatric transfers;

(v) Child abuse cases;

(vi) Pediatric cardiopulmonary or respiratory arrests;

(vii) Pediatric admissions within 48 hours of an emergency department visit;

(viii) Pediatric surgery within 48 hours of discharge from an emergency department;

(ix) Morbidity and mortality review;

(x) Medical nursing audit, utilization review, tissue review; and

(xi) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(B) For a hospital licensed as a critical access hospital, in addition to the requirements of OAC 310:667-39-7, the quality improvement programs shall include:

(i) Trauma registry;

(ii) Audit for all pediatric deaths to include prehospital care and care received at a transferring facility;

(iii) Incident reports related to pediatric patients;

(iv) Pediatric transfers;

(v) Child abuse cases;

(vi) Pediatric cardiopulmonary or respiratory arrests;

(vii) Pediatric admissions within 48 hours of an emergency department visit;

(viii) Pediatric surgery within 48 hours of discharge from an emergency department;

(ix) Morbidity and mortality review;

(x) Medical nursing audit, utilization review, tissue review; and

(xi) The availability and response times of on call staff specialists shall be defined in writing, documented, and

continuously monitored.

(C) For a facility licensed as a birthing center, in addition to the requirements of OAC 310:616-5-2, the quality improvement programs shall include:

(i) Trauma registry;

(ii) Audit for all pediatric deaths to include prehospital care and care received at a transferring facility;

(iii) Incident reports related to pediatric patients;

(iv) Pediatric transfers;

(v) Child abuse cases;

(vi) Pediatric cardiopulmonary or respiratory arrests;

(vii) Pediatric admissions within 48 hours of an emergency department visit;

(viii) Pediatric surgery within 48 hours of discharge from an emergency department;

(ix) Morbidity and mortality review;

(x) Medical nursing audit, utilization review, tissue review; and

(xi) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(b) **Level III.** A Level III facility shall provide emergency pediatric medicine and trauma services with an organized trauma service and emergency department. A physician and nursing staff with special capability in trauma care shall be on site twenty-four (24) hours a day. General surgery and anesthesiology services shall be available either on duty or on call. The hospital shall have basic facilities for the management of minor pediatric inpatient problems. A hospital shall be classified at Level III for emergency pediatric medicine and trauma services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Trauma service.** A trauma service shall be established by the medical staff and shall be responsible for coordinating the care of injured patients, the training of personnel, and trauma quality improvement. Privileges for physicians participating in the trauma service shall be determined by the medical staff credentialing process. All patients with multiple-system or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the admitted patient shall be identified.

(B) **Emergency services.** A physician deemed competent in the care of the seriously ill or injured patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in trauma care shall be on site twenty-four (24) hours a day. The emergency service may also serve as the trauma service.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(C) **Poison control center.** The facility shall have access by telephone or other electronic means to a regional poison control center.

(D) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(E) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(F) **Internal medicine.** A physician board certified, board eligible, or residency trained in internal medicine shall be on call twenty-four (24) hours a day and promptly available in the emergency department.

(G) **Operating suite.** An operating suite with thermal control equipment for patients and infusion of blood and fluids shall be available twenty-four (24) hours a day.

(H) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(I) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program.

(J) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(K) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected

patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Therapeutic drug monitoring;

(iv) Coagulation studies;

(v) Blood gas/pH analysis;

(vi) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vii) Drug and alcohol screening.

(viii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ix) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(L) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(M) **Burn Care.** If the hospital does not meet the requirements at OAC 310:667-59-13(d)(1)(U)(i) it shall have a transfer agreement with a hospital capable of providing burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(N) **Spinal cord and head injury management.** If the hospital does not meet the requirements at OAC 310:667-59-9(d)(1)(P)(i) it shall have a transfer agreement with a hospital capable of providing acute spinal cord and head injury management and rehabilitation.

(O) **Rehabilitation services.** If the hospital does not meet the requirements at OAC 310:667-59-13(d)(1)(W)(i) it shall have a transfer agreement with a hospital which meets the requirements of Subchapter 35 of this Chapter and is capable of providing rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(P) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(2) **Personnel.**

(A) **Trauma service director.** The medical staff shall designate a surgeon as trauma service director. Through the quality improvement process, the director shall have responsibility for all trauma patients and administrative authority for the hospital's trauma program. The director shall be responsible for recommending appointment to and removal from the trauma service.

(B) **Emergency services director.** The medical staff shall

designate a physician credentialed to provide emergency medical care as emergency services director.

(C) **Surgical director.** The medical staff shall designate a surgeon credentialed by the hospital to be the director of care for surgical and critical care for trauma patients.

(D) **Pediatrics.** A physician board certified, board eligible, or residency trained in pediatrics and deemed competent in the care of pediatric emergencies shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four hours a day.

(E) **Orthopedics.** A physician board certified, board eligible, or residency trained in orthopedics and deemed competent in the care of pediatric orthopedic emergencies shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four hours a day.

(3) **Supplies and equipment.**

(A) **Emergency department.** The hospital shall have equipment for use in the resuscitation of pediatric patients on site, functional, and immediately available, including at least the following:

(i) Spine board (child/adult) for cardiopulmonary resuscitation and papoose board for immobilization of infants and toddlers;

(ii) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, oxygen, and oxygen delivery equipment. Masks and cannula shall be available in infant, child, and adult sizes;

(iii) Pulse oximeter with adult and pediatric probes;

(iv) Infant, child, adult, and thigh blood pressure cuffs;

(v) Rectal thermometer probe;

(vi) Suction devices suitable for infants, children, and adults;

(vii) Electrocardiograph-oscilloscope-defibrillator-pacer with pediatric capability;

(viii) Apparatus to establish central venous pressure monitoring;

(ix) Standard intravenous fluids and administration devices suitable for infants, children, and adults including infusion pumps with microinfusion capability and large-bore intravenous catheters;

(x) Specialized pediatric procedure trays:

(I) Lumbar puncture;

(II) Urinary catheterization;

(III) Umbilical vessel cannulation;

(IV) Airway control/cricothyrotomy;

(V) Thoracotomy;

(VI) Chest decompression.

(VII) Intraosseous infusion;

(VIII) Vascular access; and

(IX) Needle cricothyroidotomy set.

(xi) Magill forceps (pediatric and adult);

(xii) Equipment for gastric decompression;
(xiii) Fracture management devices including:
(I) Skeletal traction devices including cervical immobilization device suitable for pediatric patients;
(II) Extremity splints; and
(III) Child and adult femur splints.
(xiv) Slit lamp;
(xv) Drugs necessary for pediatric emergency care with printed pediatric doses and pediatric reference materials such as precalculated drug sheets or length-based tape;
(xvi) Infant scale;
(xvii) Thermal control equipment for patients including a heat source or procedure for infant warming; and
(xviii) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4).

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Quality Improvement**. In addition to any other applicable requirements of this Chapter, the facility quality improvement programs shall include a review of the following indicators:
(A) Trauma registry;
(B) Audit for all pediatric deaths to include prehospital care and care received at a transferring facility;
(C) Incident reports related to pediatric patients;
(D) Pediatric transfers;
(E) Child abuse cases;
(F) Pediatric cardiopulmonary or respiratory arrests;
(G) Pediatric admissions within 48 hours of an emergency department visit;
(H) Pediatric surgery within 48 hours of discharge from an emergency department;
(I) Morbidity and mortality review;
(J) Medical nursing audit, utilization review, tissue review;
(K) Published on call schedules for surgeons, neurosurgeons, and orthopedic surgeons;
(L) Review of the times and reasons for trauma-related bypass; and
(M) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(c) **Level II.** A Level II facility shall provide emergency pediatric medicine and trauma services with organized emergency and pediatrics departments and an organized pediatric trauma service with a designated general or pediatric surgeon as director. A physician and nursing staff with special capability in pediatric emergency and trauma care shall be on site twenty-four (24) hours a day. General surgery and anesthesiology services shall be available on site or on call twenty-four (24) hours a day. Services from additional clinical specialties including pediatrics, neurosurgery, orthopedics, and

critical care shall be promptly available on call. A hospital shall be classified at Level II for emergency pediatric medicine and trauma services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Pediatric trauma service.** A pediatric trauma service shall be established by the medical staff and shall be responsible for coordinating the care of injured pediatric patients, the training of personnel, and trauma quality improvement. Privileges for physicians participating in the pediatric trauma service will be determined by the medical staff credentialing process. All pediatric patients with multiple-system or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the admitted patient shall be identified.

(B) **Emergency services.** A physician deemed competent in the care of the seriously ill or injured pediatric patient and credentialed by the hospital to provide pediatric emergency medical services and nursing personnel with special capability in pediatric emergency and trauma care shall be on site twenty-four (24) hours a day. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(C) **Poison control center.** The facility shall have access by telephone or other electronic means to a regional poison control center.

(D) **Pediatric services.** The hospital shall have an organized pediatric service with appropriately credentialed physicians experienced in the care of seriously ill or injured pediatric patients immediately available twenty-four (24) hours a day. Physicians shall be board certified, board eligible, or residency trained in pediatrics. On call physicians shall respond as required by the hospital's policy.

(E) **General surgery.** A general surgeon or senior surgical resident deemed competent and appropriately credentialed by the hospital shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. A stated goal of the general surgery service shall be to have the attending trauma surgeon authorized and designated by the trauma service director present in the emergency room at the time of the severely injured patient's arrival. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(F) **Anesthesia.** An board certified, board eligible, or residency trained anesthesiologist shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. If the anesthesiologist is not present in the facility, prior to the physician's arrival, anesthesia services may be provided by a certified registered nurse anesthetist (CRNA). The CRNA shall be deemed competent in the assessment of emergent situations in trauma patients and of initiating and providing any indicated treatment. All anesthesia

shall be administered as required in OAC 310:667-25-2.

(G) **Neurologic surgery.** A board certified, board eligible, or residency trained neurosurgeon or other physician deemed competent in the care of pediatric patients with neurotrauma and appropriately credentialed shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department. If care is initiated by a physician other than a neurosurgeon, the neurosurgeon on call shall respond as required by the hospital's policy.

(H) **Orthopedics.** A physician board certified, board eligible, or residency trained in orthopedics and deemed competent in the care of pediatric orthopedic emergencies shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department.

(I) **Other specialties.** The hospital shall also have services from the following specialties on call and promptly available:

(i) Cardiac surgery;
(ii) Cardiology;
(iii) Neurology;
(iv) Obstetric/gynecologic surgery;
(v) Ophthalmic surgery;
(vi) Oral/maxillofacial surgery;
(vii) Orthopedic surgery;
(viii) Otolaryngology;
(ix) Plastic surgery;
(x) Pulmonary medicine;
(xi) Radiology;
(xii) Thoracic surgery; and
(xiii) Urology and urologic surgery.

(J) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained.

(K) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(L) **Intensive care unit.** The hospital shall have an intensive care unit and/or pediatric intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the unit whenever the unit has a patient(s). The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall continuously monitor compliance with these requirements through the quality improvement program. A registered nurse shall be on call and immediately available when no patients are in the unit. Nursing personnel shall have completed the Pediatric Advanced Life Support Program (PALS) offered through the American Heart Association or have equivalent training. A physician with privileges in critical care shall be

on duty in the unit or immediately available in the hospital twenty-four (24) hours a day.

(M) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiology technologist and computerize tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;

(ii) Ultrasonography;

(iii) Computed tomography;

(iv) Magnetic resonance imaging;

(v) Neuroradiology; and

(vi) Nuclear medicine imaging.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(N) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Therapeutic drug monitoring;

(iv) Cerebrospinal fluid and other body fluid cell counts;

(v) Coagulation studies;

(vi) Blood gas/pH analysis;

(vii) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(viii) Drug and alcohol screening.

(ix) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(O) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply

with OAC 310:667-23-6.

(P) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(Q) **Burn Care.** If the hospital does not meet the requirements at OAC 310:667-59-13(d)(1)(U)(i) it shall have a transfer agreement with a hospital capable of providing burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(R) **Spinal cord and head injury management.** The hospital shall provide acute spinal cord and head injury management including at least the ability to initiate rehabilitative care prior to transfer and shall have a transfer agreement with a hospital that meets the requirements at OAC 310:667-59-9(d)(1)(P)(i) if comprehensive rehabilitation services are not available within the facility.

(S) **Rehabilitation services.** If the hospital does not meet the requirements at OAC 310:667-59-13(d)(1)(W)(i) it shall have a transfer agreement with a hospital which meets the requirements of Subchapter 35 of this Chapter and is capable of providing rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(T) **Acute hemodialysis.** The hospital shall have the capability to provide acute hemodialysis services twenty-four (24) hours a day. All nursing staff providing hemodialysis patient care shall have documented hemodialysis training and experience.

(2) **Personnel.**

(A) **Pediatric trauma service director.** The medical staff shall designate a general or pediatric surgeon as trauma service director. Through the quality improvement process, the director shall have responsibility for all trauma patients and administrative authority for the hospital's trauma program. The trauma service director shall be responsible for recommending appointment to and removal from the trauma service.

(B) **Pediatric trauma coordinator.** The hospital shall have a designated trauma coordinator who may also serve as the prevention coordinator. Under the supervision of the trauma service director, the trauma coordinator is responsible for organizing the services and systems of the trauma service to ensure there is a multidisciplinary approach throughout the continuum of trauma care. The trauma coordinator shall have an active role in the following:

(i) Clinical activities such as design of clinical protocols, monitoring care, and assisting the staff in problem solving;

(ii) Educational activities such as professional staff development, case reviews, continuing education, and community trauma education and prevention programs;

(iii) Quality improvement activities such as development of quality monitors, audits, and case reviews in all phases of trauma care;

(iv) Administrative tasks for the trauma service such as those related to services' organization, personnel, budget preparation, and accountability;

(v) Trauma registry data collection, coding, scoring, and validation; and

(vi) Consultation and liaison to the medical staff, prehospital emergency medical service agencies, patient families, and the community at large.

(C) **Prevention coordinator.** The hospital shall have a designated prevention coordinator who may also serve as the trauma coordinator. Under the supervision of the trauma director, the prevention coordinator is responsible for the organization and management of the hospital's outreach, prevention, and public education activities.

(D) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(E) **Surgical director.** The medical staff shall designate a surgeon credentialed by the hospital to be the director of care for surgical and critical care for trauma patients.

(F) **Pediatric services director.** The medical staff shall designate a physician credentialed to provide pediatric care as pediatric services director.

(G) **Physician qualifications.** A physician board certified, board eligible, or residency trained in pediatric critical care medicine shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(H) **Training.** Emergency room and intensive care personnel shall have completed the Pediatric Advanced Life Support (PALS) program through the American Heart Association or have equivalent training.

(3) **Supplies and equipment.**

(A) **Emergency department.** The hospital shall have equipment for use in the resuscitation of pediatric patients on site, functional, and immediately available, including at least the following:

(i) Spine board (child/adult) for cardiopulmonary resuscitation and papoose board for immobilization of infants and toddlers;

(ii) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, oxygen, and oxygen delivery equipment. Masks and cannula shall be available in infant, child, and adult sizes;

(iii) Pulse oximeter with adult and pediatric probes;

(iv) End-tidal $CO_2$ determination;

(v) Infant, child, adult, and thigh blood pressure cuffs;

(vi) Rectal thermometer probe;

(vii) Suction devices suitable for infants, children, and adults;

(viii) Electrocardiograph-oscilloscope-defibrillator-pacer

with pediatric capability;

(ix) Apparatus to establish central venous pressure monitoring;

(x) Standard intravenous fluids and administration devices suitable for infants, children, and adults including infusion pumps with microinfusion capability and large-bore intravenous catheters;

(xi) Specialized pediatric procedure trays:

(I) Lumbar puncture;

(II) Urinary catheterization;

(III) Umbilical vessel cannulation;

(IV) Airway control/cricothyrotomy;

(V) Thoracotomy;

(VI) Chest decompression.

(VII) Intraosseous infusion;

(VIII) Vascular access;

(IX) Needle cricothyroidotomy set; and

(X) Peritoneal lavage.

(xii) Magill forceps (pediatric and adult);

(xiii) Equipment for gastric decompression;

(xiv) Fracture management devices including:

(I) Skeletal traction devices including cervical immobilization device suitable for pediatric patients;

(II) Extremity splints; and

(III) Child and adult femur splints.

(xv) Slit lamp;

(xvi) Drugs necessary for pediatric emergency care with printed pediatric doses and pediatric reference materials such as precalculated drug sheets or length-based tape;

(xvii) Infant scale;

(xviii) Thermal control equipment for patients including a heat source or procedure for infant warming; and

(xix) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4);

(B) **Operating suite.** The operating suite shall have the following supplies and equipment on site, functional and available for use:

(i) Thermal control equipment for patients and infusion of blood, blood products, and other fluids;

(ii) X-ray capability including c-arm intensifier;

(iii) Endoscopes;

(iv) Craniotomy instruments; and

(v) Equipment appropriate for fixation of long-bone and pelvic fractures.

(C) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Equipment for the continuous monitoring of intracranial pressure;

(iii) Pulse oximetry;

(iv) End-tidal $CO_2$ determination; and
(v) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(D) **Intensive care unit.** The intensive care unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;
(ii) Cardiopulmonary resuscitation cart;
(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;
(iv) Sterile surgical sets for:
(I) Airway control/cricothyrotomy;
(II) Thoracotomy;
(III) Vascular access; and
(IV) Chest decompression.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Quality Improvement**. In addition to any other applicable requirements of this Chapter, the facility quality improvement programs shall include a review of the following indicators:
(A) Trauma registry;
(B) Audit for all pediatric deaths to include prehospital care and care received at a transferring facility;
(C) Incident reports related to pediatric patients;
(D) Pediatric transfers;
(E) Child abuse cases;
(F) Pediatric cardiopulmonary or respiratory arrests;
(G) Pediatric admissions within 48 hours of an emergency department visit;
(H) Pediatric surgery within 48 hours of discharge from an emergency department;
(I)Morbidity and mortality review;
(J) Medical nursing audit, utilization review, tissue review;
(K) Published on call schedules for surgeons, neurosurgeons, and orthopedic surgeons;
(L) Review of the times and reasons for trauma-related bypass; and
(M) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(6) **Continuing education.** The hospital shall provide and document formal continuing education programs for physicians, nurses, allied health personnel, and community physicians. Continuing education programs shall be available to all state physicians, nurses, allied health personnel, and emergency medical service providers.

(7) **Organ Procurement.** The hospital, in association with an organ procurement organization certified by CMS, shall develop policies and procedures to identify and refer potential organ donors.

(8) **Outreach programs.** The hospital shall have organized outreach

programs under the direction of a designated prevention coordinator.

(A) **Consultation.** The hospital shall provide on-site and/or electronic consultations with community health care providers and those in outlying areas as requested and appropriate.

(B) **Prevention and public education programs.** The hospital shall serve as a public information resource and collaborate with other institutions and national, regional, and state programs in research and data collection projects in epidemiology, surveillance, and injury prevention, and other areas.

(d) **Level I.** A Level I facility shall provide emergency pediatric medicine and trauma services with organized emergency and pediatrics departments and an organized pediatric trauma service with a designated pediatric surgeon as director. Pediatric surgery, pediatric anesthesiology, pediatric neurosurgery, and pediatric critical care services including a dedicated pediatric intensive care unit (PICU) shall be available on site twenty-four (24) hours a day. The facility shall also have the prompt availability of additional clinical services and specialties such as pediatric cardiology, pediatric nephrology, and pediatric infectious disease specialists. A level I facility shall also have an organized trauma research program with a designated director. A hospital shall be classified at Level I for emergency pediatric medicine and trauma services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Pediatric trauma service.** A pediatric trauma service shall be established by the medical staff and shall be responsible for coordinating the care of injured pediatric patients, the training of personnel, and trauma quality improvement. Privileges for physicians participating in the pediatric trauma service will be determined by the medical staff credentialing process. All pediatric patients with multiple-system or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the patient shall be identified.

(B) **Emergency services.** A physician deemed competent in the care of the critically injured pediatric patient and credentialed by the hospital to provide pediatric emergency medical services and nursing personnel with special capability in pediatric emergency and trauma care shall be on site twenty-four (24) hours a day. The emergency department shall have geographically separate and distinct pediatric medical/trauma areas that have all the staff, equipment, and skills necessary for comprehensive pediatric emergency care. Separate fully equipped pediatric resuscitation rooms shall be available and capable of supporting at least two simultaneous resuscitations. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(C) **Poison control center.** The facility shall have access by telephone or other electronic means to a regional poison control center.

(D) **Pediatric services.** The hospital shall have an organized

pediatric service with appropriately credentialed physicians experienced in the care of seriously ill or injured pediatric patients immediately available twenty-four (24) hours a day. Physicians shall be board certified, board eligible, or residency trained in pediatrics. On call physicians shall respond as required by the hospital's policy.

(E) **Cardiac catheterization laboratory**. The facility shall have a full-service cardiac catheterization laboratory or laboratories capable of providing both diagnostic and therapeutic procedures on the heart and great vessels for a wide variety of cardiovascular diseases. Diagnostic, therapeutic, and electrophysiology laboratories shall be supervised by physicians with appropriate training and expertise in the procedures performed and who are properly credentialed by the medical staff. When primary percutaneous transluminal coronary angioplasty (PTCA) is performed, prompt access to emergency coronary arterial bypass graft (CABG) surgery shall also be available.

(F) **Pediatric surgery.** A board certified, board eligible, or residency trained pediatric surgeon or senior surgical resident deemed competent and appropriately credentialed by the hospital shall be on site twenty-four (24) hours a day and promptly available in the emergency department. A stated goal of the pediatric surgery service shall be to have the attending pediatric trauma surgeon authorized and designated by the pediatric trauma service director present in the emergency room at the time of the severely injured pediatric patient's arrival. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(G) **Pediatric anesthesia.** An board certified, board eligible, or residency trained pediatric anesthesiologist shall be on site twenty-four (24) hours a day and promptly available in the emergency department. If the anesthesiologist is not present in the facility, prior to the physician's arrival, anesthesia services may be provided by a certified registered nurse anesthetist (CRNA). The CRNA shall be deemed competent in the assessment of emergent situations in pediatric patients and of initiating and providing any indicated treatment. All anesthesia shall be administered as required in OAC 310:667-25-2. All anesthesia shall be administered as required in OAC 310:667-25-2.

(H) **Neurologic surgery.** A board certified, board eligible, or residency trained neurosurgeon or other physician deemed competent in the care of pediatric patients with neurotrauma and appropriately credentialed shall be on site twenty-four (24) hours a day and promptly available in the emergency department. If care is initiated by a physician other than a neurosurgeon, the neurosurgeon on call shall respond as required by the hospital's policy.

(I) **Orthopedics.** A physician board certified, board eligible, or residency trained in orthopedics and deemed competent in the care of pediatric orthopedic emergencies shall be on site or on call twenty-four (24) hours a day and promptly available in the

emergency department.

(J) **Other specialties.** The hospital shall also have services from the following specialties on call and promptly available:

(i) Cardiovascular surgery;
(ii) Hand surgery;
(iii) Microvascular surgery;
(iv) Ophthalmology;
(v) Oral/maxillofacial surgery;
(vi) Otolaryngology;
(vii) Pediatric allergy/immunology;
(viii) Pediatric cardiology;
(ix) Pediatric endocrinology;
(x) Pediatric gastroenterology;
(xi) Pediatric hematology/oncology;
(xii) Pediatric infectious disease;
(xiii) Pediatric intensivist;
(xiv) Pediatric nephrology;
(xv) Pediatric neurology;
(xvi) Pediatric pulmonology;
(xvii) Plastic surgery;
(xviii) Psychiatry/psychology;
(xix) Radiology; and
(xx) Urology and urologic surgery.

(K) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained.

(L) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or surgical intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(M) **Pediatric intensive care unit (PICU).**

(i) The hospital shall have a pediatric intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). The hospital shall define and document in writing the minimum staffing requirements for the pediatric intensive care unit. A registered nurse shall be on call and immediately available when no patients are in the unit. A physician with privileges in pediatric critical care shall be on duty in the unit or immediately available in the hospital twenty-four (24) hours a day.

(ii) The pediatric intensive care unit shall be a distinct, separate unit within the hospital, with privileges of physicians and allied health personnel delineated in writing.

(iii) Written policies shall be established and approved by the medical director and medical staff for at least the following:

(I) Admission/discharge;
(II) Minimum staffing;

(III) Patient monitoring;
(IV) Safety;
(V) Nosocomial infection;
(VI) Patient isolation;
(VII) Visitation;
(VIII) Traffic control;
(IX) Equipment operation and maintenance;
(X) Coping with and recovering from the breakdown of essential equipment; and
(XI) Patient record-keeping.

(N) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;
(ii) Ultrasonography;
(iii) Computed tomography;
(iv) Magnetic resonance imaging;
(v) Neuroradiology; and
(vi) Nuclear medicine imaging.
(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(O) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. The clinical laboratory shall have the capability to analyze microspecimen volumes when appropriate. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;
(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;
(iii) Therapeutic drug monitoring;
(iv) Cerebrospinal fluid and other body fluid cell counts;
(v) Coagulation studies;
(vi) Blood gas/pH analysis;
(vii) Comprehensive microbiology services with immediate availability of Gram stain preparations and at least

appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(viii) Drug and alcohol screening.

(ix) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(P) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(Q) **Acute hemodialysis.** The hospital shall have the capability to provide acute hemodialysis services twenty-four (24) hours a day. All nursing staff providing hemodialysis patient care shall have documented hemodialysis training and experience with pediatric patients.

(R) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(S) **Physical and occupational therapy services.** Physical and occupational therapy shall be available and provided as required in Subchapter 23 of this Chapter.

(T) **Dietetic and nutrition services.** Dietetic and nutrition services shall be available and provided as required in Subchapter 17 of this Chapter.

(U) **Burn Care.**

(i) The hospital shall provide burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient; or

(ii) If the hospital does not meet the requirements at OAC 310:667-59-13(d)(1)(U)(i), it shall have a written transfer agreement with a hospital capable of providing burn care in a physician-directed, organized burn care center with a staff of nursing personnel trained in burn care and equipped properly for care of the extensively burned patient.

(V) **Spinal cord and head injury management.** The hospital shall provide acute spinal cord and head injury management including at least the ability to initiate rehabilitative care prior to transfer and shall have a transfer agreement with a hospital that meets the requirements at OAC 310:667-59-9(d)(1)(P)(i) if comprehensive rehabilitation services are not available within the facility.

(W) **Rehabilitation services.**

(i) The hospital shall provide rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient; or

(ii) If the hospital does not meet the requirements at OAC 310:667-59-13(d)(1)(W)(i) it shall have a written transfer agreement with a hospital which meets the requirements of Subchapter 35 of this Chapter and is capable of providing

rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically injured patient.

(2) **Personnel.**

(A) **Pediatric trauma service director.** The medical staff shall designate a board certified, board eligible, or residency trained pediatric surgeon as pediatric trauma service director. Through the quality improvement process, the director shall have responsibility for all pediatric trauma patients and administrative authority for the hospital's pediatric trauma program. The pediatric trauma service director shall be responsible for recommending appointment to and removal from the pediatric trauma service.

(B) **Pediatric trauma coordinator.** The hospital shall have a designated pediatric trauma coordinator who may also serve as the prevention coordinator. Under the supervision of the pediatric trauma service director, the pediatric trauma coordinator is responsible for organizing the services and systems of the pediatric trauma service to ensure there is a multidisciplinary approach throughout the continuum of pediatric trauma care. The pediatric trauma coordinator shall have an active role in the following:

(i) Clinical activities such as design of clinical protocols, monitoring care, and assisting the staff in problem solving;

(ii) Educational activities such as professional staff development, case reviews, continuing education, and community trauma education and prevention programs;

(iii) Quality improvement activities such as development of quality monitors, audits, and case reviews in all phases of pediatric trauma care;

(iv) Administrative tasks for the pediatric trauma service such as those related to services' organization, personnel, budget preparation, and accountability;

(v) Trauma registry data collection, coding, scoring, and validation; and

(vi) Consultation and liaison to the medical staff, prehospital emergency medical service agencies, patient families, and the community at large.

(C) **Prevention coordinator.** The hospital shall have a designated prevention coordinator who may also serve as the pediatric trauma coordinator. Under the supervision of the pediatric trauma director, the prevention coordinator is responsible for the organization and management of the hospital's outreach, prevention, and public education activities.

(D) **Emergency services director.** The medical staff shall designate a physician credentialed to provide pediatric emergency medical care as emergency services director.

(E) **Surgical director.** The medical staff shall designate a board certified, board eligible, or residency trained pediatric surgeon credentialed by the hospital to provide pediatric critical care as the surgical director for trauma patients.

(F) **Research director.** The medical staff shall designate a physician as research director who may also serve as the pediatric trauma service director. The research director is responsible for the organization and management of the hospital's trauma and emergency operative research activities.

(G) **PICU medical director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in critical care medicine as PICU medical director. The PICU medical director shall participate in developing and reviewing PICU policies, promote policy implementation, participate in budget preparation, help coordinate staff education, supervise resuscitation techniques, lead quality improvement activities, and coordinate research.

(H) **PICU nurse manager.** The hospital shall have a PICU nurse manager with training and experience in pediatric critical care dedicated to the PICU. The PICU nurse manager shall participate in the development of written policies and procedures for the PICU, coordinate staff education, budget preparation, and coordination of research.

(3) **Supplies and equipment.**

(A) **Emergency department.** The hospital shall have equipment for use in the resuscitation of pediatric patients on site, functional, and immediately available, including at least the following:

(i) Spine board (child/adult) for cardiopulmonary resuscitation and papoose board for immobilization of infants and toddlers;

(ii) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, oxygen, and oxygen delivery equipment. Masks and cannula shall be available in infant, child, and adult sizes;

(iii) Pulse oximeter with adult and pediatric probes;

(iv) End-tidal $CO_2$ determination;

(v) Infant, child, adult, and thigh blood pressure cuffs;

(vi) Rectal thermometer probe;

(vii) Suction devices suitable for infants, children, and adults;

(viii) Electrocardiograph-oscilloscope-defibrillator-pacer with pediatric capability;

(ix) Portable electroencephalographic equipment;

(x) Apparatus to establish central venous pressure monitoring;

(xi) Standard intravenous fluids and administration devices suitable for infants, children, and adults including infusion pumps with microinfusion capability and large-bore intravenous catheters;

(xii) Specialized pediatric procedure trays:

(I) Lumbar puncture;

(II) Urinary catheterization;

(III) Umbilical vessel cannulation;

(IV) Airway control/cricothyrotomy;

(V) Thoracotomy;
(VI) Chest decompression.
(VII) Intraosseous infusion;
(VIII) Vascular access;
(IX) Needle cricothyroidotomy set;
(X) Peritoneal lavage; and
(XI) Subdural access.

(xiii) Magill forceps (pediatric and adult);
(xiv) Equipment for gastric decompression;
(xv) Fracture management devices including:
(I) Skeletal traction devices including cervical immobilization device suitable for pediatric patients;
(II) Extremity splints; and
(III) Child and adult femur splints.

(xvi) Slit lamp;
(xvii) Drugs necessary for pediatric emergency care with printed pediatric doses and pediatric reference materials such as precalculated drug sheets or length-based tape;
(xviii) Infant scale;
(xix) Thermal control equipment for patients including a heat source or procedure for infant warming; and
(xx) Two-way communication with vehicles of emergency transport system as required at OAC 310:667-29-1(c)(4).

(B) **Operating suite.** The operating suite shall have the following supplies and equipment on site, functional and available for use:
(i) Cardiopulmonary bypass capability;
(ii) Operating microscope;
(iii) Thermal control equipment for patients and infusion of blood, blood products, and other fluids;
(iv) X-ray capability including c-arm intensifier;
(v) Pediatric endoscopes and bronchoscopes;
(vi) Craniotomy instruments; and
(vii) Equipment appropriate for fixation of long-bone and pelvic fractures.

(C) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;
(ii) Equipment for the continuous monitoring of intracranial pressure;
(iii) Pulse oximeter with adult and pediatric probes;
(iv) End-tidal $CO_2$ determination; and
(v) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(D) **Pediatric intensive care unit.** The pediatric intensive care unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange. Bedside monitors in the pediatric intensive care unit shall have audible and

visible high and low alarms for each statistic, provide a hard copy of the heart rhythm strip, and have the capability of simultaneously monitoring:

(I) Systemic arterial pressure;
(II) Central venous pressure;
(III) Pulmonary arterial pressure;
(IV) Intracranial pressures;
(V) Heart rate and rhythm;
(VI) Respiratory rate; and
(VII) Temperature.

(ii) Cardiopulmonary resuscitation cart;
(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;
(iv) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;
(II) Thoracotomy;
(III) Vascular access; and
(IV) Chest decompression.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Quality Improvement.** In addition to any other requirements of this Chapter, the hospital quality improvement program shall include:

(A) **Trauma committee.** The hospital shall establish a multidisciplinary trauma committee composed of the trauma service director, emergency services director, trauma coordinator, and other members of the medical and nursing staff that treat trauma and emergency operative patients. The trauma committee shall meet regularly to review and evaluate patient outcomes and the quality of care provided by the trauma service. The quality improvement program shall include:

(i) Trauma registry;
(ii) Audit for all pediatric deaths to include prehospital care and care received at a transferring facility;
(iii) Incident reports related to pediatric patients;
(iv) Pediatric transfers;
(v) Child abuse cases;
(vi) Pediatric cardiopulmonary or respiratory arrests;
(vii) Pediatric admissions within 48 hours of an emergency department visit;
(viii) Pediatric surgery within 48 hours of discharge from an emergency department;
(ix) Morbidity and mortality review;
(x) Regularly scheduled multidisciplinary trauma and emergency operative services review conference;
(xi) Medical nursing audit, utilization review, tissue review;
(xii) Published on call schedules for surgeons, neurosurgeons, and orthopedic surgeons;
(xiii) Review of the times and reasons for trauma-related

bypass;

(xiv) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored; and

(xv) Quality improvement staff with the time dedicated to and specific for trauma and emergency operative services.

(B) **PICU committee.** The hospital shall establish a PICU committee composed of physicians, nurses, and other allied health personnel directly involved with activities in the PICU. The PICU committee shall meet regularly to review and evaluate patient outcomes and the quality of care provided by the PICU. The PICU quality improvement program may be conducted in conjunction with the trauma and emergency operative services program and shall include:

(i) Special audit for all PICU deaths;

(ii) Morbidity and mortality review;

(iii) Medical nursing audit, utilization review, tissue review;

(iv) Regularly scheduled multidisciplinary PICU review conference;

(v) Review of prehospital care;

(vi) Published on call schedules for surgeons, neurosurgeons, and orthopedic surgeons; and

(vii) The availability and response times of on call staff specialists shall be defined in writing, documented, and continuously monitored.

(6) **Continuing education.** The hospital shall provide and document formal continuing education programs for physicians, nurses, allied health personnel, and community physicians. Continuing education programs shall be available to all state physicians, nurses, allied health personnel, and emergency medical service providers.

(7) **Organ Procurement.** The hospital, in association with the local organ procurement organization, shall develop policies and procedures to identify and refer potential organ donors.

(8) **Outreach programs.** The hospital shall have organized outreach programs under the direction of a designated prevention coordinator.

(A) **Consultation.** The hospital shall provide on-site and/or electronic consultations with community health care providers and those in outlying areas as requested and appropriate.

(B) **Prevention and public education programs.** The hospital shall serve as a public information resource and collaborate with other institutions and national, regional, and state programs in research and data collection projects in epidemiology, surveillance, and injury prevention, and other areas.

(9) **Research programs.** The hospital shall have an organized pediatric services research program under the direction of a designated research director. Research groups shall meet regularly and all research proposals shall be approved by an Institutional Review Board (IRB) prior to launch. The research director shall maintain evidence of the productivity of the research program through documentation of presentations and copies of published articles.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-59-14.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-15. Classification of emergency dental services**

(a) **Level III.** A Level III facility shall provide basic emergency dental services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level III for emergency dental services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** The hospital shall have drugs necessary for the treatment of dental emergencies such as analgesics and antibiotics on site and immediately available:

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a dentist or oral and maxillofacial surgeon to provide immediate consultative services for dental patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient referral to an alternate

facility or immediate transfer to a facility capable of providing definitive dental care when appropriate.

(b) **Level II.** A Level II facility shall provide emergency dental services with an organized emergency department. A physician and nursing staff shall be on site twenty-four (24) hours a day. The hospital shall have basic facilities for the management of minor dental emergencies. A hospital shall be classified at Level II for emergency dental services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the seriously ill or injured patient and credentialed by the hospital to provide emergency medical services and nursing personnel shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **Dental services.** An appropriately credentialed dental practitioner shall be on call twenty-four (24) hours a day and promptly available in the emergency department.

(C) **Oral and maxillofacial surgery.** An appropriately credentialed oral and maxillofacial surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(D) **Operatory.** An operatory or operating room equipped to provide treatment for dental emergencies such as odontalgia, oral hemorrhage, dental abscesses, and subluxated, avulsed, and fractured teeth shall be available twenty-four (24) hours a day.

(E) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services including intraoral radiography capability available twenty-four (24) hours a day. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For a hospital licensed as critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(F) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(ii) Coagulation studies;

(iii) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures.

(iv) For a hospital licensed as general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(v) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(2) **Personnel.**

(A) **Dental practitioner.** An appropriately credentialed dental practitioner shall be available for consultation on site or on call and promptly available in the emergency room twenty-four (24) hours a day.

(B) **Dental assistant.** A dental assistant or other appropriately trained staff shall be on site or on call and promptly available to assist the dental practitioner in the operatory or operating room.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available: **Operatory.** The operatory or operating room shall have stationary or portable equipment for use in the management of minor dental emergencies on site, functional, and available including at least the following:

(A) Contour treatment chair or operating table appropriate for use in dental procedures;

(B) Dental operative light;

(C) Dental delivery unit with:

(i) High and low-speed handpieces;

(ii) Three way air/water syringe;

(iii) High volume suction; and

(iv) Saliva ejector.

(D) Amalgamator;

(E) Spot welder;

(F) Rubber dams, punch, and clamps;

(G) Sterile procedure sets for:

(i) Tooth avulsions;

(ii) Minor alveolar fractures;

(iii) Endodontic kit; and

(iv) Soft tissue tray for lacerations.

(H) Appropriate dental tools such as mirrors, explorers, probes, curettes, excavators, burs and stones, rongeurs, elevators, files, reamers, mallet and chisels, mouth props, and amalgam tools as appropriate;

(I) Rotary drill; and

(J) Drugs and consumable supplies necessary for the treatment of dental emergencies such as analgesics, antibiotics, adhesives and cements.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(c) **Level I.** A Level I facility shall provide comprehensive emergency dental services with an organized dental service and emergency department. A physician and nursing staff shall be on site twenty-four (24) hours a day. An oral and maxillofacial surgeon and anesthesiology services shall be available either on duty or on call. The hospital shall be able to provide definitive care for complex dental emergencies. A hospital shall be classified at Level I for emergency dental services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the seriously ill or injured patient and credentialed by the hospital to provide emergency medical services and nursing personnel shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospitals, emergency services shall also comply with OAC 310:667-39-14.

(B) **Dental services.** A dental service shall be established by the medical staff. Privileges for physicians and dental practitioners participating in the dental service shall be determined by the medical staff credentialing process. The dental service shall be consulted on all patients with oral-facial pain, infection, swelling, and/or trauma.

(C) **Oral and maxillofacial surgery.** A board certified or board prepared oral and maxillofacial surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(D) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(E) **Other specialties.** The hospital shall also have services from the following specialties available as needed either on site or as part of a dental referral network:

(i) Endodontics;

(ii) Orthodontics;

(iii) Pedodontics;

(iv) Periodontics; and

(v) Prosthodontics.

(F) **Operatory.** A operatory equipped to provide treatment for dental emergencies such as odontalgia, oral hemorrhage, dental abscesses, and subluxated, avulsed, and fractured teeth shall be available twenty-four (24) hours a day.

(G) **Operating suite.** An operating suite with thermal control

equipment for patients and infusion of blood and fluids shall be available twenty-four (24) hours a day.

(H) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or surgical intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(I) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit.

(J) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services including intraoral radiography capability available twenty-four (24) hours a day. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. In addition to intraoral radiography, the diagnostic imaging service shall provide at least the following services:

(i) Panoramic radiography; and

(ii) Cephalometric radiography.

(iii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(iv) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(K) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis; and

(v) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures.

(vi) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(vii) For a hospital licensed as a critical access hospital,

clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(2) **Personnel.**

(A) **Dental practitioner.** Practitioners board certified or board prepared in endodontics, orthodontics, periodontics, and prosthodontics shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(B) **Dental assistant.** A dental assistant or other appropriately trained staff shall be available to assist the dental practitioner in the operatory twenty-four hours a day.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available: **Operatory.** The operatory shall have stationary or portable equipment for use in the management of minor dental emergencies on site, functional, and available including at least the following:

(A) Contour treatment chair;

(B) Dental operative light;

(C) Dental delivery unit with:

(i) High and low-speed handpieces;

(ii) Three way air/water syringe;

(iii) High volume suction; and

(iv) Saliva ejector.

(D) Amalgamator;

(E) Spot welder;

(F) Rubber dams, punch, and clamps;

(G) Sterile procedure sets for:

(i) Tooth avulsions;

(ii) Minor alveolar fractures;

(iii) Endodontic kit; and

(iv) Soft tissue tray for lacerations.

(H) Appropriate dental tools such as mirrors, explorers, probes, curettes, excavators, burs and stones, rongeurs, elevators, files, reamers, mallet and chisels, mouth props, and amalgam tools as appropriate;

(I) Rotary drill; and

(J) Drugs and consumable supplies necessary for the treatment of dental emergencies such as analgesics, antibiotics, adhesives and cements.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-59-16.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-17. Classification of emergency obstetric and gynecologic services**

(a) **Level IV.** A Level IV facility shall provide basic obstetric and gynecologic services, including emergency delivery, with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level IV for emergency obstetric and gynecologic services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in evaluating obstetric risk factors and protocols for immediate transfer of high risk obstetric cases shall be established and followed.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Obstetrics pack;

(B) Nitrazine (pH) paper for detecting amniotic fluid when membranes are ruptured;

(C) Equipment to monitor fetal heart rate and pattern electronically or by auscultation;

(D) Heat source or procedure for infant warming; and

(E) Ophthalmic antiseptics for neonates.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients

which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility. Written policies and procedures shall include where and how neonates shall be cared for until transfer to an appropriate facility can be completed.

(B) The facility shall have a written agreement with a hospital, or obstetrician-gynecologist, or group of obstetrician-gynecologists to provide immediate consultative services for obstetric and gynecologic patients twenty-four (24) hours a day. Such services shall include the immediate interpretation of obstetric and neonatal risk factors and providing instructions for the initiation of appropriate therapy and/or patient transfer.

(b) **Level III.** A Level III facility shall provide emergency medical services with an organized emergency department. A physician and nursing staff with special capability in obstetric and gynecologic care shall be on site twenty-four (24) hours a day. A hospital shall be classified at Level III for emergency obstetric and gynecologic services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent obstetric or gynecologic patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in obstetric and gynecologic care shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(C) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(D) **Operating suite.** An operating suite with thermal control equipment for patients and infusion of blood and fluids shall be available twenty-four (24) hours a day.

(E) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(F) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall

define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program.

(G) **Diagnostic imaging.** The hospital shall have diagnostic x-ray and ultrasonography services available twenty-four (24) hours a day. A radiology technologist and staff designated as qualified to perform ultrasonography shall be on duty or on call and immediately available twenty-four (24) hours a day. The diagnostic imaging service shall provide at least the following services:

(i) Ultrasonography.

(ii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(iii) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(H) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products, including Rho (D) immune globulin shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing including urine and serum assays for the beta subunit of human chorionic gonadotropin (β-hCG) and quantitative or semiquantitative urine protein;

(iii) Coagulation studies including:

(I) Prothrombin time (PT) and activated partial thromboplastin time (aPTT);

(II) Fibrinogen; and

(III) Assay for fibrin degradation products or an equivalent test;

(iv) Blood gas/pH;

(v) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Drug and alcohol screening.

(vii) For a hospital licensed as a general medical surgical hospital or a specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(viii) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(I) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Obstetrician-gynecologist.** A physician board certified, board eligible, or residency trained in obstetrics and gynecology shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(3) **Supplies and equipment.**

(A) **Emergency department.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies for use in the management of emergent obstetric, gynecologic, and neonatal patients on site, functional, and available in the emergency department, including at least the following:

(i) Obstetrics pack;

(ii) Nitrazine (pH) paper for detecting amniotic fluid when membranes are ruptured;

(iii) Equipment to monitor fetal heart rate and pattern electronically or by auscultation;

(iv) Heat source or procedure for infant warming;

(v) Ophthalmic antiseptics for neonates;

(vi) Pulse oximetry with adult and pediatric probes;

(vii) Drugs necessary for care of the emergent obstetric or gynecologic patient including:

(I) Oxytocic agents;

(II) Tocolytic agents;

(III) Prostaglandins;

(IV) Ergotic agents;

(V) Antihypertensives; and

(VI) Magnesium sulfate.

(viii) Drugs necessary for care of the depressed neonatal patient including:

(I) Epinephrine;

(II) Volume expanders

(III) Sodium bicarbonate;

(IV) Dextrose solutions; and

(V) Naloxone hydrochloride.

(ix) Sterile procedure trays for episiotomy; and

(x) Supplies, equipment, and written protocols for the examination of sexual assault victims and for the collection of specimens and the preservation of the chain of evidence including:

(I) Preassembled sexual assault examination kits;

(II) Consent, chain of evidence, and sexual assault examination forms; and

(III) Long-wave ultraviolet lamp;

(B) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Pulse oximetry;

(iii) End-tidal $CO_2$ determination; and

(iv) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(C) **Intensive care unit.** The intensive care unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Cardiopulmonary resuscitation cart;

(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;

(iv) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and

(IV) Chest decompression.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility. Written policies and procedures shall include where and how neonates shall be cared for until transfer to an appropriate facility can be completed.

(B) The facility shall have a written agreement with a hospital, or obstetrician-gynecologist, or group of obstetrician-gynecologists to provide immediate consultative services for obstetric and gynecologic patients twenty-four (24) hours a day. Such services shall include the immediate interpretation of obstetric and neonatal risk factors and providing instructions for the initiation of appropriate therapy and/or patient transfer.

(c) **Level II.** A Level II facility shall provide emergency medical services with organized emergency and obstetrics-gynecology and departments. A physician and nursing staff with special capability in obstetric and gynecologic care shall be on site twenty-four (24) hours a day. The facility shall have a dedicated obstetrics unit as well as a newborn nursery and shall have the capability to provide immediate delivery by emergency cesarean section. Laparoscopy and laparotomy procedures shall be immediately available when required for obstetric and gynecologic emergencies. A hospital shall be classified at Level II for emergency obstetric and gynecologic services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent obstetric or gynecologic patient and credentialed by the hospital to provide emergency medical services and nursing

personnel with special capability in obstetric and gynecologic care shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **Obstetrics and gynecology.** The facility shall have an organized obstetrics-gynecology service with appropriately credentialed physicians experienced in obstetric and gynecologic procedures on call and immediately available twenty-four (24) hours a day. Physician members of the obstetric-gynecology service shall be board certified, board eligible, or residency trained in obstetrics and gynecology. On call physicians shall respond as required by the hospital's policy.

(C) **Obstetrics unit.** The hospital shall have a dedicated obstetrics unit available twenty-four (24) hours a day. Labor, delivery, and recovery areas shall be appropriately equipped to manage high-risk pregnancies and deliveries including equipment and medications necessary for maternal and neonatal resuscitation procedures. Labor, delivery, and recovery areas shall be staffed with nursing personnel with special capability in obstetric and neonatal care.

(D) **Newborn nursery.** The hospital shall have a dedicated newborn nursery appropriately equipped and staffed with nursing personnel with special capability in neonatal care.

(E) **Pediatrics.** A physician board certified, board eligible, or residency trained in pediatrics and deemed competent in the care of pediatric emergencies shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four hours a day.

(F) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(G) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(H) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained.

(I) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(J) **Intensive care unit.** The hospital shall have an intensive

care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program.

(K) **Diagnostic imaging.** The hospital shall have diagnostic x-ray, computerized tomography, and ultrasonography services available twenty-four (24) hours a day. A radiologic technologist, computerized tomography technologist, and staff designated as qualified to perform ultrasonography shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Ultrasonography;

(I) Transabdominal; and

(II) Endovaginal.

(ii) Computed tomography;

(iii) Magnetic resonance imaging;

(iv) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(v) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(L) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products, including Rho (D) immune globulin shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing including urine and serum assays for the beta subunit of human chorionic gonadotropin (β-hCG);

(iii) Tests for fetal lung maturity;

(iv) Serum hormone tests including:

(I) Progesterone;
(II) Follicle stimulating hormone;
(III) Leutinizing hormone; and
(IV) Prolactin.

(v) Coagulation studies including:
(I) Prothrombin time (PT) and activated partial thromboplastin time (aPTT);
(II) Plasminogen;
(III) Factor assays;
(IV) Fibrinogen; and
(V) Assay for fibrin degradation products or an equivalent test;

(vi) Blood gas/pH;

(vii) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(viii) Drug and alcohol screening.

(ix) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(x) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(M) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(N) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Obstetrics-gynecology services director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in obstetrics and gynecology and credentialed to provide obstetric and gynecologic care as obstetric-gynecology services director.

(C) **Pediatric services director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in pediatrics and credentialed to provide care as pediatric services director.

(D) **Newborn nursery services director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in pediatrics and credentialed to provide pediatric care as the newborn nursery services director. The pediatric services director may also serve as the newborn nursery services director.

(E) **Physician qualifications.** Physician members of the obstetrics-gynecology service shall be board certified, board

eligible, or residency trained in obstetrics and gynecology.

(F) **Training.** Emergency room, obstetrics unit, and newborn nursery nursing personnel shall have completed the Pediatric Advanced Life Support Program (PALS) offered through the American Heart Association or have equivalent training.

(3) **Supplies and equipment.**

(A) **Emergency department.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies for use in the management of emergent obstetric, gynecologic, and neonatal patients on site, functional, and available in the emergency department, including at least the following:

(i) Obstetrics pack;

(ii) Nitrazine (pH) paper for detecting amniotic fluid when membranes are ruptured;

(iii) Equipment to monitor fetal heart rate and pattern electronically;

(iv) Ophthalmic antiseptics for neonates;

(v) Pulse oximetry with adult and pediatric probes;

(vi) Drugs necessary for care of the emergent obstetric or gynecologic patient including:

(I) Oxytocic agents;

(II) Tocolytic agents;

(III) Prostaglandins;

(IV) Ergotic agents;

(V) Antihypertensives; and

(VI) Magnesium sulfate.

(vii) Drugs necessary for care of the depressed neonatal patient including:

(I) Epinephrine;

(II) Volume expanders

(III) Sodium bicarbonate;

(IV) Dextrose solutions; and

(V) Naloxone hydrochloride.

(viii) Radiant warmer;

(ix) Sterile procedure trays for episiotomy; and

(x) Supplies, equipment, and written protocols for the examination of sexual assault victims and for the collection of specimens and the preservation of the chain of evidence including:

(I) Preassembled sexual assault examination kits;

(II) Consent, chain of evidence, and sexual assault examination forms; and

(II) Long-wave ultraviolet lamp;

(B) **Obstetrics unit.** The obstetrics unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Cardiopulmonary resuscitation cart;

(ii) Electrocardiograph-oscilloscope-defibrillator-pacer;

(iii) Equipment for continuous electronic fetal monitoring;

(iv) Equipment for external tocography

(v) An open, stable area under a radiant warmer with

available oxygen and suction and the following equipment for use in neonatal resuscitation:

(I) Bulb syringe;

(II) Assorted suction catheters;

(III) Neonatal oral airways of various sizes;

(IV) Neonatal endotracheal tubes of various sizes and stylets;

(V) Neonatal ventilation masks and bag-mask resuscitator;

(VI) Neonatal laryngoscope with #0 and #1 blades; and

(VII) Neonatal orogastric tube.

(vi) Drugs necessary for care of the depressed neonatal patient including:

(I) Epinephrine;

(II) Volume expanders

(III) Sodium bicarbonate;

(IV) Dextrose solutions; and

(V) Naloxone hydrochloride.

(C) **Operating suite.** The operating suite shall have the following supplies and equipment on site, functional and available for use:

(i) Thermal control equipment for patients and infusion of blood, blood products, and other fluids;

(ii) X-ray capability including c-arm intensifier; and

(iii) Endoscopes.

(D) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Pulse oximetry;

(iii) End-tidal $CO_2$ determination; and

(iv) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(E) **Intensive care unit.** The intensive care unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Cardiopulmonary resuscitation cart;

(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;

(iv) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and

(IV) Chest decompression.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(d) **Level I.** A Level I facility shall provide emergency medical services with organized emergency, obstetrics-gynecology and neonatology

departments. A physician and nursing staff with special capability in obstetric and gynecologic care shall be on site twenty-four (24) hours a day. The facility shall have a dedicated obstetrics unit as well as a newborn nursery and neonatal intensive care unit. The hospital shall have the capability to provide immediate delivery by emergency cesarean section. Laparoscopy and laparotomy procedures shall be immediately available when required for obstetric and gynecologic emergencies. A hospital shall be classified at Level I for emergency obstetric and gynecologic services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent obstetric or gynecologic patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in obstetric and gynecologic care shall be on site twenty-four (24) hours a day. For hospitals licensed as general medical surgical hospitals or specialty hospitals, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(B) **Obstetrics and gynecology.** The facility shall have an organized obstetrics-gynecology service with appropriately credentialed physicians experienced in obstetric and gynecologic procedures on call and immediately available twenty-four (24) hours a day. Physician members of the obstetric-gynecology service shall be board certified, board eligible, or residency trained in obstetrics and gynecology. On call physicians shall respond as required by the hospital's policy.

(C) **Neonatology.** The facility shall have an organized neonatology service with appropriately credentialed physicians experienced in the care of the seriously ill neonatal patient on call and immediately available twenty-four (24) hours a day. Physician members of the neonatology service shall be board certified, board eligible, or residency trained in neonatology. On call physicians shall respond as required by the hospital's policy.

(D) **Obstetrics unit.** The hospital shall have a dedicated obstetrics unit available twenty-four (24) hours a day. Labor, delivery, and recovery areas shall be appropriately equipped to manage high-risk pregnancies and deliveries including equipment and medications necessary for maternal and neonatal resuscitation procedures. Labor, delivery, and recovery areas shall be staffed with nursing personnel with special capability in obstetric and neonatal care.

(E) **Pediatrics.** A physician board certified, board eligible, or residency trained in pediatrics and deemed competent in the care of pediatric emergencies shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four hours a day.

(F) **Newborn nursery.** The hospital shall have a dedicated newborn nursery appropriately equipped and staffed with nursing personnel with special capability in neonatal care.

(G) **Neonatal intensive care unit.** The hospital shall have a dedicated neonatal intensive care unit appropriately equipped and

staffed with nursing personnel with special capability in neonatal care. A board certified, board eligible, or residency trained neonatologist or senior resident deemed competent and appropriately credentialed by the hospital shall be on site twenty-four (24) hours a day at all times when patients are in the unit. If a senior neonatology resident is staffing the unit, an attending neonatologist shall be on call and promptly available twenty-four (24) hours a day.

(H) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(I) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(J) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained.

(K) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(L) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program.

(M) **Diagnostic imaging.** The hospital shall have diagnostic x-ray, computerized tomography, and ultrasonography services available twenty-four (24) hours a day. A radiologic technologist, computerized tomography technologist, and staff designated as qualified to perform ultrasonography shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Ultrasonography;
  (I) Transabdominal; and
  (II) Endovaginal.
(ii) Angiography;
(iii) Computed tomography;

(iv) Magnetic resonance imaging;
(v) Neuroradiology; and
(vi) Nuclear medicine imaging.
(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(N) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products, including Rho (D) immune globulin shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;
(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing including urine and serum assays for the beta subunit of human chorionic gonadotropin (β-hCG);
(iii) Tests for fetal lung maturity;
(iv) Serum hormone tests including:
(I) Progesterone;
(II) Follicle stimulating hormone;
(III) Leutinizing hormone; and
(IV) Prolactin.
(v) Coagulation studies including:
(I) Prothrombin time (PT) and activated partial thromboplastin time (aPTT);
(II) Plasminogen;
(III) Factor assays;
(IV) Fibrinogen; and
(V) Assay for fibrin degradation products or an equivalent test;
(vi) Blood gas/pH;
(vii) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and
(viii) Drug and alcohol screening.
(ix) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(O) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(P) **Acute hemodialysis.** The hospital shall have the capability to provide acute hemodialysis services twenty-four (24) hours a day. All staff providing hemodialysis patient care shall have documented hemodialysis training and experience.

(Q) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Obstetrics-gynecology services director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in obstetrics and gynecology and credentialed to provide obstetric and gynecologic care as obstetric-gynecology services director.

(C) **Pediatric services director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in pediatrics and credentialed to provide care as pediatric services director,

(D) **Newborn nursery services director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in pediatrics and credentialed to provide pediatric care as the newborn nursery services director. The pediatric services director my also serve as the newborn nursery services director.

(E) **Neonatology services director.** The medical staff shall designate a physician board certified, board eligible, or residency trained in neonatology and credentialed to provide neonatal care as neonatology services director.

(F) **Physician qualifications.**

(i) Physician members of the obstetrics-gynecology service shall be board certified, board eligible, or residency trained in obstetrics and gynecology.

(ii) Physician members of the neonatology service shall be board certified, board eligible, or residency trained in neonatology.

(G) **Training.** Emergency room, obstetrics unit, newborn nursery, and neonatal intensive care unit nursing personnel shall have completed the Pediatric Advanced Life Support Program (PALS) and or the Neonatal Advanced Life Support Program (NALS) offered through the American Heart Association or have equivalent training.

(3) **Supplies and equipment.**

(A) **Emergency department.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies for use in the management of emergent obstetric and gynecologic patients on site, functional, and available in the emergency department, including at least the following:

(i) Obstetrics pack;

(ii) Nitrazine (pH) paper for detecting amniotic fluid when membranes are ruptured;

(iii) Equipment to monitor fetal heart rate and pattern electronically;
(iv) Ophthalmic antiseptics for neonates;
(v) Pulse oximetry with adult and pediatric probes;
(vi) Drugs necessary for care of the emergent obstetric or gynecologic patient including:
(I) Oxytocic agents;
(II) Tocolytic agents;
(III) Prostaglandins;
(IV) Ergotic agents;
(V) Antihypertensives; and
(VI) Magnesium sulfate.
(vii) Drugs necessary for care of the depressed neonatal patient including:
(I) Epinephrine;
(II) Volume expanders
(III) Sodium bicarbonate;
(IV) Dextrose solutions; and
(V) Naloxone hydrochloride.
(viii) Radiant warmer;
(ix) Sterile procedure trays for episiotomy;
(x) Supplies, equipment, and written protocols for the examination of sexual assault victims and for the collection of specimens and the preservation of the chain of evidence including:
(I) Preassembled sexual assault examination kits;
(II) Consent, chain of evidence, and sexual assault examination forms; and
(III) Long-wave ultraviolet lamp;

(B) **Obstetrics unit.** The obstetrics unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Cardiopulmonary resuscitation cart;
(ii) Electrocardiograph-oscilloscope-defibrillator-pacer;
(iii) Equipment for continuous electronic fetal monitoring;
(iv) Equipment for external tocography;
(v) An open, stable area under a radiant warmer with available oxygen and suction and the following equipment for use in neonatal resuscitation:
(I) Bulb syringe;
(II) Assorted suction catheters;
(III) Neonatal oral airways of various sizes;
(IV) Neonatal endotracheal tubes of various sizes and stylets;
(V) Neonatal ventilation masks and bag-mask resuscitator;
(VI) Neonatal laryngoscope with #0 and #1 blades; and
(VII) Neonatal orogastric tube.
(vi) Drugs necessary for care of the depressed neonatal patient including:
(I) Epinephrine;
(II) Volume expanders
(III) Sodium bicarbonate;

(IV) Dextrose solutions; and
(V) Naloxone hydrochloride.

(B) **Operating suite.** The operating suite shall have the following supplies and equipment on site, functional and available for use:
(i) Cardiopulmonary bypass capability;
(ii) Operating microscope;
(iii) Thermal control equipment for patients and infusion of blood, blood products, and other fluids;
(iv) X-ray capability including c-arm intensifier; and
(v) Endoscopes.

(C) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;
(ii) Equipment for the continuous monitoring of intracranial pressure;
(iii) Pulse oximetry;
(iv) End-tidal $CO_2$ determination; and
(v) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(D) **Intensive care unit.** he intensive care unit shall have the following supplies and equipment on site, functional, and available for use:
(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;
(ii) Cardiopulmonary resuscitation cart;
(iii) Electrocardiograph-oscilloscope-defibrillator-pacer;
(iv) Sterile surgical sets for:
(I) Airway control/cricothyrotomy;
(II) Thoracotomy;
(III) Vascular access; and
(IV) Chest decompression.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-59-18.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-19. Classification of emergency ophthalmology services**

(a) **Level III.** A Level III facility shall provide services with at least a licensed independent practitioner, registered nurse, licensed

practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level III for emergency ophthalmology services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Ophthalmic irrigating device or procedure and sterile irrigating solution suitable for ophthalmic irrigation;

(B) Nitrazine pH paper;

(C) Distance and near vision charts or projector, or other equipment for the proper assessment of visual acuity;

(D) Ophthalmoscope;

(E) Agents for pupillary dilation such as:

(i) Topical sympathomimetic; and

(ii) Topical parasympatholytics.

(F) Drugs for the treatment of acute angle-closure glaucoma including:

(i) Topical miotic agents;

(ii) Topical adrenergic antagonists;

(iii) Oral and intravenous carbonic anhydrase inhibitors; and

(iv) Hyperosmotic agents.

(G) Topical anesthetic agents;

(H) Penlight and loupes or magnifying lenses;

(I) Equipment for tonometry;

(J) Sterile, individually wrapped, fluorescein impregnated paper strips;
(K) Light source with a blue filter or Wood lamp;
(L) Lid retractors;
(M) Ophthalmic spud device or equivalent;
(N) Topical antibiotics;
(O) Eye shields; and
(P) Supplies and equipment necessary for patching the eye.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained ophthalmologist, or group of ophthalmologists to provide immediate consultative services for ophthalmology patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer. Appropriately trained and credentialed optometrists may also provide consultative and therapeutic services within their scope of practice.

(b) **Level II.** A Level II facility shall provide emergency medical services with an organized emergency department. A physician and nursing staff shall be on site twenty-four (24) hours a day. A hospital shall be classified at Level II for emergency ophthalmology services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent ophthalmology patient and credentialed by the hospital to provide emergency medical services and nursing personnel shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For a hospital licensed as a critical access hospitals, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(C) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by

arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(ii) Coagulation studies;

(iii) Blood gas/pH analysis; and

(iv) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(v) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(vi) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Ophthalmologist.** A physician board certified, board eligible, or residency trained in ophthalmology shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(C) **Optometrist.** Appropriately trained and credentialed optometrists may also provide consultative and therapeutic services within their scope of practice.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Ophthalmic irrigating device or procedure and sterile irrigating solution suitable for ophthalmic irrigation;

(B) Nitrazine pH paper;

(C) Distance and near vision charts or projector, or other equipment for the proper assessment of visual acuity;

(D) Ophthalmoscope;

(E) Agents for pupillary dilation such as:

(i) Topical sympathomimetic; and

(ii) Topical parasympatholytics.

(F) Drugs for the treatment of acute angle-closure glaucoma including:

(i) Topical miotic agents;

(ii) Topical adrenergic antagonists;

(iii) Oral and intravenous carbonic anhydrase inhibitors; and

(iv) Hyperosmotic agents.

(G) Topical anesthetic agents;

(H) Penlight and loupes or magnifying lenses;

(I) Equipment for tonometry;

(J) Slit-lamp biomicroscope;

(K) Sterile, individually wrapped, fluorescein impregnated

paper strips;
(L) Lid retractors;
(M) Ophthalmic spud device or equivalent;
(N) Topical antibiotics;
(O) Eye shields; and
(P) Supplies and equipment necessary for patching the eye.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained ophthalmologist, or group of ophthalmologists to provide immediate consultative services for ophthalmology patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer.

(c) **Level I.** A facility providing emergency medical services with organized emergency and ophthalmology departments. A physician and nursing staff with special capability in ophthalmic care shall be on site twenty-four (24) hours a day. The facility shall have the capability to provide immediate diagnostic imaging and sight saving surgical intervention twenty-four (24) hours a day. A hospital shall be classified at Level I for emergency ophthalmology services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent ophthalmology patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in ophthalmic care shall be on site twenty-four (24) hours a day. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(B) **Ophthalmology and ophthalmic surgery.** The facility shall have an organized ophthalmology and ophthalmic surgery service with appropriately credentialed physicians experienced in ophthalmic medical and surgical procedures immediately available twenty-four (24) hours a day. Physician members of the ophthalmology service shall be board certified, board eligible, or residency trained in ophthalmology. On call physicians shall respond as required by the hospital's policy.

(C) **Neurology.** A board certified, board eligible, or residency trained neurologist shall be on site or on call twenty-four (24) hours a day and promptly available in the emergency department.

(D) **Anesthesia.** A board certified, board eligible, or residency trained anesthesiologist shall be on site or on call twenty-four (24) hours a day and promptly available. All anesthesia shall be administered as required in OAC 310:667-25-2.

(E) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the

minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained. At least one operating suite shall have conventional and laser surgery and photocoagulation capability.

(F) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(G) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program.

(H) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray, computed tomography, and ultrasonography services available twenty-four (24) hours a day. A radiologic technologist, computerized tomography technologist, and staff designated as qualified to perform ultrasonography shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;

(ii) Ultrasonography;

(iii) Computed tomography;

(iv) Magnetic resonance imaging; and

(v) Neuroradiology.

(vi) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(I) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis; and

(v) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(J) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Ophthalmology services director.** The medical staff shall designate a physician credentialed to provide medical and/or surgical ophthalmic care as ophthalmology services director.

(C) **Physician qualifications.** Physician members of the ophthalmology service shall be board certified, board eligible, or residency trained in ophthalmology.

(D) **Optometrist.** Appropriately trained and credentialed optometrists may also provide consultative and therapeutic services within their scope of practice.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-19(b)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Gonioscopy equipment; and

(B) Equipment for indirect ophthalmoscopy.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-59-20. Classification of emergency stroke services**

(a) **Level I Stroke Center.** A Level I Stroke Center shall be deemed to adhere to primary and secondary stroke recognition and prevention guidelines as required by state law and serve as a resource center for other hospitals in the region and be a comprehensive receiving facility staffed and equipped to provide total care for all major needs of the stroke patient as determined by:

(1) An up-to-date certification as a Comprehensive Stroke Center from a Centers for Medicare and Medicaid Services deemed accrediting agency or a Department approved organization that uses a nationally recognized set of guidelines; and

(2) Providing quality assurance information, including benchmark tracking and other data to the department upon request.

(b) **Level II Stroke Center.** A Level II Stroke Center shall be deemed to

adhere to primary and secondary stroke recognition and prevention guidelines as required by state law and be a receiving center staffed by in-patient stroke services staff and be equipped to provide definitive care for a major proportion of stroke patients within the region as determined by:

(1) An up-to-date certification as a Primary Stroke Center from a Centers for Medicare and Medicaid Services deemed accrediting agency or a Department approved organization that uses a nationally recognized set of guidelines; and

(2) Providing quality assurance information, including benchmark tracking and other data to the department upon request.

(c) **Level III Stroke Center.** A Level III Stroke Center shall be deemed to adhere to secondary stroke recognition and prevention guidelines as required by state law and be staffed and equipped to provide initial diagnostic services, stabilization, thrombolytic therapy, emergency care to patients who have suffered an acute stroke (which is a stroke wherein symptoms have on-set within the immediately preceding twelve (12) hours). They shall have an up-to-date certification as an Acute Stroke Ready Hospital from a Centers for Medicare and Medicaid Services deemed accrediting agency or from a department approved organization that uses a nationally recognized set of guidelines or from the department for a period not to exceed three years and meet the following requirements:

(1) **Stroke Team:**

(A) Having a stroke team available twenty-four (24) hours a day, seven (7) days a week;

(B) Having a licensed physician trained in the care of the emergent stroke patient and credentialed by the hospital to provide emergency medical service for stroke patients, including the ability to administer thrombolytic agents;

(C) Having designated stroke team(s) that are identified in writing, which is either on-site or each member is able to respond to the hospital within twenty (20) minutes to the emergency department of the Stroke Center;

(D) Having members trained in the care of a stroke patient, with said training updated annually;

(E) Having response times of the stroke team established and tracked in writing;

(F) Adoption of standard practice protocols for the care of a stoke patient in writing, which shall include the appropriate administration of an FDA-approved thrombolytic agent within sixty (60) minutes following the arrival of a patient who has suffered a stroke at the emergency department at least fifty percent (50%) of the time;

(G) Written emergency stroke care protocols adopted; and

(H) A licensed nurse or other health professional designated as the stroke coordinator.

(2) **Emergency Department:**

(A) A licensed independent practitioner able to recognize, assess and if indicated administer thrombolytic therapy to stroke patients;

(B) A licensed independent practitioner will assess potential stroke patients within 15 minutes of arrival;

(C) Having nursing personnel available on-site twenty-four (24) hours a day, seven (7) days a week who are trained in emergent stroke care, which is demonstrated at least every two (2) years through evidence of competency;

(D) For a hospital, licensed as a general medical surgical hospital or a specialty hospital, all emergency services shall meet the requirements of Oklahoma Administrative Code (OAC) 310:667-29-1 and 310:667-29-2;

(E) For a hospital, licensed as critical access hospital, all emergency services shall meet the requirements of OAC 310:667-39-14;

(F) Adopt written comprehensive stroke protocols for the treatment and stabilization of a stroke patient, which shall include, but not be limited to:

(i) Detailed instructions on IV thrombolytic use;

(ii) Reversal of anticoagulation in patients with hemorrhagic stroke;

(iii) A standardized stroke assessment scale;

(iv) Protocols for the control of seizures;

(v) Blood pressure management; and

(vi) Care for patients, who have suffered a stroke, but are not eligible to receive thrombolytic agents.

(G) Collaborate with emergency medical service agencies to develop inter-facility transfer protocols for stroke patients and will only use those emergency medical service agencies that have a Department approved protocol for the inter-facility transfer of stroke patients.

(3) **Supplies and equipment:**

(A) All equipment and supplies shall meet the requirements of OAC 310:667-59-9 (a);

(B) Have available on-site, twenty-four (24) hours a day, seven (7) days a week, thrombolytic agents, which are FDA approved for the treatment of acute non-hemorrhagic stroke;

(C) Have available on-site, twenty-four (24) hours a day, seven (7) days a week, seizure control agents; and

(D) Have available on-site, twenty-four (24) hours a day, seven (7) days a week, thiamine and glucose for intravenous administration.

(4) **Neuroimaging services:**

(A) Have available on-site, twenty-four (24) hours a day, seven (7) days a week diagnostic x-ray and computerized tomography (CT) services;

(B) Have on duty or on call with a twenty (20) minute response time, twenty-four (24) hours a day, seven (7) days a week radiologic technologist and CT technologist. A single technologist designated as qualified in both diagnostic x-ray and CT procedures by the radiologist may be used to meet this requirement if an on-call schedule of additional diagnostic imaging personnel is maintained;

(C) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in OAC 310:667-23 of this

Chapter; and

(D) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in OAC 310:667-39.

(5) **Laboratory services:**

(A) Laboratory services shall be provided on-site and available twenty-four (24) hours a day, seven (7) days a week, and at a minimum provide the following:

(i) A complete blood count;

(ii) Metabolic profile;

(iii) Coagulation studies (prothrombin time, international normalized ratio);

(iv) Pregnancy testing; and

(v) Troponin I.

(B) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in OAC 310:667-23; and

(C) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in OAC 301:667-39.

(6) **Outcome and quality improvement:** Outcome and quality improvement activities shall include the tracking of all stroke patients, appropriate use of thrombolytic therapy, performance measures and at a minimum the following steps shall be accomplished, which shall be verifiable and made available upon request by the Department:

(A) The facility will track the number of stroke and acute stroke patients, the number treated with thrombolytic therapy, including how soon after hospital presentation (arrival to needle time), the number of acute stroke patients not treated and indications for why they were not treated;

(B) There will be an official policy to review the care of all acute stroke patients that were eligible for thrombolytics and did not receive them;

(C) There will be a policy for and review of all patients who received thrombolytics more than 60 minutes after hospital presentation;

(D) If a facility fails to provide thrombolytics within 60 minutes to at least 50% of eligible patients for two consecutive quarters, they will develop and implement an internal plan of corrections;

(E) Provide no less than quarterly feedback to:

(i) Hospital physicians and other health professionals;

(ii) Emergency medical service agencies; and

(iii) Referring hospitals;

(F) There will be a review of all acute stroke patients who require more than 2 hours to be transferred (arrival-to-departure time);

(G) The time from ordering to interpretation of a head CT or MRI will be tracked; and

(H) Door-to-computer link time for cases where a tele-technology is used.

(7) **Agreements and policies:**

(A) The stroke center shall develop and implement a written plan

for transfer of patients to a Level I or Level II stroke facility as appropriate, defining medical conditions and circumstances for those emergency patients who:

(i) May be retained for treatment in-house;

(ii) Require stabilizing treatment; and

(iii) Require transfer to another facility.

(B) If a stroke telemedicine program is utilized, there will be a written, contractual agreement addressing, at a minimum, performance standards, legal issues and reimbursement.

(d) **Level IV Stroke Referral Center.** A Level IV Stroke referral center shall be deemed to adhere to secondary stroke recognition and prevention guidelines as required by state law and is a referral center lacking sufficient resources to provide definitive care for stroke patients. A Level IV Stroke referral Center shall provide prompt assessment, indicated resuscitation and appropriate emergency intervention. The Level IV Stroke referral Center shall arrange and expedite transfer to a higher level stroke center as appropriate. A hospital shall receive a Level IV Stroke referral Center designation by the Department, which shall be renewed in three (3) year intervals, providing the hospital is not certified as a level I, II or III stroke center and meets the following requirements:

(1) **Emergency Department:**

(A) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall comply with the requirements of OAC 310:667-29-1 and OAC 310:667-29-2;

(B) For a hospital licensed as a critical access hospital, emergency services shall comply with OAC 310:667-39-14;

(C) For acute stroke patients requiring transfer by emergency medical services, said services will be contacted and emergently requested no more than 20 minutes after patient arrival;

(D) Enter into transfer agreements for expeditious transfer of acute stroke patients to stroke centers able to provide a higher level of care;

(E) Have a comprehensive plan for the prompt transfer of acute stroke patients to higher level stroke centers which includes an expected arrival-to-departure time of < 60 minutes, with the ability to provide documentation demonstrating the ability to meet this requirement at least 65% of the time on a quarterly basis;

(F) A health care professional able to recognize stroke patients will assess the patient within 15 minutes of arrival; and

(G) Collaborate with emergency medical service agencies to develop inter-facility transfer protocols for stroke patients and will only use those emergency medical service agencies that have a Department approved protocol for the inter-facility transfer of stroke patients.

(2) **Supplies and equipment:** All Level IV Stroke referral Centers shall meet the requirements of OAC 310:667-59-9(a)(3).

(3) **Laboratory services:**

(A) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in OAC 310:667-23; and

(B) For a hospital licensed as a critical access hospital,

clinical laboratory services shall also comply with the applicable requirements in OAC 310:667-39.

(4) **Outcome and quality improvement:** The following outcome and quality improvement requirements are applicable to Level IV Stroke referral Centers, which include tracking of all patients seen with acute stroke:

(A) A facility will meet the applicable outcome and quality measures listed in section 310:667-59-20(G) [1] ; and

(B) Track and review all acute stroke transfer cases requiring longer than an arrival-to-departure time of > 60 minutes. If over two consecutive quarters inter-facility transfers (arrival-to-departure) exceeds > 60 minutes more than 35% of the time the facility will create and implement an internal plan of correction.

(5) **Agreements and policies:**

(A) A Level IV Stroke referral Center shall develop and implement a written plan for transfer of patients to a Level I, II or III Stroke Center. The written plan shall establish medical conditions and circumstances to determine:

(i) Which patients may be retained or referred for palliative or end-of-life care;

(ii) Which patients shall require stabilizing treatment; and

(iii) Which patients shall require transfer to a Level I, II or III Stroke Center;

(B) Development and implementation of policy and transfer agreements directing transfer of acute stroke patients to the closest appropriate higher level facility. Patient preference may be taken into consideration when making this decision.

[**Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00; Added at 25 Ok Reg 2785, eff 7-17-08 (emergency); Added at 26 Ok Reg 2054, eff 6-25-09; Amended at 27 Ok Reg 2542, eff 7-25-10; Revoked at 32 Ok Reg 1790, eff 9-11-15]

***AGENCY NOTE:*** *[1]In the process of drafting and revising new language for this section 310:667-59-20, a change in numbering was not captured in the new rule text in subparagraph (d)(4)(A) of this section. The cross-reference to 310:667-59-20(G) in this subparagraph is invalid and refers to a non-existent subsection. The cross-reference should refer to 310:667-59-20(c)(6), relating to outcome and quality improvement measures. This error will be revised in future rule-making.*

**310:667-59-21. Classification of emergency neurology services**

(a) **Level III.** A Level III facility shall provide services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level III for emergency neurology services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or

paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Seizure control agents;

(B) Thiamine and glucose for intravenous administration; and

(C) Antipyretics and procedures for reducing body temperature when necessary.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained neurologist, or group of neurologists to provide immediate consultative services for neurology patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer.

(b) **Level II.** A Level II facility shall provide emergency medical services with an organized emergency department. A physician and nursing staff shall be on site twenty-four (24) hours a day. A hospital shall be classified at Level II for emergency neurology services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent neurology patient and credentialed by the hospital to provide emergency medical services and nursing personnel shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical

hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **Diagnostic imaging.** The hospital shall have diagnostic x-ray and computerized tomography services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Ultrasonography; and

(ii) Computed tomography.

(iii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(iv) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(C) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(ii) Cerebrospinal fluid, cell count, white blood cell differential, protein, glucose, Gram stain, and antigen testing when appropriate;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis;

(v) Drug and alcohol screening; and

(vi) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(viii) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical

care as emergency services director.

(B) **Neurologist.** A physician board certified, board eligible, or residency trained in neurology shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Equipment to perform electroencephalographic (EEG) testing;

(B) Seizure control agents;

(C) Thiamine and glucose for intravenous administration;

(D) Antipyretics and procedures for reducing body temperature when necessary;

(E) Sterile procedure trays for:

(i) Lumbar puncture and measurement of intracranial pressure; and

(ii) Gastric lavage and administration of activated charcoal.

(F) Agents to manage increased intracranial pressure including:

(i) Osmotic diuretics such as mannitol;

(ii) Loop diuretics such as furosemide; and

(iii) Corticosteriods when appropriate.

(G) Drugs to manage migraine headache such as sumatriptin, ergotic agents, antinauseants, narcotic analgesics, etc.; and

(H) Thrombolytic agents for treatment of acute nonhemorrhagic stroke.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained neurologist, or group of neurologists to provide immediate consultative services for neurology patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer.

(c) **Level I.** A Level I facility shall provide emergency medical services with organized emergency, neurology, and neurosurgery departments. A physician and nursing staff with special capability in neurologic care shall be on site twenty-four (24) hours a day. The facility shall have the capability to provide immediate diagnostic imaging and neurosurgical intervention twenty-four (24) hours a day. A hospital shall be classified at Level I for emergency neurology services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent neurology patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in neurologic care shall be on site twenty-four (24) hours a day. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC

310:667-29-2.

(B) **Neurology.** The facility shall have organized neurology service with appropriately credentialed physicians experienced in neurologic procedures immediately available twenty-four (24) hours a day. Physician members of the neurology services shall be board certified, board eligible, or residency trained in neurology. On call physicians shall respond as required by the hospital's policy.

(C) **Neurosurgery.** The facility shall have organized neurosurgery service with appropriately credentialed physicians experienced in neurosurgical procedures immediately available twenty-four (24) hours a day. Physician members of the neurosurgery service shall be board certified, board eligible, or residency trained in neurosurgery. On call physicians shall respond as required by the hospital's policy.

(D) **Anesthesia.** A board certified, board eligible, or residency trained anesthesiologist shall be on site or on call twenty-four (24) hours a day and promptly available. All anesthesia shall be administered as required in OAC 310:667-25-2.

(E) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. An on call schedule for emergency replacement staff shall be maintained.

(F) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care.

(G) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program.

(H) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray and computed tomography services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Cerebral angiography;
(ii) Myelography;
(iii) Ultrasonography;
(iv) Computed tomography;
(v) Magnetic resonance imaging; and

(vi) Neuroradiology.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(I) **Electrophysiologic Testing.** The hospital shall have electrophysiologic testing services including electroecephalography (EEG), electrocardiography (ECG), and electromyography (EMG) services available as needed.

(J) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Cerebrospinal fluid, cell count, white blood cell differential, protein, glucose, gram stain, and antigen testing when appropriate;

(iv) Coagulation studies;

(v) Blood gas/pH analysis; and

(vi) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(K) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(L) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(M) **Rehabilitation services.**

(i) The hospital shall provide rehabilitation services in a rehabilitation center with a staff of personnel trained in rehabilitation care and equipped properly for acute care of the critically ill patient; or

(ii) If the hospital does not meet the requirements at OAC 310:667-59-21(c)(1)(M)(i) it shall have a written transfer agreement with a hospital which meets the requirements of Subchapter 35 of this Chapter and is capable of providing rehabilitation services in a rehabilitation center with a staff

of personnel trained in rehabilitation care and equipped properly for acute care of the critically ill patient.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Neurology services director.** The medical staff shall designate a physician credentialed to provide neurologic and/or neurosurgical care as neurology services director.

(C) **Physician qualifications.**

(i) Physician members of the neurology service shall be board certified, board eligible, or residency trained in neurology.

(ii) Physician members of the neurosurgical service shall be board certified, board eligible, or residency trained in neurosurgery.

(3) **Supplies and equipment.**

(A) **Emergency department.** In addition to the requirements at OAC 310:667-59-19(d)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(i) Equipment to perform electroencephalographic (EEG) testing;

(ii) Seizure control agents;

(iii) Thiamine and glucose for intravenous administration;

(iv) Antipyretics and procedures for reducing body temperature when necessary;

(v) Sterile procedure trays for:

(I) Lumbar puncture and measurement of intracranial pressure;

(II) Gastric lavage and administration of activated charcoal; and

(III) Emergency burr hole.

(vi) Agents to manage increased intracranial pressure including:

(I) Osmotic diuretics such as mannitol;

(II) Loop diuretics such as furosemide; and

(III) Corticosteriods when appropriate.

(vii) Drugs to manage migraine headache such as sumatriptin, ergotic agents, antinauseants, narcotic analgesics, etc.;

(viii) Thrombolytic agents for treatment of acute nonhemorrhagic stroke; and

(ix) Equipment to monitor intracranial pressure.

(B) **Operating suite.** The operating suite shall have the following supplies and equipment on site, functional and available for use:

(i) Cardiopulmonary bypass capability;

(ii) Operating microscope;

(iii) Thermal control equipment for patients and infusion of blood, blood products, and other fluids;

(iv) X-ray capability including c-arm intensifier;

(v) Endoscopes;

(vi) Craniotomy instruments; and

(vii) Equipment for the continuous monitoring of intracranial pressure.

(C) **Post-anesthesia recovery unit.** The post-anesthesia recovery unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Equipment for the continuous monitoring of intracranial pressure;

(iii) Pulse oximetry;

(iv) End-tidal $CO_2$ determination; and

(v) Thermal control equipment for patients and infusion of blood, blood products, and other fluids.

(D) **Intensive care unit.** The intensive care unit shall have the following supplies and equipment on site, functional, and available for use:

(i) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Equipment for the continuous monitoring of intracranial pressure;

(iii) Cardiopulmonary resuscitation cart;

(iv) Electrocardiograph-oscilloscope-defibrillator-pacer; and

(v) Sterile surgical sets for:

(I) Airway control/cricothyrotomy;

(II) Thoracotomy;

(III) Vascular access; and

(IV) Chest decompression.

(4) **Policies on transfers**. The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-59-22.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-23. Classification of emergency psychiatric services**

(a) **Level III.** A Level III facility shall provide emergency medical services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level III for emergency psychiatric services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Outpatient psychiatric resources.** The hospital shall maintain a current list of outpatient psychiatric resources available within the community or region and make appropriate referrals for patients who do not require emergency inpatient psychiatric treatment.

(4) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Psychotropic medications appropriate for treating psychiatric emergencies including benzodiazepines such as lorazepam and neuroleptics such as haloperidol; and

(B) Thiamine and glucose for intravenous administration.

(5) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained psychiatrist, or group of psychiatrists to provide immediate consultative services for psychiatric patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer.

(b) **Level II.** A Level II facility shall provide emergency medical services with an organized emergency department. A physician and nursing staff shall be on site twenty-four (24) hours a day. A hospital shall be classified at Level II for emergency psychiatric services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent psychiatric patient and credentialed by the hospital to provide emergency medical services and nursing personnel shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **Outpatient psychiatric resources.** The hospital shall maintain a current list of outpatient psychiatric resources available within the community or region and make appropriate referrals for patients who do not require emergency inpatient psychiatric treatment.

(C) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiologic technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(D) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(ii) Coagulation studies;

(iii) Blood gas/pH analysis;

(iv) Therapeutic drug monitoring;

(v) Drug and alcohol screening; and

(vi) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(viii) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall

designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Psychiatrist.** A physician board certified, board eligible, or residency trained in psychiatry shall be available for consultation on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Equipment to perform electroencephalographic (EEG) testing;

(B) Psychotropic medications appropriate to deal with psychiatric emergencies including benzodiazepines such as lorazepam and neuroleptics such as haloperidol; and

(C) Thiamine and glucose for intravenous administration.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital, or board certified, board eligible, or residency trained psychiatrist, or group of psychiatrists to provide immediate consultative services for psychiatric patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer.

(c) **Level I.** A Level I facility shall provide emergency medical services with organized emergency and psychiatry departments. A physician and nursing staff with special capability in psychiatric care shall be on site twenty-four (24) hours a day. The facility shall have the capability to provide immediate emergency inpatient psychiatric treatment twenty-four (24) hours a day. A hospital shall be classified at Level I for emergency psychiatric services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent psychiatric patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in psychiatric care shall be on site twenty-four (24) hours a day. Emergency room personnel shall be provided with training on the facility's policies and procedures related to psychiatric patients including those for the use of physical and chemical restraints and seclusion, obtaining informed consent for psychotropic medications, suicide precautions, patient right to refuse treatment and the duty to protect, Emergency Order of Detention and commitment procedures, and determining a patient's legal status. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(B) **Psychiatry.** The facility shall have an organized psychiatric service with appropriately credentialed physicians immediately available twenty-four (24) hours a day. Physician members of the

psychiatric service shall be board certified, board eligible, or residency trained in psychiatry. On call physicians shall respond as required by the hospital's policy.

(C) **Outpatient psychiatric resources.** The hospital shall maintain a current list of outpatient psychiatric resources available within the community or region and make appropriate referrals and follow-ups for patients who do not require emergency inpatient psychiatric treatment.

(D) **Inpatient psychiatric services.** All inpatient psychiatric services shall be provided under the direction of a physician director of inpatient psychiatric services and shall comply with Subchapter 33 of this Chapter.

(E) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray and computed tomography services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Computed tomography;

(ii) Magnetic resonance imaging; and

(iii) Neuroradiology.

(iv) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(F) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(ii) Coagulation studies;

(iii) Blood gas/pH analysis; and

(iv) Therapeutic drug monitoring;

(v) Drug and alcohol screening; and

(vi) Comprehensive microbiology services or at least appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(G) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Psychiatric services director.** The medical staff shall designate a physician credentialed to provide psychiatric care as psychiatric services director.

(C) **Psychiatric nursing services director.** A registered nurse with experience in psychiatric nursing shall be responsible for psychiatric nursing service administration.

(D) **Physician qualifications.** Physician members of the psychiatry service shall be board certified, board eligible, or residency trained in psychiatry.

(3) **Supplies and equipment: Emergency department.** In addition to the requirements at OAC 310:667-59-19(d)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Equipment to perform electroencephalographic (EEG) testing;

(B) Psychotropic medications appropriate to deal with psychiatric emergencies including benzodiazepines such as lorazepam and neuroleptics such as haloperidol; and

(C) Thiamine and glucose for intravenous administration.

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**310:667-59-24.** [RESERVED]

**[Source:** Reserved at 17 Ok Reg 2992, eff 7-13-00]

**310:667-59-25. Classification of emergency general medicine services**

(a) **Level IV.** A Level IV facility shall provide emergency medical services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified at Level IV for emergency general medicine services if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques

and be deemed competent to initiate treatment of the emergency patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** The hospital shall have equipment for use in the resuscitation of patients of all ages on site, functional, and immediately available, including at least the items specified in OAC 310:667-59-9(a)(3)

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(b) **Level III.** A Level III facility shall provide emergency medical services with an organized emergency department. A physician and nursing staff with special capability in emergency care shall be on site twenty-four (24) hours a day. General surgery and anesthesiology services shall be available either on duty or on call. A hospital shall be classified at Level III for emergency general medicine services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the critically injured and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in emergency care shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital, emergency services shall also comply with OAC 310:667-39-14.

(B) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(C) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(D) **Internal medicine.** A physician board certified, board eligible, or residency trained in internal medicine shall be on call twenty-four (24) hours a day and promptly available in the emergency department.

(E) **Other specialties.** The hospital shall also have services from the following specialties on call and promptly available:

(i) Family/general medicine;

(ii) Pathology; and

(iii) Radiology.

(F) **Operating suite.** An operating suite with thermal control equipment for patients and infusion of blood and fluids shall be available twenty-four (24) hours a day.

(G) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care. The post-anesthesia recovery unit shall be equipped as required by OAC 310:667-59-9(b)(3)(B).

(H) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program. The intensive care unit shall be equipped as required by OAC 310:667-59-9(b)(3)(C).

(I) **Diagnostic imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiology technologist shall be on duty or on call and immediately available twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For a hospital licensed as critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(J) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored.

The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis;

(v) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Drug and alcohol screening.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(viii) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(K) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel: Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medial care as emergency services director. The emergency services director may serve as the trauma service director.

(3) **Supplies and equipment: Emergency department.** The emergency department shall have equipment for use in the resuscitation of patients of all ages on site, functional, and available in the emergency department, including at least the items specified in OAC 310:667-59-9(b)(3)(A).

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Organ Procurement.** The hospital, in association with an organ procurement organization certified by the CMS, shall develop policies and procedures to identify and refer potential organ donors.

(c) **Level II.** A facility providing emergency medical services with an organized emergency department. A physician and nursing staff with special capability in emergency care shall be on site twenty-four (24) hours a day. General surgery and anesthesiology services shall be available on site or on call twenty-four (24) hours a day. Services from an extensive group of clinical specialties including infectious disease, internal medicine, nephrology, and orthopedics shall be promptly available on call. A hospital shall be classified at Level II for emergency general medicine services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in emergency care shall be on site twenty-four

(24) hours a day. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(B) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(C) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(D) **Internal medicine.** A physician board certified, board eligible, or residency trained in internal medicine shall be on call twenty-four (24) hours a day and promptly available in the emergency department.

(E) **Other specialties.** The hospital shall also have services from the following specialties on call and promptly available:

(i) Cardiology;
(ii) Family/general medicine;
(iii) Infectious disease.
(iv) Neurology;
(v) Obstetrics/gynecology;
(vi) Ophthalmology;
(vii) Orthopedics;
(viii) Otolaryngology;
(ix) Pathology;
(x) Pediatrics;
(xi) Psychiatry;
(xii) Pulmonary medicine;
(xiii) Radiology; and
(xiv) Urology.

(F) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. The operating room shall be equipped as required by OAC 310:667-59-9(c)(3)(B). An on call schedule for emergency replacement staff shall be maintained.

(G) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care. The post-anesthesia recovery unit shall be equipped as required by OAC 310:667-59-9(c)(3)(C).

(H) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements

for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program. The intensive care unit shall be equipped as required by OAC 310:667-59-9(c)(3)(D).

(I) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;

(ii) Ultrasonography;

(iii) Computed tomography;

(iv) Magnetic resonance imaging;

(v) Neuroradiology; and

(vi) Nuclear medicine imaging.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(J) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis; and

(v) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Drug and alcohol screening.

(vii) For a hospital licensed as general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(K) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC

310:667-23-6.

(L) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel: Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(3) **Supplies and equipment: Emergency department.** The emergency department shall have equipment for use in the resuscitation of patients of all ages on site, functional, and available in the emergency department, including at least the items specified in OAC 310:667-59-9(c)(3)(A).

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Organ Procurement.** The hospital, in association with an organ procurement organization certified by CMS, shall develop policies and procedures to identify and refer potential organ donors.

(d) **Level I.** A Level I facility shall provide emergency medical services with an organized emergency department. A physician and nursing staff with special capability in emergency care shall be on site twenty-four (24) hours a day. General surgery and anesthesiology services shall be available on site or on call twenty-four (24) hours a day. Additional clinical services and specialties such as nuclear diagnostic imaging, dermatology, endocrinology, and hematology/oncology specialists shall also be promptly available. A hospital shall be classified at Level I for emergency general medicine services if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent patient and credentialed by the hospital to provide emergency medical services and nursing personnel with special capability in emergency care shall be on site twenty-four (24) hours a day. For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(B) **General surgery.** A board certified, board eligible, or residency trained general surgeon shall be on call twenty-four (24) hours a day and promptly available in the emergency department. For a hospital licensed as a general medical surgical hospital, surgical services shall also comply with the requirements of OAC 310:667-25-1 through OAC 310:667-25-2.

(C) **Anesthesia.** Anesthesia services shall be on call twenty-four (24) hours a day, promptly available, and administered as required in OAC 310:667-25-2.

(D) **Internal medicine.** A physician board certified, board eligible, or residency trained in internal medicine shall be on call twenty-four (24) hours a day and promptly available in the emergency department.

(E) **Other specialties.** The hospital shall also have services

from the following specialties on call and promptly available:

(i) Cardiology;
(ii) Critical care medicine;
(iii) Dermatology;
(iv) Emergency medicine;
(v) Endocrinology;
(vi) Family/general medicine;
(vii) Gastroenterology;
(viii) Hematology/oncology;
(ix) Infectious disease;
(x) Nephrology;
(xi) Neurology;
(xii) Obstetrics/gynecology;
(xiii) Ophthalmology;
(xiv) Orthopedics;
(xv) Otolaryngology;
(xvi) Pathology;
(xvii) Pediatrics;
(xviii) Psychiatry;
(xix) Pulmonary medicine
(xx) Radiology;
(xxi) Rheumatology; and
(xxii) Urology.

(F) **Operating suite.** An operating suite with adequate staff and equipment shall be immediately available twenty-four (24) hours a day. The hospital shall define and document in writing the minimum staffing requirements for the operating suite. The operating room shall be equipped as required by OAC 310:667-59-9(d)(3)(B). An on call schedule for emergency replacement staff shall be maintained.

(G) **Post-anesthesia recovery unit.** The hospital shall have a post-anesthesia recovery room or intensive care unit in compliance with OAC 310:667-15-7 with nursing personnel and anesthesia services remaining in the unit until the patient is discharged from post-anesthesia care. The post-anesthesia recovery unit shall be equipped as required by OAC 310:667-59-9(d)(3)(C).

(H) **Intensive care unit.** The hospital shall have an intensive care unit in compliance with OAC 310:667-15-7 with a registered nurse on duty in the intensive care unit whenever the unit has a patient(s). A registered nurse shall be on call and immediately available when no patients are in the unit. The hospital shall define and document in writing the minimum staffing requirements for the intensive care unit and shall monitor compliance with these requirements through the quality improvement program. The intensive care unit shall be equipped as required by OAC 310:667-59-9(d)(3)(D). A physician with privileges in critical care shall be on duty in the unit or immediately available in the hospital twenty-four (24) hours a day.

(I) **Diagnostic Imaging.** The hospital shall have diagnostic x-ray services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both

diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained. The diagnostic imaging service shall provide at least the following services:

(i) Angiography;

(ii) Ultrasonography;

(iii) Computed tomography;

(iv) Magnetic resonance imaging;

(v) Neuroradiology; and

(vi) Nuclear medicine imaging.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(J) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Comprehensive immunohematology services including blood typing and compatibility testing. A supply of blood and blood products shall be on hand and adequate to meet expected patient needs. All blood and blood products shall be properly stored. The hospital shall have access to services provided by a community central blood bank;

(ii) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis;

(v) Comprehensive microbiology services or appropriate supplies for the collection, preservation, and transport of clinical specimens for aerobic and anaerobic bacterial, mycobacterial, and fungus cultures; and

(vi) Drug and alcohol screening.

(vii) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(K) **Respiratory therapy.** Routine respiratory therapy procedures and mechanical ventilators shall be available twenty-four (24) hours a day. Respiratory therapy services shall comply with OAC 310:667-23-6.

(L) **Acute hemodialysis.** The hospital shall have the capability to provide acute hemodialysis services twenty-four (24) hours a day. All staff providing hemodialysis patient care shall have documented hemodialysis training and experience.

(M) **Social services.** Social services shall be available and provided as required in Subchapter 31 of this Chapter.

(2) **Personnel: Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care

as emergency services director.

(3) **Supplies and equipment: Emergency department.** The emergency department shall have equipment for use in the resuscitation of patients of all ages on site, functional, and available in the emergency department, including at least the items specified in OAC 310:667-59-9(d)(3)(A).

(4) **Policies on transfers.** The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(5) **Organ Procurement.** The hospital, in association with an organ procurement organization certified by CMS, shall develop policies and procedures to identify and refer potential organ donors.

**[Source:** Added at 17 Ok Reg 2992, eff 7-13-00; Amended at 20 Ok Reg 1664, eff 6-12-2003]

**APPENDIX A. VENTILATION REQUIREMENTS FOR AREAS AFFECTING PATIENT CARE IN HOSPITALS AND OUTPATIENT FACILITIES[1]**

| Area Designation | Air movement relationship to adjacent area[2] | Minimum of air changes of outdoor air per hour[3] | Minimum total air changes per hour[4,5] | All air exhausted directly to outdoors[6] | Recirculated by means of room units[7] | Relative humidity[8] (%) | Design temperature[9] (degrees F) |
|---|---|---|---|---|---|---|---|
| **SURGERY AND CRITICAL CARE** | | | | | | | |
| Operating/surgical cystoscopic rooms[10,11] | Out | 3 | 15 | -- | No | 30-60 | 68-73 |
| Delivery room[10] | Out | 3 | 15 | -- | No | 30-60 | 68-73 |
| Recovery room[10] | -- | 2 | 6 | -- | No | 30-60 | 70-75 |
| Critical and intensive care | -- | 2 | 6 | -- | No | 30-60 | 70-75 |
| Newborn intensive care | -- | 2 | 6 | -- | No | 30-60 | 72-78 |
| Treatment room[13] | -- | -- | 6 | -- | -- | --- | 75 |
| Trauma room[13] | Out | 3 | 15 | -- | No | 30-60 | 70-75 |
| Anesthesia gas storage | In | -- | 8 | Yes | -- | --- | --- |
| Endoscopy | In | 2 | 6 | -- | No | 30-60 | 68-73 |
| Bronchoscopy[11] | In | 2 | 12 | Yes | No | 30-60 | 68-73 |
| ER waiting rooms | In | 2 | 12 | Yes[14,15] | -- | -- | 70-75 |
| Triage | In | 2 | 12 | Yes[14] | -- | -- | 70-75 |
| Radiology waiting rooms | In | 2 | 12 | Yes[14,15] | -- | -- | 70-75 |
| Procedure room | Out | 3 | 15 | -- | No | 30-60 | 70-75 |
| **NURSING** | | | | | | | |
| Patient room | -- | 2 | 6[16] | -- | -- | --- | 70-75 |
| Toilet room | In | -- | 10 | Yes | -- | --- | --- |
| Newborn nursery suite | -- | 2 | 6 | -- | No | 30-60 | 72-78 |
| Protective environment room[11,17] | Out | 2 | 12 | -- | No | --- | 75 |
| Airborne infection isolation room[11,18] | In | 2 | 12 | Yes[15] | No | --- | 75 |
| Isolation alcove | In/Out | -- | 10 | Yes | No | --- | --- |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| or anteroom[17,18] | | | | | | | |
| Labor/delivery/recovery | -- | 2 | 6[16] | -- | -- | --- | 70-75 |
| Labor/delivery/recovery/ Postpartum | -- | 2 | 6[16] | -- | -- | --- | 70-75 |
| Patient corridor | -- | -- | 2 | -- | -- | --- | --- |
| **ANCILLARY** | | | | | | | |
| Radiology[19] | | | | | | | |
| X-ray (surgical/critical care and catheterization) | Out | 3 | 15 | -- | No | 30-60 | 70-75 |
| X-ray (diagnostic and treatment) | -- | -- | 6 | -- | -- | --- | 75 |
| Darkroom | In | -- | 10 | Yes | No | --- | --- |
| Laboratory | | | | | | --- | --- |
| General[19] | -- | -- | 6 | -- | -- | --- | 75 |
| Biochemestry[19] | Out | -- | 6 | -- | No | --- | 75 |
| Cytology | In | -- | 6 | Yes | No | --- | 75 |
| Glass washing | In | -- | 10 | Yes | -- | --- | --- |
| Histology | In | -- | 6 | Yes | No | --- | 75 |
| Microbiology[19] | In | -- | 6 | Yes | No | --- | 75 |
| Nuclear medicine | In | -- | 6 | Yes | No | --- | 75 |
| Pathology | In | -- | 6 | Yes | No | --- | 75 |
| Serology | Out | -- | 6 | -- | No | --- | 75 |
| Sterilizing | In | -- | 10 | Yes | -- | --- | --- |
| Autopsy room[11] | In | -- | 12 | Yes | No | --- | --- |
| Nonrefrigerated body-holding room | In | -- | 10 | Yes | Yes | --- | 70 |
| Pharmacy | Out | -- | 4 | -- | -- | --- | --- |
| **DIAGNOSTIC AND TREATMENT** | | | | | | | |
| Examination room | -- | -- | 6 | -- | -- | --- | 75 |
| Medication room | Out | -- | 4 | -- | -- | --- | --- |
| Treatment room | -- | -- | 6 | -- | -- | --- | 75 |
| Physical therapy and hydrotherapy | In | -- | 6 | -- | -- | --- | 75 |
| Soiled workroom or soiled holding | In | -- | 10 | Yes | No | --- | --- |
| Clean workroom or clean holding | Out | -- | 4 | -- | -- | --- | --- |

**APPENDIX A. VENTILATION REQUIREMENTS FOR AREAS AFFECTING PATIENT CARE IN HOSPITALS AND OUTPATIENT FACILITIES[1] (Continued)**

| Area Designation | Air movement relationship to adjacent area[2] | Minimum of air changes of outdoor air per hour[3] | Minimum total air changes per hour[4,5] | All air exhausted directly to outdoors[6] | Recirculated by means of room units[7] | Relative humidity[8] (%) | Design temperature[9] (degrees F) |
|---|---|---|---|---|---|---|---|
| **STERILIZING AND SUPPLY** | | | | | | | |
| ETO-sterilizer room | In | -- | 10 | Yes | No | 30-60 | 75 |
| Sterilizer equipment room | In | -- | 10 | Yes | -- | --- | --- |
| Central medical and surgical supply | | | | | | | |
| Soiled or decontamination room | In | -- | 6 | Yes | No | --- | 68-73 |
| Clean workroom | Out | -- | 4 | -- | No | 30-60 | 75 |
| Sterile storage | Out | -- | 4 | -- | -- | (Max) 70 | --- |
| **SERVICE** | | | | | | | |
| Food preparation center[20] | -- | -- | 10 | -- | No | -- | --- |
| Warewashing | In | -- | 10 | Yes | No | -- | --- |
| Dietary day storage | In | -- | 2 | -- | -- | -- | --- |
| Laundry, general | -- | -- | 10 | Yes | -- | -- | --- |
| Soiled linen (sorting and storage) | In | -- | 10 | Yes | No | -- | --- |
| Bedpan room | In | -- | 10 | Yes | -- | -- | --- |
| Bathroom | In | -- | 10 | -- | -- | -- | 75 |
| Janitor's closet | In | -- | 10 | Yes | No | -- | --- |

**APPENDIX A NOTES:**

[1] The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of acute care hospitals that directly affect patient care and are determined based on health care facilities being predominantly "no smoking" facilities. Where smoking may be allowed, ventilation rates will need adjustments. Areas where specific ventilation rates are not given in the table shall be ventilated in accordance with ASHRAE Standard 62, Ventilation for Acceptable Indoor Air Quality, and

*ASHRAE Handbook - HVAC Applications*. Specialized patient care areas, including organ transplant units, burn units, specialty procedure rooms, etc., shall have additional ventilation provisions for air quality control as may be appropriate. OSHA standards and/or NIOSH criteria require special ventilation requirements for employee health and safety within health care facilities.

[2] Design of the ventilation system shall provide air movement which is generally from "clean to less clean" areas. If any form of variable air volume or load shedding system is used for energy conservation, it must not compromise the corridor-to-room pressure balancing relationships or the minimum air changes required by the appendix.

[3] To satisfy exhaust needs, replacement air from outside is necessary. Appendix A does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice. Minimum outside air quantities shall remain constant while the system is in operation.

[4] Number of air changes may be reduced when the room is unoccupied if provisions are made to ensure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not indicated as having continuous directional control may have ventilation systems shut down when space is unoccupied and ventilation is not otherwise needed, if the maximum infiltration or exfiltration permitted in Note 2 is not needed and if adjacent pressure balancing relationships are not compromised. Air quantity calculations must account for filter loading such that the indicated air change rates are provided up until the time of filter change-out.

[5] Air change requirements indicated are minimum values. Higher values should be used when required to maintain indicated room conditions (temperature and humidity), based on the cooling load of the space (lights, equipment, people, exterior walls and windows, etc.)

[6] Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas. Note that individual circumstances may require special consideration for air exhaust to outside, e.g., an intensive care unit in which patients with pulmonary infection are treated, and rooms for burn patients.

[7] Recirculating room HVAC units refers to those units that are used primarily for heating and cooling of air, and not disinfection of air. Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." However, for airborne infection control, air may be recirculated within individual isolation rooms if HEPA filters are used. Isolation and intensive care unit rooms may be ventilated by reheat induction units in which only the primary air supplied from a central system passes through the reheat unit. Gravity-type heating

or cooling units such as radiators or convectors shall not be used in operating rooms and other special care areas.

[8] The ranges listed are the minimum and maximum limits where control is specifically needed. The maximum and minimum limits are not intended to be independent of a space's associated temperature. The humidity is expected to be at the higher end of the range when the temperature is also at the higher end of the range, and vice versa.

[9] Where temperature ranges are indicated, the systems shall be capable of maintaining the rooms at any point within the range during normal operation. A single figure indicates a heating or cooling capacity of at least the indicated temperature. This is usually applicable when patients may be undressed and require a warmer environment. Nothing in these guidelines shall be construed as precluding the use of temperatures lower than those noted when the patients' comfort and medical conditions make lower temperatures desirable. Unoccupied areas such as storage rooms shall have temperatures appropriate for the function intended.

[10] National Institute of Occupational Safety and Health (NIOSH) Criteria Documents regarding Occupational Exposure to Waste Anesthetic Gases and Vapors, and Control of Occupational Exposure to Nitrous Oxide indicate a need for both local exhaust (scavenging) systems and general ventilation of the areas in which the respective gases are utilized.

[11] Differential pressure shall be a minimum of 0.01" water gauge (2.5 Pa). If alarms are installed, allowances shall be made to prevent nuisance alarms of monitoring devices.

[12] Some surgeons may require room temperatures that are outside of the indicated range. All operating room design conditions shall be developed in consultation with surgeons, anesthesiologists, and nursing staff.

[13] The term *trauma room* as used here is the operating room space in the emergency department or other trauma reception areas that is used for emergency surgery. The first aide room and/or "emergency room" used for initial treatment of accident victims may be ventilated as noted for the "treatment room." Treatment rooms used for Bronchoscopy shall be treated as Bronchoscopy rooms. Treatment rooms used for cryosurgery procedures with nitrous oxide shall contain provisions for exhausting waste gases.

[14] In a ventilation system that recirculates air, HEPA filters can be used in lieu of exhausting the air from these spaces to the outside. In this application, the return air shall be passed through the HEPA filters before it is introduced into any other spaces.

[15] If it is not practical to exhaust the air from the airborne infection isolation room to the outside, the air may be returned through HEPA filters to the air-handling system exclusively serving the isolation room.

[16] Total air changes per room for patient rooms, labor/delivery/recovery rooms, and labor/delivery/recovery/postpartum rooms may be reduced to 4 when supplemental heating and/or cooling systems (radiant heating and cooling, baseboard heating, etc.) are used.

[17] The protective environment airflow design specifications protect the patient from common environmental airborne infectious microbes (i.e., Aspergillus spores). These special ventilation areas shall be designed to provide directed airflow from the cleanest patient care area to less clean areas. These rooms shall be protected with HEPA filters at 99.97 percent efficiency for a 0.3μm sized particle in the supply airstream. These interrupting filters protect patient rooms from maintenance-derived release of environmental microbes from the ventilation system components. Recirculation HEPA filters can be used to increase the equivalent room air changes. Constant volume airflow is required for consistent ventilation for the protected environment. If the facility determines that airborne infection isolation is necessary for protective environment patients, an anteroom should be provided. Rooms with reversible airflow provisions for the purpose of switching between protective environment and AII functions are not acceptable.

[18] The infectious disease isolation room described in these guidelines is to be used for isolating the airborne spread of infectious diseases, such as measles, varicella, or tuberculosis. The design of airborne infection isolation (AII) rooms should include the provision for normal patient care during periods not requiring isolation precautions. Supplemental recirculating devices may be used in the patient room, to increase the equivalent room air exchanges; however, such recirculating devices do not provide the outside air requirements. Air may be recirculated within individual isolation rooms if HEPA filters are used. Rooms with reversible airflow provisions for the purpose of switching between protective environment and AII functions are not acceptable.

[19] When required, appropriate hoods and exhaust devices for the removal of noxious gases or chemical vapors shall be provided (see OAC 310:667-49-31 and NFPA 99).

[20] Food preparation centers shall have ventilation systems whose air supply mechanisms are interfaced appropriately with exhaust hood controls or relief vents so that the exfiltration or infiltration to or from exit corridors does not compromise the exit corridor restrictions of NFPA 90A, the pressure requirements of NFPA 96, or the maximum defined in the table. The number of air changes may be

reduced or varied to any extent required for odor control when the space is not is use. See OAC 310:667-49-31 for designation of hoods.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## APPENDIX B. STATION OUTLETS FOR OXYGEN, VACUUM (SUCTION), AND MEDICAL AIR SYSTEMS IN HOSPITALS[1]

| Location | Oxygen | Vacuum | Medical Air |
|---|---|---|---|
| Patient Rooms (Medical and Surgical) | 1 (bed) | 1 (bed) | -- |
| Examination/Treatment (Medical, Surgical and Postpartum Care) | 1 | 1 | -- |
| Isolation (Infectious and Protective) (Medical and Surgical) | 1 | 1 | -- |
| Security Room (Medical, Surgical, and Postpartum) | 1 | 1 | -- |
| Critical Care (General) | 3 | 3 | 1 |
| Isolation (Critical) | 3 | 3 | 1 |
| Coronary Critical Care | 3 | 2 | 1 |
| Pediatric Critical Care | 3 | 3 | 1 |
| Newborn Intensive Care | 3(per bassinet) | 3(per bassinet) | 3(per bassinet) |
| Newborn Nursery (Full-term) | 1(per 4 bassinets)[2] | 1(per 4 bassinets)[2] | 1(per 4 bassinets)[2] |
| Pediatric and Adolescent | 1 | 1 | 1 |
| Pediatric Nursery | 1(per bassinet) | 1(per bassinet) | 1(per bassinet) |
| Psychiatric Patient Rooms | -- | -- | -- |
| Seclusion Treatment Room | -- | -- | -- |
| General Operating Room | 2 | 3 | |
| Cardio, Ortho, Neurological | 2 | 3 | |
| Orthopedic Surgery | 2 | 3 | |
| Surgical Cysto and Endo | 1 | 3 | |
| Post-Anesthetic Care Unit | 1(bed) | 3(bed) | 1(bed) |
| Anesthesia Workroom | 1 per workstation | -- | 1 per workstation |
| Phase II Recovery[3] | 1(bed) | 3(bed) | |
| Postpartum Bedroom | 1(bed) | 1(bed) | -- |
| Caesarean/Delivery Room | 2 | 3 | 1 |
| Infant resuscitation station[4] | 1 (per bassinet) | 1 (per bassinet) | 1 (per bassinet) |
| Labor Room | 1 | 1 | 1 |

| | | | |
|---|---|---|---|
| OB Recovery Room | 1 | 3 | 1 |
| Labor/Delivery/Recovery (LDR)[5] | 2(bed) | 2(bed) | |
| Labor/Delivery/Recovery/Postpartum (LDRP)[5] | 2(bed) | 2(bed) | |
| Initial Emergency Management | 1(bed) | 1(bed) | |
| Triage Area (Definitive Emergency Care) | 1(station) | 1(station) | -- |
| Definitive Emergency Care (Exam/Treatment Rooms) | 1(bed) | 1(bed) | 1(bed) |
| Definitive Emergency Care Holding Area | 1(bed) | 1(bed) | -- |
| Trauma/Cardiac Room(s) | 2(bed) | 3(bed) | 1(bed) |
| Orthopedic and Cast Room | 1 | 1 | |
| Cardiac Catheterization Lab | 2(bed) | 2(bed) | 2(bed) |
| Autopsy | -- | 1 per workstation | 1 per workstation |

**APPENDIX B NOTES:**

[1] For any area or room not described above, the facility clinical staff shall determine outlet requirements after consultation with the Department.

[2] Four bassinets may share one outlet that is accessible to each bassinet.

[3] If Phase II recovery is a separate area from the PACU, only one vacuum outlet per bed or station shall be required.

[4] When infant resuscitation takes place in a room such as caesarean section/delivery or LDRP, then the infant resuscitation services must be provided in that room in addition to the minimum service required for the mother.

[5] Two outlets for mother and two for one bassinet.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## APPENDIX C. SOUND TRANSMISSION LIMITATIONS IN GENERAL HOSPITALS

| | Airborne sound transmission class (STC)1 | |
|---|---|---|
| | Partitions | Floors |
| **New Construction**[2] | | |
| Patient room to patient room | 45 | 40 |
| Public space to patient rooms[3] | 55 | 40 |
| Service areas to patient room[4] | 65 | 45 |
| Patient room access corridor[5] | 45 | 45 |
| **Exam room to exam room** | 45 | -- |
| Exam room to public space | 45 | -- |
| Toilet room to public space | 45 | -- |
| Consultation rooms/conference rooms to public space | 45 | -- |
| Consultation rooms/conference rooms to patient rooms | 45 | -- |
| Staff lounges to patient rooms | 45 | -- |
| **Existing construction**[2] | | |
| Patient room to patient room | 35 | 40 |
| Public space to patient room[3] | 40 | 40 |
| Service areas to patient room[4] | 45 | 45 |

**APPENDIX C NOTES:**

[1] Sound and transmission class (STC) shall be determined by tests in accordance with methods set forth in ASTM E90 and ASTM E413. *Where partitions do not extend to the structure above, sound transmission through ceilings and composite STC performance must be considered.*

[2] Treatment rooms shall be treated the same as patient rooms.

[3] Public space includes corridors (except patient room access corridors), lobbies, dining rooms, recreation rooms, and similar space.

[4] Service areas include kitchens, elevators, elevator machine rooms, laundries, garages, maintenance rooms, boiler and mechanical equipment rooms, and similar spaces of high noise. Mechanical equipment located on the same floor or above patient rooms, offices, nurses stations, and similar occupied space shall be effectively isolated from the floor.

[5] Patient room access corridors contain composite walls with doors/windows and have direct access to patient rooms.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

## APPENDIX D. FILTER EFFICIENCIES FOR CENTRAL VENTILATION AND AIR CONDITIONING SYSTEMS IN GENERAL HOSPITALS

| Area Designation | Number Filter beds | Filter Bed No. 1(%) | Filter Bed No. 2[1](%) |
|---|---|---|---|
| All areas for inpatient care, treatment, and diagnosis, and those areas providing direct service or clean supplies such as sterile and clean processing, etc. | 2 | 30 | 90 |
| Protective environment room | 2 | 30 | 90 |
| Laboratories | 1 | 80 | __ |
| Administrative, bulk storage, soiled holding areas, food preparation areas, and laundries | 1 | 30 | __ |

**APPENDIX D NOTES:**

[1]These requirements do not apply to small primary (neighborhood) outpatient facilities or outpatient facilities that do not perform invasive applications or procedures.

Additional roughing or pre-filters should be considered to reduce maintenance required for filters with efficiency higher than 75%.

The filtration efficiency ratings are based on average dust spot efficiency per ASHRAE 52.1-1992.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked and Reenacted at 20 Ok Reg 1664, eff 6-12-2003; Revoked and Reenacted at 21 Ok Reg 2785, eff 7-12-2004]

## APPENDIX E. HOT WATER USE - GENERAL HOSPITAL

| | Clinical | Dietary | Laundry |
|---|---|---|---|
| Liters per second per bed[1] | 11.9 | 7.2 | 7.6 |
| Gallons per hour per bed[1] | 3 | 2 | 2 |
| Temperature (°C) | 41-49[2] | 49[3] | 71[4] |
| Temperature (°F) | 105-120[2] | 120[3] | 160[4] |

**APPENDIX E NOTES:**

[1] Quantities indicated for design demand of hot water are for general reference minimums and shall not substitute for accepted engineering design procedures using actual number and types of fixtures to be installed. Design will also be affected by temperatures of cold water used for mixing, length of run and insulation relative to heat loss, etc. As an example, total quantity of hot water needed will be less when temperature available at the outlet is very nearly that of the source tank and the cold water used for tempering is relatively warm.

[2] The range represents the maximum and minimum allowable temperatures.

[3] Provisions shall be made to provide 180°F (82°C) rinse water at warewasher. (May be by separate booster.)

[4] Provisions shall be made to provide 160°F (71°C) hot water at the laundry equipment when needed. (This may be by steam jet or separate booster heater.) However, it is emphasized that this does not imply that all water used would be at this temperature. Water temperatures required for acceptable laundry results will vary according to type of cycle, time of operation, and formula of soap and bleach as well as type and degree of soil. Lower temperatures may be adequate for most procedures in many facilities but the higher 160°F (71°C) should be available when needed for special conditions.

[**Source:** Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]