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

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 929) requests: The names and addresses of the Board of Directors for the hospital.

(3) The Designation of Licensed Beds Form (Form 929) 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 marshal.

(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 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 21 Ok Reg 573, eff 1-12-04 (emergency); Amended at 21 Ok Reg 2785, eff 7-12-04; Amended at 21 Ok Reg 2437, eff 7-11-05; Amended at 24 Ok Reg 2018, eff 6-25-07; Amended at 36 Ok Reg 1730, eff 9-13-19]

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

(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

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

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

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

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

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

(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

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 fifteen (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 fifteen (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, cystic fibrosis, congenital adrenal hyperplasia, medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, organic acid disorders, severe combined immunodeficiency (SCID), spinal muscular atrophy (SMA), x-linked adrenoleukodystrophy (X-ALD), mucopolysaccharidoisis type I (MPS I) and Pompe disease upon completion of laboratory validation studies, establishment of short-term follow-up services, and approval by the Commissioner of Health as defined in Chapter 550 of this Title. All infants born at a birthing facility in Oklahoma shall be screened for Critical Congenital Heart Disease (CCHD) utilizing pulse oximetry. A parent or guardian may refuse newborn screening and/or pulse oximetry screening of their newborn on the grounds that such examination conflicts with their religious tenets and/or practices. A parent or guardian who refuses newborn screening or pulse oximetry screening of their newborn on the grounds that such examination conflicts with their religious tenets and/or practices shall also indicate in writing this refusal in the newborn's medical record with a copy sent to the Newborn Screening Program, 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 screening specimen prior to transfusion, as early as possible after twenty-four (24) hours of age or immediately prior to discharge, whichever comes first. Specimens shall be collected on the Newborn Screening 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 at or prior to twenty-four (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 ensuring 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 ensure that all infants are screened prior to discharge. If an infant is discharged prior to specimen collection, the Newborn Screening Program Coordinator shall be notified by contacting Newborn Screening Program, 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 ensuring the specimen is collected as early as possible after twenty-four (24) hours of age.

(C) **Pulse oximetry screening for birthing hospitals**. For all live hospital births, the physician or licensed independent practitioner shall order the pulse oximetry screening for newborns to be performed after twenty-four (24) hours of age or prior to discharge from a facility.

(i)If unable to perform the screening after twenty-four (24) hours of age or prior to discharge, schedule the infant to be screened at the hospital between twenty-four (24) hours and forty-eight (48) hours of life; or notify the infant's physician if screening was not performed.

(ii) If the newborn infant is discharged from a facility after twelve (12) hours of life but before twenty-four (24) hours of life, the birthing facility shall perform screening as late as is practical before the newborn infant is discharged from the birthing facility.

(iii) If the infant is discharged before twelve (12) hours of life, the birthing facility shall perform the screening between twenty-four (24) hours and forty-eight (48) hours of life.

(iv) For newborn infants in special care or intensive care, birthing facilities shall perform pulse oximetry screen on infants prior to discharge utilizing recommended protocol, unless the infant has an identified congenital heart defect or has an echocardiogram performed. Continuous pulse oximetry monitoring may not be substituted for CCHD screening.

(v) There may be instances where screening for CCHD is not indicated, including but not limited to instances where:

(I) The newborn infant's clinical evaluation to date has included an echocardiogram which ruled out CCHD; or

(II) The newborn infant has confirmed CCHD based on prenatal or postnatal testing.
(III) Indicate on NBS filter paper that screening was not performed.

(D) **Screening for premature/sick infants.** For all premature/sick infants, the physician or licensed independent practitioner shall order the collection of a newborn screening specimen prior to red blood cell transfusion, as early as possible after 24 hours of age but no later than three to seven days of age, or immediately prior to discharge, whichever comes first. Due to the need to identify infants at risk for the disorders quickly, the specimen should be collected as early as possible after twenty-four (24) hours of age. It is recommended that a repeat newborn screening specimen be collected at fourteen (14) days of age. Specimens shall be collected on the Newborn Screening 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 twenty-four (24) hours of age must be re-screened between seven to fourteen (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 seventh (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 ninety to one hundred and twenty (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) and TSH at seven to fourteen (7-14) days of age.

(E) **Newborn Screening 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 Screening Laboratory within twenty four to forty-eight (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 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 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, and pulse oximetry screening results.

(F) **Pulse oximetry screening hospital recording**. The hospital shall implement a procedure to assure that pulse oximetry screening has been performed on every newborn prior to discharge.

(i) All pulse oximetry screening results shall be recorded in the newborn infant's medical record and results reported to a parent or guardian prior to discharge from the hospital.

(ii) All pulse oximetry screening results shall be recorded on the Newborn Screening Form Kit, or faxed to the Oklahoma State Department of Health Newborn Screening Program.

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

(H) **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 screening specimen and proper pulse oximetry screening methods. The hospital is responsible for ensuring that employees who collect, handle or perform newborn screening tests; or perform pulse oximetry screening are informed of their responsibilities with respect to screening procedures.

(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 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 18 Ok Reg 2032, eff 6-11-01; Amended at 20 Ok Reg 1664, eff 6-12-03; Amended at 24 Ok Reg 1189, eff 4-2-07 (emergency); Amended at 25 Ok Reg 2472, eff 7-11-08; Amended at 30 Ok Reg 1966, eff 7-25-13; Amended at 31 Ok Reg 1619, eff 9-12-14; Amended at 36 Ok Reg 1730, eff 9-13-19]

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

Documentation of services shall be in accordance with The Centers of Medicare and Medicaid Services, Medicare Claims Processing Manual, Revision 4173, published November 30, 2018, incorporated herein by reference.

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-03; Amended at 36 Ok Reg 1730, eff 9-13-19]

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

(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

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

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

(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

(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

(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

(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

(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

(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

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)°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) 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

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)°F (approximately 60°C) or above or at an internal temperature of forty-one (41)°F (approximately 5°) 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

(a) The following national standards are incorporated by reference:

(1) Facility Guidelines Institute (FGI): Guidelines for Design and Construction of Hospitals 2018 Edition; and

(2) National Fire Protection Association (NFPA)101: Life Safety Code (LSC), 2012 Edition and 2012 LSC Tentative Interim Amendments (TIA) 12-1, 12-2, 12-3, and 12-4; and NFPA99 Health Care Facilities Code (HCFC), 2012 Edition, excluding Chapters 7,8, 12 and 13, and 2012 HCFC TIA 12-2, 12-3, 12-4, 12-5 and 12-6 adopted in 81 Federal Register 26871 by the Centers for Medicare& Medicaid Services on July 5, 2016.

(b) Oklahoma statutes prevail if there is conflict between the FGI Guidelines and Oklahoma statutes. For Medicare-certified hospitals, the Life Safety Code adopted by the Centers for Medicare & Medicaid Services prevails if there is a conflict between the Life Safety Code and this Chapter.

(c) A hospital may submit a request for exception or temporary waiver if the FGI Guidelines create an unreasonable hardship, or if the design and construction for the hospital property offers improved or compensating features with equivalent outcomes to the FGI Guidelines.

(d) The Department may permit exceptions and temporary waivers of the FGI Guidelines if the Department determines that such exceptions or temporary waivers comply with the requirements of 63 O.S. Section 1-701 et seq., this Chapter, and the following:

(1) Any hospital requesting an exception or temporary waiver shall apply in writing on a form provided by the Department and pay the exception to, or temporary waiver of, FGI Guidelines fee set in OAC 310:667-47-1. The form shall include:

(A) The FGI Guidelines section(s) for which the exception or temporary waiver is requested;

(B) Reason(s) for requesting an exception or temporary waiver;

(C) The specific relief requested; and
(D) Any documentation which supports the application for exception.

(2) In consideration of a request for exception or temporary waiver, the Department shall consider the following:
(A) Compliance with 63 O.S. Section 1-701 et seq.;
(B) The level of care provided;
(C) The impact of an exception on care provided;
(D) Alternative policies or procedures proposed; and
(E) Compliance history with provisions of the FGI Guidelines, Life Safety Code and this Chapter.

(3) The Department shall permit or disallow the exception or waiver in writing within forty-five (45) calendar days after receipt of the request.

(4) If the Department finds that a request is incomplete, the Department shall advise the hospital in writing and offer an opportunity to submit additional or clarifying information. The applicant shall have thirty (30) calendar days after receipt of notification to submit additional or clarifying information in writing to the Department of Health, or the request shall be considered withdrawn.

(5) A hospital which disagrees with the Department's decision regarding the exception or temporary waiver may file a written petition requesting relief through an individual proceeding pursuant to OAC 310:2 (relating to Procedures of the State Department of Health).

(6) The Department may revoke an exception or temporary waiver through an administrative proceeding in accordance with OAC 310:2 and the Oklahoma Administrative Procedures Act upon finding the hospital is operating in violation of the exception or temporary waiver, or the exception or temporary waiver jeopardizes patient care and safety or constitutes a distinct hazard to life.

(7) The Department shall publish decisions on requests for exceptions and waivers, subject to the confidentiality provisions of 63 O.S. Section 1-709.

(e) Documentation of the hospital governing body's approval of the functional program shall be sufficient to meet the requirements in this Chapter relating to Department approval of the functional program.

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-03; Amended at 34 Ok Reg 1301, eff 10-1-17; Amended at 36 Ok Reg 1730, eff 9-13-19]

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 [REVOKED]

310:667-43-1. Location [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-43-2. Facility site design [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-43-3. Environmental pollution control [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-43-4. Energy conservation [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

SUBCHAPTER 45. EQUIPMENT [REVOKED]

310:667-45-1. General [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-45-2. Classification of equipment [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-45-3. Major technical equipment [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-45-4. Equipment shown on drawings [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-45-5. Electronic equipment [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

SUBCHAPTER 47. SUBMITTAL REQUIREMENTS

310:667-47-1. Submission of plans and specifications and related requests for services

(a) **Submission of plans.** 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 as provided in OAC 310:667-47-2 or OAC 310:667-47-10.

(1) Plans and specifications are required for the following alterations:

(A) Changes that affect path of egress;

(B) Change of use or occupancy;

(C) Repurposing of spaces;

(D) Structural modifications;

(E) Heating, ventilation and air conditioning (HVAC) modifications;

(F) Electrical modifications that affect the essential electrical system;

(G) Changes that require modification or relocation of fire alarm initiation or notification devices;

(H) Changes that require modification or relocation of any portion of the automatic fire sprinkler system;

(I) Replacement of fixed medical equipment if the alteration requires any work noted in (A) through (H) of this paragraph;

(J) Replacement of or modifications to any required magnetic or radiation shielding;

(K) Changes to or addition of any egress control devices or systems.

(2) Plans and specifications are not required for the following alterations:

(A) Painting, papering, tiling, carpeting, cabinets, counter tops and similar finish work provided that the new finishes shall meet the requirements of this Chapter;

(B) Ordinary repairs and maintenance;

(C) Modifications to nurse call or other hospital signaling/communication/information technology systems provided the modifications meet the requirements of this Chapter; or

(D) Replacement of fixed or moveable medical equipment that does not affect electrical, HVAC, or shielding requirements noted above.

(b) **Fees.** Each construction project submitted for approval

under OAC 310:667-47-2 shall be accompanied by 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 $1,000,000.00: $2000.00 Fee

(c) **Fees when greater than two (2) submittals required**. The review fee shall cover the cost of review for up to two (2) stage one and two (2) stage two submittals and one final inspection. 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) **Review process.** Design and construction plans and specifications shall be reviewed in accordance with the following process.

(1) Unless otherwise provided in this Subchapter, the Department shall have ten (10) calendar days in which to determine if the filed application is administratively complete

(A) Upon determining that the application is not administratively complete, the Department shall immediately notify the applicant in writing and shall indicate with reasonable specificity the inadequacies and measures necessary to complete the application. Such notification shall not require nor preclude further review of the application and further requests for specific information. If the Department fails to notify the applicant as specified in this Paragraph, the period for technical review shall begin at the close of the administrative completeness review period. Upon submission of correction of inadequacies, the Department shall have an additional ten (10) calendar days to review the application for completeness.

(B) Upon determination that the application is administratively complete, the Department shall immediately notify the applicant in writing. The period for technical review begins.

(2) The Department shall have forty-five (45) calendar days from the date a completed application is filed to review each application for technical compliance with the relevant regulations and reach a final determination.

(A) The time period for technical review is tolled (the clock stops) when the Department has asked for supplemental information and advised the applicant that the time period is tolled pending receipt.

(B) To make up for time lost in reviewing inadequate

materials, a request for supplemental information may specify that up to 30 additional calendar days may be added to the deadline for technical review, unless the request for supplemental information is a second or later request that identifies new deficiencies not previously identified

(C) An application shall be deemed withdrawn if the applicant fails to supplement an application within 90 calendar days after the Department's request, unless the time is extended by agreement for good cause.

(D) Extensions may be made as provided by law.

(e) **Fees for other services.** Fees for other services related to construction projects are as follows:

(1) Request for exception to or temporary waiver of FGI Guidelines fee: Five Hundred Dollars ($500.00);

(2) Application for self-certification fee: One Thousand Dollars ($1,000.00);

(3) Courtesy inspection, prior to final inspection for approval of occupancy, fee: Five Hundred Dollars ($500.00);

(4) Professional consultation or technical assistance fee: Five Hundred Dollars ($500.00) for each eight staff hours or major fraction thereof. For technical assistance requiring travel, the fee may be increased to include the Department's costs for travel.

[**Source:** Added at 12 Ok Reg 1555, 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; Amended at 34 Ok Reg 1301, eff 10-1-17; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-47-2. Preparation of plans and specifications

(a) **Stage one.** Preliminary plans and outline specifications shall be submitted and include sufficient information for approval by the Department of 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. A hospital has the option, at its own risk, to bypass the stage one submittal and proceed directly to submittal of stage two documents. The option to bypass the stage one submittal does not apply if the project is being submitted for the stage two fast-track project review.

(b) **Stage two.** A proposed construction document shall be submitted that includes final drawings and specifications adequate for approval by the Department. 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) **Stage two fast-track projects.** The fast track process is a method for phased approval of a project as specified in this paragraph.

(A) Equipment and built-in furnishings are to be identified in the stage one submittal.

(B) The hospital has the option to submit two packages: civil, landscaping and structural in stage one, and the balance of the components in stage two.
(C) Fast-track projects shall have prior approval and be submitted in no more than four (4) separate packages.
(i)Site work, foundation, structural, underslab mechanical, electrical, plumbing work, and related specifications.
(ii) Complete architectural plans and specifications.
(iii) All mechanical, electrical, and plumbing plans and specifications.
(iv) Equipment and furnishings.
(D) The hospital may begin site work on packages after approval by the Department.
(2) **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.
(d) **Floor plan scale.** Floor plans are to be submitted at a scale of one-eighth (1/8) inch equals one (1) foot, with additional clarifying documents as required.
(e) **Application form.** The submittal shall be made using a Department application form which requests information required by this Chapter and specifies the number of copies and format for document submittal.

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 34 Ok Reg 1301, eff 10-1-17]

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 [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-47-6. Drawings. [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-47-7. Equipment manuals [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-47-8. Design data [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

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]

310:667-47-10. Self-certification of plans

(a) The Department shall make available professional consultation and technical assistance services covering the requirements of this section to a hospital considering self-certification of plans. The consultation and technical assistance is subject to the fee for professional consultation and technical assistance services set in OAC 310:667-47-1. The consultation is optional and not a prerequisite for filing a request through the self-certification review process.

(b) The hospital and the project architect or engineer may elect to request approval of design and construction plans through a self-certification review process. The hospital and the project architect or engineer shall submit a self-certification request on a form provided by the Department, along with a self-certification application fee set in OAC 310:667-47-1. The form shall be signed by the hospital and the project architect or engineer attesting that the plans and specifications are based upon and comply with the requirements of this Chapter. The form shall require information necessary to demonstrate compliance with OAC 310:667-47-10(c).

(c) To be eligible for self-certification, projects must comply with the following requirements:

(1) The project involves any portion of the hospital where patients are intended to be examined or treated and the total cost of design and construction is fifteen million dollars ($15,000,000.00) or less; or

(2) The project involves only portions of the hospital where patients are not intended to be examined or treated; and

(3) The project architect or engineer attesting the application has held a license to practice architecture or engineering for at least five (5) years prior to the submittal of the application, is licensed to practice in Oklahoma; and

(4) The hospital owner/operator acknowledges that the Department retains the authority to:

(A) Perform audits of the self-certification review program and select projects at random for review;

(B) Review final construction documents;

(C) Conduct on-site inspections of the project;

(D) Withdraw approval based on the failure of the hospital or project architect or engineer to comply with the requirements of this Chapter; and

(5) The hospital agrees to make changes required by the Department to bring the construction project into compliance with this Chapter.

(d) Within twenty-one (21) calendar days after receipt of a complete application, the Department shall approve or deny the application for self-certification and send notification to the hospital. If the application is denied, the hospital shall have thirty (30) calendar days to submit additional or supplemental information demonstrating that the application complies with the requirements for self-certification of plans and specifications. The Department shall have fourteen (14) calendar days after receipt of supplemental information to reconsider the initial denial and issue a final approval or denial of the self-certification request.

(e) After denial of the application for self-certification and prior

to the start of construction, the hospital shall pay the applicable fee for plan review specified in OAC 310:667-47-1(b)(1) through (5). Upon receipt of the plan review fee, the Department shall review the hospital's plans in accordance with the process in OAC 310:667-47-1(d).

[**Source**: Added at 34 Ok Reg 1301, eff 10-1-17]

SUBCHAPTER 49. GENERAL MEDICAL SURGICAL HOSPITAL CONSTRUCTION REQUIREMENTS [REVOKED]

310:667-49-1. General considerations [REVOKED]

[Source: Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-49-2. Nursing unit - medical and surgical [REVOKED]

310:667-49-3. Critical care unit [REVOKED]

310:667-49-4. Nurseries [REVOKED]

310:667-49-5. Pediatric and adolescent unit [REVOKED]

310:667-49-6. Psychiatric nursing unit [REVOKED]

310:667-49-7. Surgical suite [REVOKED]

310:667-49-8. Obstetrical services [REVOKED]

310:667-49-9. Emergency service [REVOKED]

310:667-49-10. Imaging suite [REVOKED]

310:667-49-11. Nuclear medicine [REVOKED]

310:667-49-12. Laboratory suite [REVOKED]

310:667-49-13. Rehabilitation therapy department [REVOKED]

310:667-49-14. Respiratory therapy service [REVOKED]

310:667-49-15. Morgue [REVOKED]

310:667-49-16. Pharmacy or drug room [REVOKED]

310:667-49-17. Dietary service facilities [REVOKED]

310:667-49-18. Administration and public areas [REVOKED]

310:667-49-20. Central services [REVOKED]

310:667-49-21. General stores [REVOKED]

310:667-49-22. Linen services [REVOKED]

310:667-49-23. Facilities for cleaning and sanitizing carts [REVOKED]

310:667-49-24. Employee facilities [REVOKED]

310:667-49-25. Housekeeping rooms [REVOKED]

310:667-49-26. Engineering service and equipment areas [REVOKED]

310:667-49-27. Waste processing services [REVOKED]

310:667-49-28. General standards for details and finishes [REVOKED]

310:667-49-29. Design and construction, including fire-resistive standards [REVOKED]

310:667-49-30. Special systems [REVOKED]

310:667-49-31. Mechanical systems [REVOKED]

310:667-49-32. Electrical systems [REVOKED]

310:667-49-33. Skilled nursing unit - distinct part [REVOKED]

310:667-49-34. Outpatient services [REVOKED]

310:667-49-35. Endoscopy suite [REVOKED]

310:667-49-36. Renal dialysis unit (acute and chronic) [REVOKED]

SUBCHAPTER 51. REHABILITATION HOSPITAL AND REHABILITATION UNIT CONSTRUCTION REQUIREMENTS [REVOKED}

310:667-51-1. General considerations [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-51-2. Evaluation unit [REVOKED]

310:667-51-3. Psychological services unit [REVOKED]

310:667-51-4. Social services unit [REVOKED]

310:667-51-5. Vocational services unit [REVOKED]

310:667-51-6. Dining, recreation, and day spaces [REVOKED]

310:667-51-7. Dietary facility services [REVOKED]

310:667-51-8. Personal care unit for inpatients [REVOKED]

310:667-51-9. Activities for daily living unit [REVOKED]

310:667-51-10. Administration and public areas [REVOKED]

310:667-51-11. Engineering service and equipment areas [REVOKED]

310:667-51-12. Linen services [REVOKED]

310:667-51-13. Housekeeping room(s) [REVOKED]

310:667-51-14. Employee facilities [REVOKED]

310:667-51-15. Nursing unit (for inpatients) [REVOKED]

310:667-51-16. Sterilizing facilities [REVOKED]

310:667-51-17. Physical therapy unit [REVOKED]

310:667-51-18. Occupational therapy unit [REVOKED]

310:667-51-19. Prosthetics and orthotics unit [REVOKED]

310:667-51-20. Speech and hearing unit [REVOKED]

310:667-51-21. Dental unit [REVOKED]

310:667-51-22. Imaging suite [REVOKED]

310:667-51-23. Pharmacy or drug room [REVOKED]

310:667-51-24. Details and finishes [REVOKED]

310:667-51-25. Design and construction, including fire-resistive standards [REVOKED]

310:667-51-26. Special systems [REVOKED]

310:667-51-27. Mechanical systems [REVOKED]

310:667-51-28. Electrical systems [REVOKED]

310:667-51-29. Outpatient services [REVOKED]

SUBCHAPTER 53. PSYCHIATRIC HOSPITAL CONSTRUCTION REQUIREMENTS [REVOKED]

310:667-53-1. General conditions [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12

Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-53-2. General psychiatric nursing unit [REVOKED]

310:667-53-3. Child psychiatric unit [REVOKED]

310:667-53-5. Forensic psychiatric unit [REVOKED]

310:667-53-6. Imaging suite [REVOKED]

310:667-53-7. Nuclear medicine [REVOKED]

310:667-53-8. Laboratory suite [REVOKED]

310:667-53-9. Rehabilitation therapy services [REVOKED]

310:667-53-10. Pharmacy or drug room [REVOKED]

310:667-53-11. Dietary service facilities [REVOKED]

310:667-53-12. Administration and public areas [REVOKED]

310:667-53-13. Medical records [REVOKED]

310:667-53-14. Central services [REVOKED]

310:667-53-15. General storage [REVOKED]

310:667-53-16. Linen services [REVOKED]

310:667-53-17. Facilities for cleaning and sanitizing carts [REVOKED]

310:667-53-18. Employee facilities [REVOKED]

310:667-53-19. Housekeeping room(s) [REVOKED]

310:667-53-20. Engineering service and equipment area [REVOKED]

310:667-53-21. Waste processing services [REVOKED]

310:667-53-22. General standards for details and finishes [REVOKED]

310:667-53-23. Design and construction, including fire-resistive standards [REVOKED]

310:667-53-24. Special systems [REVOKED]

310:667-53-25. Mechanical systems [REVOKED]

310:667-53-26. Electrical systems [REVOKED]

310:667-53-27. Outpatient services [REVOKED]

SUBCHAPTER 55. CONSTRUCTION REQUIREMENTS FOR CRITICAL ACCESS HOSPITALS [REVOKED]

310:667-55-1. General requirements [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, 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; Revoked at 36 Ok Reg 1730, eff 9-13-19]

310:667-55-2. Existing facilities [REVOKED]

SUBCHAPTER 56. CONSTRUCTION REQUIREMENTS FOR EMERGENCY HOSPITALS

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 310:667-41. 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 6-12-03; Amended at 36 Ok Reg 1730, eff 9-13-19**]**

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 310:667-41.

[**Source:** Added at 20 Ok Reg 1664, eff 6-12-03; Amended at 36 Ok Reg 1730, eff 9-13-19]

SUBCHAPTER 57. DAY TREATMENT PROGRAM STANDARDS

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 310:667-47 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; Amended at 36 Ok Reg 1730, eff 9-13-19]

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

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 Level I or Level II 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 Level I or Level II 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 6-12-03; Amended at 21 Ok Reg 573, eff 1-12-04 (emergency); Amended at 21 Ok Reg 2785, eff 7-12-04; Amended at 25 Ok Reg 2785, eff 7-17-08 (emergency); Amended at 26 Ok Reg 2054, eff 6-25-09; Amended at 36 Ok Reg 1730, eff 9-13-19]

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 [REVOKED]

[**Source**: Added at 12 Ok Reg 1555, eff 4-12-95 (emergency) ; Added at 12 Ok Reg 2429, eff 6-26-95; Revoked and reenacted at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

APPENDIX B. STATION OUTLETS FOR OXYGEN, VACUUM (SUCTION), AND MEDICAL AIR SYSTEMS IN HOSPITALS[1] [REVOKED]

[Source: Added at 12 Ok Reg 1555, eff 4-12-95 (emergency) ; Added at 12 Ok Reg 2429, eff 6-26-95; Revoked and reenacted at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

APPENDIX C. SOUND TRANSMISSION LIMITATIONS IN GENERAL HOSPITALS [REVOKED]

[Source: Added at 12 Ok Reg 1555, eff 4-12-95 (emergency) ; Added at 12 Ok Reg 2429, eff 6-26-95; Revoked and reenacted at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]

APPENDIX D. FILTER EFFICIENCIES FOR CENTRAL VENTILATION AND AIR CONDITIONING SYSTEMS IN GENERAL HOSPITALS [REVOKED]

[**Source**: Added at 12 Ok Reg 1555, eff 4-12-95 (emergency) ; Added at 12 Ok Reg 2429, eff 6-26-95; Revoked and reenacted at 20 Ok Reg 1664, eff 6-12-03; Revoked and reenacted at 21 Ok Reg 2785, eff 7-12-04; Revoked at 36 Ok Reg 1730, eff 9-13-19]

APPENDIX E. HOT WATER USE - GENERAL HOSPITAL [REVOKED]

[**Source:** Added at 12 Ok Reg 1555, eff 4-12-95 (emergency) ; Added at 12 Ok Reg 2429, eff 6-26-95; Revoked and reenacted at 20 Ok Reg 1664, eff 6-12-03; Revoked at 36 Ok Reg 1730, eff 9-13-19]