

NOTICES OF SUPPLEMENTAL PROPOSED RULEMAKING

After an agency has filed a Notice of Proposed Rulemaking with the Secretary of State's Office for *Register* publication and filing and the agency decides to prepare a Notice of Supplemental Proposed Rulemaking for submission to the Office, the Secretary of State shall publish the Notice under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.). Publication of the Notice of Supplemental Proposed Rulemaking shall appear in the *Register* before holding any oral proceedings (A.R.S. § 41-1022).

NOTICE OF SUPPLEMENTAL PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES

HEALTH CARE INSTITUTIONS: LICENSURE

PREAMBLE

1. Register citation and date for the original Notice of Proposed Rulemaking

7 A.A.R. 4791, October 19, 2001

2. Sections Affected

Rulemaking Action

Article 2	Amend
R9-10-201	New Section
R9-10-206	New Section
R9-10-207	New Section
R9-10-215	Repeal
R9-10-215	New Section
R9-10-216	Repeal
R9-10-216	New Section
R9-10-217	Repeal
R9-10-217	New Section
R9-10-220	Repeal
R9-10-220	New Section
R9-10-223	Repeal
R9-10-223	New Section
R9-10-228	Repeal
R9-10-228	New Section
R9-10-229	Repeal
R9-10-229	New Section
R9-10-230	Repeal
R9-10-230	New Section
R9-10-232	Amend

3. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-132(A), 36-136(F)

Implementing statutes: A.R.S. §§ 36-405, and 36-406

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

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5. An explanation of the rule, including the agency's reasons for initiating the rule:

A.R.S. § 36-132(A) requires the Arizona Department of Health Services (Department) to license and regulate health care institutions in Arizona. A.R.S. § 36-405(A) requires the Director of the Department to adopt rules establishing minimum standards and requirements for the construction, modification and licensure of health care institutions necessary to assure the public health, safety and welfare. It further requires that the standards and requirements relate to the construction, equipment, sanitation, staffing for medical, nursing, and personal care services, and recordkeeping pertaining to the administration of medical, nursing, and personal care services in accordance with generally accepted practices of health care. A.R.S. § 36-405 also requires that the Director use the current standards adopted by the Joint Commission on Accreditation of Hospitals and the Commission on Accreditation of the American Osteopathic Association or those adopted by any recognized accreditation organization approved by the Department as guidelines in prescribing minimum standards and requirements.

The proposed rules mirror many of the Joint Commission on Accreditation of Healthcare Organizations standards for hospitals (JCAHO) and the Health Care Financing Administration's (recently renamed Centers for Medicare and Medicaid Services or CMS) Medicare Conditions of Participation for hospitals. A hospital rules task force was established in July 1999 and met almost monthly for approximately two years to review the draft rules, discuss issues, and assist with the proposed language to ensure that the requirements accurately reflect current hospital standards while maintaining the Department's statutory mandate. The result of this collaborative effort is a negotiated proposed rulemaking with input from individuals representing the hospital community, physicians, nurses, administrators, professional associations, consumer advocacy groups, insurance industry, state agencies, and the Department. The rules provide hospitals with flexibility to adapt to the latest advances in medicine and technology. Similar to JCAHO and CMS, the Department's approach in rewriting the rules emphasizes performance and patient outcome rather than process. The Department believes that the rulemaking is necessary to provide updated requirements to protect the public health, safety, and welfare, accurately reflect industry standards, and meet rulemaking requirements.

The proposed rules replace and update current rules by setting forth the Department requirements for application requirements, quality management, administration, contracted services, personnel, medical staff, nursing services, patient rights, admission, discharge planning and discharge, transport, transfer, surgical services, anesthesia services, emergency services, pharmaceutical services, clinical laboratory and pathology services, radiology and diagnostic imaging services, intensive care services, respiratory care services, perinatal services, pediatric services, rehabilitation services, social services, dietary services, medical records services, infection control, environmental services, safety management, and physical plant standards. While the current hospital rules are written in three separate Articles in 9 A.A.C. 10, the proposed rules are written in one Article that sets forth the requirements for general hospitals, rural general hospitals, and special hospitals.

6. An explanation of the substantial change which resulted in this supplemental notice:

The Department held three oral proceedings on the proposed rules during the week of December 3, 2001. A number of written and oral comments were received throughout the comment period. The Department reviewed the comments received and decided to make modifications to the following rules in the Notice of Proposed Rulemaking published in the Arizona Administrative Register on October 19, 2001:

R9-10-201. Definitions

#9 assessment: The Department received a number of comments expressing concern that the definition did not include nursing services. The Department clarified the definition by substituting the term "hospital services" for "medical services". Hospital services are defined in the proposed rules and include medical services, nursing services and health-related services. The statutory definition of "medical services" includes any medical care provided at the direction of a physician by physicians, nurses, and other professional and technical personnel. Even though the Department believes "medical services" includes nursing services, it obviously is not clear to the reader of the rules and has been modified for clarification purposes.

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#16 certified registered nurse anesthetist: The Department received comments from the Arizona State Board of Nursing and the Arizona Association of Nurse Anesthetists requesting that the term “certified registered nurse anesthetist” be changed to “nurse anesthetist” with a modified definition to more accurately reflect current industry. The Department has changed the term to “nurse anesthetist” and changed the definition to “a registered nurse who meets the requirements of A.R.S. § 32-1661 and who has been granted clinical privileges to administer anesthesia.” A hospital has criteria established for granting clinical privileges to the different types of allied health practitioners.

#40 environmental services: The Department received comments expressing the concern that the definition is ambiguous. The definition contained the language, “other than medical services, nursing services and health-related services” which is unnecessary. The Department has rewritten the definition and removed the exclusions so that the definition is more clear and concise.

#43 general anesthesia: The Department has deleted this definition because the rules no longer use the term “general anesthesia” following the changes made to R9-10-215 Anesthesia Services in this supplemental.

#51 inpatient: The Department has clarified the definition by replacing the word “and” with the word “or” between the two requirements to reflect that either one of the requirements must be met for an individual to be classified as an inpatient. The Department also made a clarification to part (b) of this definition by changing “Is anticipated to receive hospital services for 24 consecutive hours or more” to “Receives hospital services for 24 consecutive hours or more.” What may be anticipated is not the issue. Once an individual receives hospital services for 24 hours, the individual becomes classified as an inpatient.

#53 intensive care services: The Department received a number of comments expressing concern that the definition did not include nursing services. The Department clarified the definition by substituting the term “hospital services” for “medical services”. Hospital services are defined in the proposed rules and include medical services, nursing services and health-related services. The statutory definition of “medical services” includes any medical care provided at the direction of a physician by physicians, nurses, and other professional and technical personnel. Even though the Department believes “medical services” includes nursing services, it obviously is not clear to the reader of the rules and has been modified for clarification purposes.

#64 nurse: The Department has changed the definition by deleting the word “licensed” preceding “practical nurse” for consistency with A.R.S. § 32-1601.

#65 nurse anesthetist: The Department has changed the definition of “certified registered nurse anesthetist” to “nurse anesthetist” as described above in #16.

#75 outpatient: The Department has clarified the definition by replacing the word “and” with the word “or” between the two requirements to reflect that either one of the requirements must be met for an individual to be classified as an outpatient. The Department also made a clarification to part (b) of this definition by changing “Is anticipated to receive hospital services for less than 24 consecutive hours” to “Receives hospital services for less than 24 consecutive hours.” What may be anticipated is not the issue. An individual who has received hospital services for less than 24 hours may be classified as an outpatient.

#78 patient care: The Department has clarified the definition by adding the word “members” to “medical staff” to clarify that it is inclusive of all members of the medical staff and not just physicians.

#82 person: The Department has added the phrase “and includes governmental agencies” to the definition to ensure the inclusion of governmental agencies. The governmental agencies affected by these rules are aware that they are required to comply with these rules.

#93 respiratory care services: The Department has changed the definition by replacing the word “therapy” with the word “care” to make the language consistent with the statutory definition in A.R.S. § 32-3501.

#112 treatment: The Department has made a technical change by eliminating the unnecessary words “to”.

R9-10-206. Personnel

R9-10-206(3): The Department received a written comment from a Phoenix hospital administrator informing the Department that subsection (3) lacked a beginning time-frame in which personnel must provide evidence of freedom from infectious pulmonary tuberculosis (TB). The current hospital rules require personnel to submit this evidence prior to employment. The Department inadvertently omitted the phrase “Before the initial date of work or volunteer service,” to subsection (3) to clarify that personnel must be TB tested before beginning work or volunteer services. The phrase has been added to subsection (3) for clarification.

R9-10-207. Medical Staff

The Department is deleting the term “organized” when used in conjunction with “organized medical staff” as appro-

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priate throughout the rulemaking. The term “organized medical staff” is only being used where a particular requirement involves the actual organized medical staff as a whole and not individual medical staff members. Deletion of the term “organized” as applied to the medical staff bylaws and medical staff regulations is for clarification purposes because the term is unnecessary. In addition, the Department has included language in subsection (B)(1) that provides for delayed compliance with the tuberculosis screening requirements for medical staff members. This enables hospitals to align the screening requirements with the medical staff member’s recertification, which occurs on a staggered basis every two years. If these rules become effective October 1, 2002, the date that has been requested by the Arizona Hospital and Healthcare Association and the Department, all hospitals must be in full compliance with the tuberculosis screening requirements for medical staff members by October 1, 2003.

R9-10-215. Anesthesia Services

The Department received a written request from the Arizona Association of Nurse Anesthetists to change the language in this Section by deleting the word “general” from anesthesia services to ensure that all types of anesthesia administered in conjunction with surgical services are included in this Section. There are considerable risks to patients associated with other types of anesthesia such as epidurals and spinals used during surgery. These additional types of anesthesia should be included in this rule to protect patients and ensure quality services. Additionally, “certified registered nurse anesthetist” has been changed to “nurse anesthetist” as discussed in R9-10-201 Definitions.

R9-10-216. Emergency Services

The Department made a technical change in subsection (A)(8) because of a referencing error. The chronological log requirement referenced in subsection (A)(8) is actually contained in subsection (A)(7). In addition, subsection (A)(8)(b) requiring that the chronological log be maintained by the hospital for an additional five years has been changed to four years, for a total of five years, which is consistent with federal requirements.

R9-10-217. Pharmaceutical Services

The Department has moved the medication documentation requirements in subsection (13) of the proposed rulemaking to R9-10-228 Medical Records since the rule pertains to the documentation of medication information required in a patient’s medical record. The information has been listed in both the inpatient and outpatient medical records requirements, specifically, R9-10-228 (C)(2) and (D)(2). In addition, the Department has added a new subsection (13) that references R9-10-228 for documentation of medication and biologicals administered to a patient.

R9-10-220. Intensive Care Services

The Department received a number of comments about subsection (B)(2) expressing concern that the language in the proposed rulemaking implied that only a physician could care for a patient receiving intensive care services. This was not the intent of the rule. Allied health professionals such as nurse practitioners and physician assistants provide services to patients receiving intensive care services. The rule has been modified from “a patient admitted for intensive care services is under the care of a physician” to “a patient admitted for intensive care services is personally visited by a physician at least once every 24 hours” to ensure that a physician sees the patient at least once a day to direct the patient’s overall care.

R9-10-223. Pediatric Services

The Department received a comment about subsection (C)(2) requesting that the language mirror the requirement in (A)(2) for consistency as well as the necessity to protect a hospitalized child. If there is a concern that a child’s parent(s) or guardian spending the night may jeopardize the health and safety of the child, the hospital is not required to make accommodations for the parent(s) or guardian to stay overnight.

R9-10-228. Medical Records

The Department has modified subsections (C) and (D) as described above in R9-10-217 Pharmaceutical Services by transferring the medication documentation requirements to a new (C)(2) and (D)(2) in Medical Records. In addition, references to a “medication record” have been deleted as the rules do not contain a requirement to establish a separate medication record on a patient and the term “medication record” is not defined.

R9-10-229. Infection Control

The Department has modified subsection (4)(a) by replacing the word “as” with the word “if” to clarify that performing a risk assessment is optional. In addition, the Department has received comments about subsection (5) from the Association for Professionals in Infection Control and Epidemiology (APIC), the organization responsible for establishing the standards in infection control, expressing concern that the rule requiring soiled linens and clothing to be kept in covered containers is inaccurate. The Department has changed the rule by deleting the covered container requirement and replacing with language that is consistent with APIC and infection control standards. The Department also received comments from APIC, individuals representing hospital infection control departments, and the

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Department's Infectious Disease Epidemiology Section recommending the deletion of subsection (7)(a), the requirement to maintain a chronological log of infections. The comments received informed the Department that maintaining a chronological log of infections was unrealistic and burdensome, and that hospitals do not document the information in this manner. The Department determined that by retaining the language in (7)(b), (c), and (d), the Department is confident that the infection control program will collect and document the information necessary to properly manage infection control in the hospital setting. The Department also received a request from its Infectious Disease Epidemiology Section to include the requirement that hospitals shall comply with communicable disease reporting requirements in A.A.C. Title 9, Chapter 6. This language has been added in a new subsection (B).

R9-10-230. Environmental Services

The Department has added a new subsection (1) that ensures that all individuals working in environmental services who may be at risk of transmitting pulmonary tuberculosis to patients be tested in accordance with the requirements in the personnel section. By definition, these individuals are not included in "personnel". Hospitals currently screen all employees, including environmental service employees, who may be at risk of transmitting pulmonary tuberculosis to patients. This new requirement clarifies for the hospitals that those environmental services employees who are not at risk of transmitting pulmonary tuberculosis to patients do not require an annual screening.

R9-10-232. Physical Plant Standards

The Department has received comments about subsection (A)(4), which prohibits licensed hospital premises from being leased or used by other persons. Due to the confusion with this rule, the Department has changed the rule by adding the word "licensed" to "hospital premises" and making other changes to clarify questions that have been raised. A hospital may not lease any part of the licensed hospital premise to another person. For example, if a hospital wishes to lease the sixth floor, it may do so if that part of the hospital premises is not licensed by the Department as part of the hospital.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The rulemaking incorporates existing requirements already established in rule, current industry practice, and requirements for Medicare certification and JCAHO accreditation. Some provisions within the proposed rules result in additional costs being imposed on the providers, however, the hospitals benefit by having rules that are consistent with Medicare and JCAHO. The hospitals will no longer be required to comply with three separate sets of requirements that are inconsistent. Furthermore, the proposed rules are more clearly written which reduces ambiguity and interpretation and, in turn, reduces Department and hospital personnel time currently spent clarifying existing rules. The retention of requirements already established in rule should have little or no economic impact on the hospitals. The economic impact of requirements or practices that have been in place and are now incorporated in rule will be mitigated to the extent that those affected have already incorporated these requirements and practices into their general operations. New requirements and changes in existing requirements designed to improve the delivery of hospital services and increase the efficiency of the regulatory process should also have a minimal to moderate economic impact on the hospitals. Although a new requirement of tuberculosis skin testing for screening medical staff members has been added to the rules resulting in additional costs to the hospitals, other changes in the rules will result in cost savings to the hospitals. In addition, the proposed rules allow flexibility for individual hospitals to operate efficiently and minimize administrative burdens on the hospitals. The overall economic impact to the hospitals of the proposed rulemaking is expected to be minimal to moderate, with the benefits of clear, concise, and updated rules outweighing the costs.

The rules benefit hospitals by providing consistent, accurate, and clear requirements that mirror many JCAHO Standards and Medicare Conditions of Participation, thus eliminating inconsistencies among the agencies and organizations that oversee hospital operations. The hospitals also benefit because the rules conform to the outcome-oriented approach of Medicare and JCAHO that allows extensive hospital internal reviews and the development of hospital protocols and policies by executives, physicians, and other hospital personnel. Many of the proposed changes to the rules are current hospital practice and thus the economic impact on hospitals is minimal. The Department, under contract with the U.S. Department of Health and Human Services, also surveys hospitals for Medicare certification and investigates complaints directed by Medicare and receives federal dollars accordingly. Therefore, the Department benefits by rules that are consistent with Medicare Conditions of Participation.

The Department is requesting a delayed implementation date of October 1, 2002, to allow the Department time to train surveyors and hospital personnel, and allow hospitals time to provide internal training, review policies and procedures, medical staff bylaws, and medical staff regulations for possible revision, and implement new requirements.

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The only change to the preliminary summary of the economic, small business, and consumer impact as a result of this Notice of Supplemental Proposed Rulemaking is as follows. With the addition of language that provides hospitals twelve more months to comply with the tuberculosis skin testing for medical staff members, the administrative burden of hospital compliance is minimized. The Department has mailed copies of the proposed rules to all hospital administrators throughout the rulemaking process. Therefore, most hospitals are aware of this new requirement and many have reported preparing for it already. In actuality, those hospital administrators who have read the rules and plan accordingly will have approximately 22 months to come into compliance with the requirement.

The other changes being made in this Notice of Supplemental Proposed Rulemaking should not result in a change in the economic impact above.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

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10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

The Department has scheduled the following oral proceeding:

Date: March 14, 2002
Time: 9:00 a.m.
Location: Department of Health Services,
1647 E. Morten, Hearing Room
Phoenix, AZ

A person may submit written comments on the supplemental proposed rules no later than the close of record, 5:00 p.m., March 14, 2002, to either individual listed in items #4 and #9.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

Not applicable

13. The full text of the changes follows:

Arizona Administrative Register
Notices of Supplemental Proposed Rulemaking

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSURE

ARTICLE 2. ~~GENERAL~~ HOSPITALS

Section

- R9-10-201. ~~Reserved~~ Definitions
- R9-10-206. ~~Reserved~~ Personnel
- R9-10-207. ~~Reserved~~ Medical Staff
- R9-10-215. ~~Nursing Services~~ Anesthesia Services
- R9-10-216. ~~Surgical services~~ Emergency Services
- R9-10-217. ~~Dietetic services~~ Pharmaceutical Services
- R9-10-220. ~~Environmental services~~ Intensive Care Services
- R9-10-223. ~~Pharmaceutical services~~ Pediatric Services
- R9-10-228. ~~Special Care Units~~ Medical Records
- R9-10-229. ~~Obstetrical services~~ Infection Control
- R9-10-230. ~~Pediatric services~~ Environmental Services
- R9-10-232. ~~Hospital physical plant~~ Physical Plant Standards

ARTICLE 2. ~~GENERAL~~ HOSPITALS

R9-10-201. ~~Reserved~~ Definitions

In addition to the definitions in A.R.S. § 36-401 and A.A.C. Title 9, Article 1, Chapter 10, the following definitions apply in this Article:

1. "Accredited" has the same meaning as in A.R.S. § 36-422(D).
2. "Activities of daily living" means bathing, dressing, grooming, eating, ambulating, or toileting.
3. "Acuity" means a determination of the level and type of nursing services, based on the patient's illness or injury, that are required to meet the needs of the patient.
4. "Administrator" means a chief administrative officer, or an individual who has been designated by the governing authority to act on its behalf in the onsite direction of the hospital.
5. "Admission" or "admitted" means documented acceptance by a hospital of an individual as an inpatient on the order of a medical staff member.
6. "Adult" means an individual the hospital designates as an adult based on the hospital's criteria.
7. "Adverse reaction" means an unexpected outcome that threatens the health and safety of a patient as a result of medical services provided to the patient.
8. "Anesthesiologist" means a physician granted clinical privileges to administer anesthesia.
9. "Assessment" means an analysis of a patient's need for ~~medical~~ hospital services.
10. "Attending physician" means a physician with clinical privileges who is responsible for the management of medical services delivered to a patient.
11. "Authenticate" means to establish authorship of a document or an entry in a medical record by:
 - a. A written signature;
 - b. An individual's initials, if the individual's written signature already appears in the medical record;
 - c. A rubber-stamp signature; or
 - d. An electronic signature code.
12. "Available" means:
 - a. For an individual, the ability to be contacted by any means possible such as by telephone or pager;
 - b. For equipment and supplies, retrievable at a hospital; and
 - c. For a document, retrievable at a hospital or accessible according to the time-frames in the applicable rules.
13. "Biohazardous medical waste" has the same meaning as in A.A.C. R18-13-1401.
14. "Biologicals" mean medicinal compounds prepared from living organisms and their products such as serums, vaccines, antigens, and antitoxins.
15. "Care plan" means a documented guide for providing nursing services and rehabilitative services to a patient that includes measurable objectives and the methods for meeting the objectives.
16. "Certified registered nurse anesthetist" means an individual who meets the requirements of A.R.S. § 32-1661 and who is certified by the Council on Certification of Nurse Anesthetists or is recertified by the Council on Recertification of Nurse Anesthetists.
- 17.16. "Clinical laboratory services" means the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or impairment

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- of, or the assessment of the health of, human beings, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.
- 18-17. “Clinical privilege” means authorization to a medical staff member to provide medical services granted by a governing authority or according to medical staff bylaws.
- 19-18. “Communicable disease” has the same meaning as in A.A.C. R9-6-101.
- 20-19. “Consultation” means an evaluation of a patient requested by a medical staff member.
- 21-20. “Contracted services” means hospital services provided according to a written agreement between a hospital and the person providing the hospital services.
- 22-21. “Controlled substance” has the same meaning as in A.R.S. § 36-2501.
- 23-22. “Current” means up-to-date and extending to the present time.
- 24-23. “Device” has the same meaning as in A.R.S. § 32-1901.
- 25-24. “Diet” means food and drink provided to a patient.
- 26-25. “Diet manual” means a written compilation of diets.
- 27-26. “Dietary services” means providing food and drink to a patient according to an order.
- 28-27. “Disaster” means an unexpected adverse occurrence that affects the hospital’s ability to provide hospital services.
- 29-28. “Discharge” means a hospital’s termination of hospital services to an inpatient or an outpatient.
- 30-29. “Discharge instructions” means written information relevant to the patient’s medical condition provided by a hospital to the patient at the time of discharge.
- 31-30. “Discharge planning” means a process of establishing goals and objectives for an inpatient in preparation for the inpatient’s discharge.
- 32-31. “Diversion” means notification to an emergency medical services provider, as defined in A.R.S. § 36-2201, that a hospital is unable to receive a patient from an emergency medical services provider.
- 33-32. “Documentation” or “documented” means information in written, photographic, electronic, or other permanent form.
- 34-33. “Drill” means a response to a planned, simulated event.
- 35-34. “Drug” has the same meaning as in A.R.S. § 32-1901.
- 36-35. “Drug formulary” means a written compilation of medication developed according to R9-10-217.
- 37-36. “Electronic” has the same meaning as in A.R.S. § 44-7002.
- 38-37. “Electronic signature” has the same meaning as in A.R.S. § 44-7002.
- 39-38. “Emergency” means an immediate threat to the life or health of a patient.
- 40-39. “Emergency services” means unscheduled medical services provided in a designated area to an outpatient in an emergency.
- 41-40. “Environmental services” means activities other than medical services, nursing services, or health-related services such as housekeeping, laundry, and facility and equipment maintenance.
- 42-41. “Exploitation” has the same meaning as in A.R.S. § 46-451.
43. “General anesthesia” means the administration of medication affecting the entire body resulting in loss of consciousness and protective reflexes.
- 44-42. “General hospital” means a subclass of hospital that provides surgical services and emergency services.
- 45-43. “Gynecological services” means medical services for the diagnosis, treatment, and management of conditions or diseases of the female reproductive organs and breasts.
- 46-44. “Health care directive” has the same meaning as in A.R.S. § 36-3201.
- 47-45. “Hospital” means a class of health care institution that provides, through an organized medical staff, inpatient beds, medical services and continuous nursing services for the diagnosis and treatment of patients.
- 48-46. “Hospital premises” means a hospital’s licensed space excluding, if applicable, space in an accredited outpatient facility under the hospital’s single group license, or space leased by the hospital to another entity according to the lease terms.
- 49-47. “Hospital services” means medical services, nursing services, and health-related services provided in a hospital.
- 50-48. “Incident” means an unexpected occurrence that harms or has the potential to harm a patient while the patient is on a hospital’s premises.
- 51-49. “Infection control risk assessment” means determining the risk for transmission of communicable agents.
- 52-50. “Informed consent” means advising a patient of proposed medical procedures, alternatives to the medical procedures, associated risks, and possible complications, and obtaining authorization of the patient or the patient’s representative for such procedure.
- 53-51. “Inpatient” means an individual who:
- a. Is admitted to a hospital; and
 - b. Is anticipated to receive Receives hospital services for 24 consecutive hours or more.
- 54-52. “Inservice education” means organized instruction or information related to hospital services provided to personnel or medical staff.

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- 55-53. “Intensive care services” means ~~medical~~ hospital services provided to an inpatient who requires the services of specially trained nursing and other personnel as specified in hospital policies and procedures.
- 56-54. “Interval note” means documentation updating a patient’s medical condition after a medical history and physical examination has been performed.
- 57-55. “License” means the documented authorization:
- a. Issued by the Department to operate a health care institution; or
 - b. Issued to an individual to practice a profession in this state.
- 58-56. “Manage” means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to personnel.
- 59-57. “Medical history” means a part of a patient’s medical record consisting of an account of the patient’s health, including past and present illnesses or diseases.
- 60-58. “Medical record” has the same meaning as in A.R.S. § 12-2291.
- 61-59. “Medical staff member” means a physician or other licensed individual who has clinical privileges in a hospital.
- 62-60. “Medical staff bylaws” means a document, approved by the medical staff and governing authority, that provides the framework for the organization, responsibilities and self-governance of the medical staff.
- 63-61. “Medication” has the same meaning as drug.
- 64-62. “Monitor” or “monitoring” means observing a patient’s medical condition.
- 65-63. “Neonate” means an individual:
- a. From birth until discharge following birth; or
 - b. Who is designated as such by hospital criteria.
- 66-64. “Nurse” has the same meaning as registered nurse or licensed practical nurse as defined in A.R.S. § 32-1601.
65. “Nurse anesthetist” means a registered nurse who meets the requirements of A.R.S. § 32-1661 and who has been granted clinical privileges to administer anesthesia.
- 67-66. “Nurse executive” means a registered nurse responsible for the direction of nursing services provided in a hospital.
- 68-67. “Nursery” means an area in a hospital designated only for neonates.
- 69-68. “Nurse supervisor” means a registered nurse responsible for managing nursing services provided in an organized service in a hospital.
- 70-69. “Nursing personnel” means an individual authorized by hospital policies and procedures to provide nursing services to a patient.
- 71-70. “Nutrition assessment” means a process for determining a patient’s dietary needs using information contained in the patient’s medical record.
- 72-71. “On call” means a time during which an individual is available and required to come to the hospital when requested by the hospital.
- 73-72. “Order” means an instruction to provide medical services to a patient by:
- a. A medical staff member;
 - b. An individual licensed under A.R.S. Title 32 or authorized by a hospital within the scope of the individual’s license; or
 - c. A physician who is not a medical staff member;
- 74-73. “Organized service” means specific medical services provided in an area of a hospital designated for the provision of medical services such as surgical services or emergency services.
- 75-74. “Orientation” means the initial instruction and information provided to an individual starting work in a hospital.
- 76-75. “Outpatient” means an individual who:
- a. Is not admitted to a hospital as an inpatient; ~~and~~ or
 - b. Is ~~anticipated to receive~~ Receives hospital services for less than 24 consecutive hours.
- 77-76. “Pathology” means an examination of human tissue for the purpose of diagnosis or treatment of an illness or disease.
- 78-77. “Patient” means an individual receiving hospital services.
- 79-78. “Patient care” means hospital services provided to a patient by personnel or medical staff members.
- 80-79. “Patient representative” means a patient’s legal guardian, an individual acting on behalf of a patient with the written consent of the patient, or a surrogate according to A.R.S. § 36-3201.
- 81-80. “Pediatric” means pertaining to an individual designated by a hospital as a child based on the hospital’s criteria.
- 82-81. “Perinatal services” means medical services for the treatment and management of obstetrical patients and neonates.
- 83-82. “Person” has the same meaning as in A.R.S. § 1-215 and includes governmental agencies.
- 84-83. “Personnel” or “personnel member” means:
- a. A volunteer, or
 - b. An individual, except for a medical staff member or private duty staff, who provides hospital services for compensation, including an individual who is compensated by an employment agency.
- 85-84. “Pharmacist” has the same meaning as in A.R.S. § 32-1901.

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- 86-85. “Physical examination” means to observe, test, or inspect an individual’s body to evaluate health or determine cause of illness or disease.
- 87-86. “Postanesthesia care unit” means a designated area for monitoring a patient following a medical procedure for which anesthesia was administered to the patient.
- 88-87. “Private duty staff” means an individual compensated by a patient or the patient’s representative, excluding personnel.
- 89-88. “Psychiatric services” means the diagnosis, treatment, and management of mental illness.
- 90-89. “Quality management program” means activities designed and implemented by a hospital to improve the delivery of hospital services.
- 91-90. “Registered dietitian” means an individual approved to work as a dietitian by the American Dietetic Association’s Commission on Dietetic Registration.
- 92-91. “Rehabilitation services” means medical services provided to a patient to restore or to optimize functional capability.
- 93-92. “Registered nurse” has the same meaning as in A.R.S. § 32-1601.
- 94-93. “Respiratory care services” has the same meaning as practice of respiratory therapy care as defined in A.R.S. § 32-3501.
- 95-94. “Restraint” means any chemical or physical method of restricting a patient’s freedom of movement, physical activity, or access to the patient’s own body.
- 96-95. “Require” means to establish and carry out an obligation imposed by this Article.
- 97-96. “Risk” means potential for an adverse outcome.
- 98-97. “Rural general hospital” means a subclass of hospital having 50 or fewer inpatient beds and located more than 20 surface miles from a general hospital or another rural general hospital, and which elects to be licensed as a rural general hospital rather than a general hospital.
- 99-98. “Satellite facility” has the same meaning as in A.R.S. § 36-422(I).
- 100-99. “Seclusion” means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.
- 101-100. “Shift” means the beginning and ending time of a work period established by hospital policies and procedures.
- 102-101. “Single group license” means a license that includes authorization to operate the health care institutions according to A.R.S. § 36-422(F) and (G).
- 103-102. “Social services” means assistance, other than medical services, provided by personnel to a patient to meet the needs of the patient while in the hospital or the anticipated needs of the patient after discharge.
- 104-103. “Social worker” means an individual who has at least a baccalaureate degree in social work from a program accredited by the Council on Social Work Education or who is certified according to A.R.S. Title 32, Chapter 33.
- 105-104. “Special hospital” means a subclass of hospital that:
- a. Is licensed to provide hospital services within a specific branch of medicine, or
 - b. Limits admission according to age, gender, type of disease, or medical condition.
- 106-105. “Specialty” means a specific area of medicine practiced by a licensed individual who has obtained education or qualifications in the specific area in addition to the education or qualifications required for the individual’s license.
- 107-106. “Student” means an individual attending an educational institution and working under supervision in a hospital through an arrangement between the hospital and the educational institution.
- 108-107. “Surgical services” means medical services involving the excision or incision of a patient’s body for the:
- a. Correction of a deformity or a defect;
 - b. Repair of an injury; or
 - c. Diagnosis, amelioration, or cure of disease.
- 109-108. “Telemedicine” has the same meaning as in A.R.S. § 36-3601.
- 110-109. “Transfer” means a hospital discharging a patient and sending the patient to another hospital for inpatient medical services.
- 111-110. “Transfusion” means the introduction of blood or blood products from one individual into the body of another individual.
- 112-111. “Transport” means a hospital sending a patient to another health care institution for outpatient medical services with the intent of returning the patient to the sending hospital.
- 113-112. “Treatment” means a procedure or method to cure, to improve, or to palliate an injury, an illness, or a disease.
- 114-113. “Unit” means a designated area of an organized service.
- 115-114. “Verification” means:
- a. A documented telephone call including the date and the name of the documenting individual;
 - b. A documented observation including the date and the name of the documenting individual; or
 - c. A documented confirmation of a fact including the date and the name of the documenting individual.
- 116-115. “Volunteer” means an individual, except a student, authorized by a hospital to work in the hospital who does not receive compensation.

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417-116. "Well-baby bassinet" means a receptacle used for holding a neonate who does not require treatment and whose anticipated discharge is within 96 hours of birth.

R9-10-206. Reserved Personnel

An administrator shall require that:

1. Personnel are available to meet the needs of a patient based on the acuity plan required in R9-10-208(c)(2);
2. Personnel assigned to provide medical services or nursing services demonstrate competency and proficiency according to criteria established in hospital policies and procedures;
3. Before the initial date of work or volunteer service, personnel submit one of the following as evidence of freedom from infectious pulmonary tuberculosis according to the requirements in R9-10-229(4):
 - a. A report of a negative Mantoux skin test;
 - b. If the individual has had a positive Mantoux skin test for tuberculosis, a physician's written statement that the individual is free from infectious pulmonary tuberculosis; or
 - c. A report of a negative chest x-ray;
4. Orientation occurs within the first 30 days of providing hospital services or volunteer service and includes information determined by hospital policies and procedures;
5. Hospital policies and procedures designate the categories of personnel providing medical services or nursing services who are:
 - a. Required to be qualified in cardiopulmonary resuscitation within 30 days of the individual's starting date; and
 - b. Required to maintain current qualifications in cardiopulmonary resuscitation;
6. Documentation of current qualifications in cardiopulmonary resuscitation is maintained at the hospital;
7. A personnel record for each personnel member is maintained electronically or in writing or a combination of both and includes:
 - a. Verification by the personnel member of receipt of the position job description held by the personnel member;
 - b. A personnel member's starting date;
 - c. If applicable, verification of a personnel member's education, certification, or license;
 - d. If applicable, verification of current cardiopulmonary resuscitation qualifications; and
 - e. Orientation documentation;
8. Personnel receive inservice education according to criteria established in hospital policies and procedures;
9. Inservice education documentation for each personnel member includes:
 - a. The subject matter;
 - b. The date of the inservice education; and
 - c. The signature, rubber stamp, or electronic signature code of each individual who participated in the inservice education;
10. Personnel records and inservice education documentation are maintained by the hospital at least two years after the last date the personnel member worked;
11. Personnel records and inservice education documentation are provided to the Department for review:
 - a. For current personnel, as soon as possible but not more than four hours from the time of the Department's request; and
 - b. For personnel who are not currently working in the hospital, within 24 hours of the Department's request.

R9-10-207. Reserved Medical Staff

A. A governing authority shall require that:

1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to patients a patient in a hospital;
2. The organized medical staff bylaws and organized medical staff regulations are approved according to the organized medical staff bylaws and governing authority requirements;
3. A medical staff member complies with organized medical staff bylaws and organized medical staff regulations;
4. The organized medical staff at a general hospital or a special hospital includes at least two physicians who have clinical privileges to admit patients to the general hospital or special hospital;
5. The organized medical staff at a rural general hospital includes at least one physician who has clinical privileges to admit patients to the rural general hospital and one additional physician who serves on committees according to subsection (A)(7)(c);
6. A medical staff member is available to direct patient care;
7. Organized medical Medical staff bylaws or organized medical staff regulations are established, documented, and implemented for the process of:
 - a. Conducting peer review according to A.R.S. Title 36, Chapter 4, Article 5;
 - b. Appointing members to the organized medical staff, subject to approval by the governing authority;
 - c. Establishing committees including identifying the purpose and organization of each committee;
 - d. Appointing one or more medical staff members to a committee;

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- e. Obtaining and documenting permission for an autopsy, performing an autopsy, and notifying the attending physician when an autopsy is performed;
 - f. Requiring that each inpatient has an attending physician;
 - g. Defining the responsibilities of a medical staff member to provide medical services to the medical staff member's patient;
 - h. Defining a medical staff member's responsibilities for the transport or transfer of a patient;
 - i. Specifying requirements for oral, telephone, and electronic orders including which orders require identification of the time of the order;
 - j. Establishing a time-frame for a medical staff member to complete patient medical records;
 - k. Establishing criteria for granting clinical privileges;
 - l. Specifying pre-anesthesia and post-anesthesia responsibilities; and
 - m. Approving the use of medication and devices under investigation by the U. S. Department of Health and Human Services, Food and Drug Administration including:
 - i. Establishing criteria for patient selection;
 - ii. Obtaining informed consent before administering the investigational medication or device; and
 - iii. Documenting the administration and, if applicable, the adverse reaction of an investigational medication or device;
8. The organized medical staff reviews the ~~organized~~ medical staff bylaws and the ~~organized~~ medical staff regulations at least once every 36 months and updates as needed.
- B. An administrator shall require that:**
- 1. Within 12 months from the effective date of this Article, a medical staff member submits one of the following as evidence of freedom from infectious pulmonary tuberculosis according to the requirements in R9-10-229(4):
 - a. A report of a negative Mantoux skin test;
 - b. If the individual has had a positive Mantoux skin test for tuberculosis, a physician's written statement that the individual is free from infectious pulmonary tuberculosis; or
 - c. A report of a negative chest x-ray;
 - 2. A record for each medical staff member is established and maintained electronically or in writing or a combination of both that includes:
 - a. A completed application for clinical privileges
 - b. The dates and lengths of appointment and reappointment of clinical privileges;
 - c. The specific clinical privileges granted to the medical staff member including revision or revocation dates for each clinical privilege; and
 - d. A verification of current Arizona health care professional active license according to A.R.S. Title 32;
 - 3. Except for documentation of peer review conducted according to A.R.S. § 36-445, a record is provided to the Department for review:
 - a. As soon as possible but not more than four hours from the time of the Department's request if the individual is a current medical staff member; and
 - b. Within 72 hours from the time of the Department's request if the individual is no longer a current medical staff member.

R9-10-215. Nursing services Anesthesia Services

A. Organization.

- 1. The hospital shall have an organized nursing service to provide nursing care to meet the needs of each patient.
- 2. There shall be a director of nursing.
- 3. Administrative and patient care policies and procedure for all nursing services provided shall be developed, periodically reviewed, and revised as necessary.

B. Staffing.

- 1. The nursing department shall be adequately staffed at all times based upon the number of patients and their acuity.
 - a. A registered nurse shall be in charge of the nursing service at all times.
 - b. There shall be at least 2 registered nurses on duty at all times when there are inpatients.
 - e. Each nursing unit shall be staffed by at least 1 registered nurse; nursing units with more than 40 patients shall have an additional registered nurse.
- 2. A general staffing plan shall be maintained which shall include individual staffing patterns for each nursing unit, surgical and obstetrical suites, outpatient department, emergency services, and special care units.

C. Nursing care plans. There shall be a written nursing care plan developed for each patient consistent with the medical plan of care and coordinated with the total health team. The plan shall include the problems, needs, approaches and goals, and shall be available to all members of the health team.

D. Physician's orders. Telephone orders to nursing units shall be taken only by registered nurses or licensed practical nurses. If such orders are taken by a licensed practical nurse, they shall be reviewed and countersigned by a registered nurse prior to implementation.

An administrator shall require that:

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1. General anesthesia Anesthesia services are provided in conjunction with surgical services are provided as an organized service under the direction of a medical staff member;
2. Documentation is available in the surgical services area that specifies the medical staff member's clinical privileges to administer anesthesia;
3. An anesthesiologist or a certified registered nurse anesthetist performs, except in an emergency, a pre-anesthesia evaluation within 48 hours before general anesthesia is administered in conjunction with surgical services;
4. Anesthesia administration is documented in a patient's medical record that includes:
 - a. A pre-anesthesia evaluation, if applicable;
 - b. An intra-operative anesthesia record;
 - c. The postoperative status of the patient upon leaving the operating room; and
 - d. A post-anesthesia notation by the individual performing the post-anesthesia evaluation that includes the information required by the organized medical staff bylaws and organized medical staff regulations;
5. A registered nurse or a physician documents resuscitative measures in the patient's medical record.

R9-10-216. Surgical services Emergency Services

- ~~A.~~ The general hospital shall have at least 1 operating room.
- ~~B.~~ A roster specifying the surgical privileges of physicians shall be kept in the operating room or suite.
- ~~C.~~ The medical staff shall establish policies specifying the surgical procedures which will require a second physician as assistant in surgery.
- ~~D.~~ A chronological register of surgical operations performed shall be maintained in the surgical suite.
- ~~E.~~ Except in a documented emergency, a history shall be taken and physical examination shall be performed on every patient prior to surgery. Results shall be documented in the clinical record.
- ~~F.~~ There shall be policies and procedures for the immediate post-operative care.
- ~~G.~~ The operating room shall be supervised by a qualified registered nurse.
- ~~H.~~ There shall be a registered nurse functioning as circulating nurse during each surgical procedure.
- ~~I.~~ The operating room(s) and support services shall be located to prevent through traffic.
- ~~J.~~ General anesthesia shall be administered by an anesthesiologist or an anesthetist, or by a trainee under the supervision of an anesthesiologist.
- ~~K.~~ The recovery room shall be supervised by a qualified registered nurse.
- ~~L.~~ There shall be available a current listing of all types of surgical procedures offered by the hospital. The current edition of the American Medical Association Procedural Terminology shall be used as a guide when preparing this list.
- ~~M.~~ Policies shall be adopted regarding the content of, and timing for, anesthetic follow-up notes.
- A.** An administrator of a general hospital or a rural general hospital shall require that:
 1. Emergency services are provided 24 hours a day in a designated area of the hospital;
 2. Emergency services are provided as an organized service under the direction of a medical staff member;
 3. The scope and extent of emergency services offered are documented;
 4. Emergency services are provided to an individual, including a woman in active labor, requesting emergency services;
 5. If emergency services cannot be provided at the hospital to meet the needs of a patient in an emergency, measures and procedures are implemented to minimize the patient's risk until the patient is transported or transferred to another hospital;
 6. A roster of on-call medical staff members is available in the emergency services area;
 7. There is a chronological log of emergency services that includes:
 - a. The patient's name;
 - b. The date, time, and mode of arrival; and
 - c. The disposition of the patient including discharge, transfer, or admission;
 8. The chronological log required in subsection (A)(8) (A)(7) is maintained:
 - a. In the emergency services area for a minimum of 12 months from the date of the emergency services; and
 - b. By the hospital for an additional 5 4 years.
- B.** An administrator of a special hospital that provides emergency services shall comply with subsection (A).
- C.** An administrator of a hospital that provides outpatient emergency services but does not provide perinatal organized services, shall require that emergency perinatal services are provided within the hospital's capabilities to meet the needs of a patient and a neonate including the capability to deliver a neonate and to keep the neonate warm until transfer to a hospital providing perinatal organized services.

R9-10-217. Dietetic services Pharmaceutical Services

- A.** Organization
 1. The hospital shall have an organized dietetic department under the direction of a qualified food services director who has authority and accountability for the dietetic services.
 2. Each hospital shall have at least 1 dietitian employed on either a full time, part time or consultant basis to direct the nutritional aspects of patient care and to advise on food preparation and services.
 3. There shall be written policies and procedures established for all dietetic services.

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B. Staffing

1. Staffing of dietetic services shall be maintained at levels to assure adequate production and delivery of food.
2. Time schedules and job assignments shall be on file.
3. Adequate numbers of dietitians, technical, clerical and other appropriately qualified personnel shall be employed to complete all dietary functions.

C. Facilities. Adequate space, equipment, and supplies shall be provided for the efficient, safe and sanitary receiving, storage, refrigeration, preparation and service of food.

D. Nutritional care

1. A current diet manual shall be readily available to attending physicians, food service personnel, and licensed nursing personnel.
2. Pertinent observations and information related to special diets, patient's food habits and dietetic treatment shall be recorded in the patient's medical record.
3. A written order for modified diet prescriptions as recorded in the patient's medical record shall be kept on file in the dietetic services office throughout the duration of the order.

E. Sanitation. Food service sanitation shall be maintained in accordance with the Department's Regulations Chapter 8, Article 1, Food and Drink.

An administrator shall require that:

1. Pharmaceutical services are provided under the direction of a pharmacist according to A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and A.A.C. Title 4, Chapter 23;
2. A copy of the pharmacy license is provided to the Department for review upon the Department's request;
3. A committee, composed of at least one physician, one pharmacist, and other personnel as determined by hospital policies and procedures is established to:
 - a. Develop a drug formulary;
 - b. Update the drug formulary at least every 12 months;
 - c. Develop medication usage and medication substitution policies and procedures; and
 - d. Specify which medication, medication categories, and biologicals are required to be automatically stopped after a specified time period unless the medical staff member specifically orders otherwise;
4. An expired, mislabeled, or unusable medication or biological is disposed of according to hospital policies and procedures;
5. A medication administration error or an adverse reaction is reported to the ordering medical staff member or the medical staff member's designee;
6. A pharmacy medication dispensing error is reported to the pharmacist;
7. In the absence of a pharmacist, personnel designated by hospital policies and procedures have access to a locked area containing a medication or biological;
8. A medication or biological is maintained at temperatures recommended by the manufacturer;
9. A cart used for an emergency:
 - a. Contains medication, supplies, and equipment as specified in hospital policies and procedures;
 - b. Is available to a unit; and
 - c. Is sealed until opened in an emergency;
10. Emergency cart contents and sealing the emergency cart are verified and documented according to hospital policies and procedures.
11. There are hospital policies and procedures that specify individuals who may:
 - a. Order medication and biologicals; and
 - b. Administer medication and biologicals;
12. A medication or biological is administered in compliance with an order;
13. A medical record for a patient includes:
 - a. The patient's name, age, and weight;
 - b. Medication or biological allergies or sensitivities;
 - c. Medication or biologicals ordered by the medical staff; and
 - d. A medication or biological administered to the patient including:
 - i. The date and time of administration;
 - ii. The name, strength, dosage, amount, and route of administration;
 - iii. The identification and authentication of the individual administering the medication or biological; and
 - iv. Any adverse reaction a patient has to the medication or biological;
13. A medication or a biological administered to a patient is documented as required in R9-10-228;
14. If pain medication is administered to a patient, documentation in the patient's medical record includes:
 - a. An assessment of the patient's pain before administering the medication; and
 - b. The effect of the pain medication administered;
15. Hospital policies and procedures specify a process for quality management program review of:
 - a. A medication administration error;

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- b. An adverse reaction to a medication; and
- c. A pharmacy medication dispensing error;

R9-10-220. Environmental services Intensive Care Services

- ~~A. A committee composed of members of the medical staff, nursing staff, laboratory staff, and other appropriate persons shall develop policies and procedures for investigating, controlling and preventing infections in the hospital and shall monitor staff performance in implementation of these procedures. All cases of reportable diseases shall be reported in accordance with applicable rules and regulations adopted by the Department. There shall be a method of control used in relation to sterilization of supplies and water and a written policy requiring sterile supplies to be reprocessed at specified time periods.~~
- ~~B. The hospital shall be kept clean, free of insects, rodents, litter and rubbish. All areas shall be regularly and appropriately cleaned in accordance with administrative policies and procedures.~~
- ~~C. The hospital physical plant, including equipment, shall be periodically inspected and, where appropriate, tested, calibrated, serviced or repaired to assure that all equipment is free of fire and electrical hazards and is functioning properly. Records shall be maintained to assure that appropriate inspections and maintenance of equipment are periodically accomplished by qualified personnel.~~
- ~~D. There shall be available at all times clean linen essential to the proper care and comfort of the patients. Linens shall be handled, stored, processed and transported in a manner which will prevent the spread of infection.~~
- ~~E. All potentially hazardous wastes such as waste from isolation rooms and materials contaminated with secretions, excretions or blood, patient care and laboratory animal care wastes, laboratory wastes and the like shall be sterilized by autoclaving and buried in a Department approved sanitary landfill or may be disposed of by incinerating in an incinerator approved by the Air Pollution Control Officer having jurisdiction. Provisions of 9 A.A.C. 8, Article 4 pertaining to disposal of such material shall be observed.~~
- ~~F. When oxygen is being used, the following precautions shall be taken:
 - 1. A warning sign shall be placed at each entrance to the room.
 - 2. Ash trays, matches, and other smoking material shall be removed from the room.
 - 3. Oxygen tanks shall be secured at all times. Additional precautions shall be taken in accordance with the Life Safety Code adopted by reference in A.A.C. R9-1-412(B) and the Inhalation Anesthetics Code adopted by reference in A.A.C. R9-1-417(A).
 - 4. Hydrocarbon greases shall not be used.~~
- ~~G. Electrical safety
 - 1. Extension cords shall not be used except for maintenance services.
 - 2. Equipment and appliances, including radios and television sets, which use electricity as a source of energy shall be grounded.
 - 3. Additional precautions shall be taken in accordance with the National Electrical Code adopted by reference in A.A.C. R9-1-412(E).~~
- ~~H. There shall be written policies concerning syringe and needle storage, handling and disposal.~~
- ~~I. Water supply shall be in accordance with the Department's regulations contained in 9 A.A.C. 8, Article 2.~~
- A. A general hospital or special hospital may provide intensive care services. A rural general hospital shall not provide intensive care services.
- B. An administrator of a hospital that provides intensive care services shall require that:
 - 1. Intensive care services are provided as an organized service in a designated area under the direction of a medical staff member;
 - 2. A patient admitted for intensive care services is under the care of personally visited by a physician at least once every 24 hours;
 - 3. Admission and discharge criteria for intensive care services are established;
 - 4. Personnel responsibilities for initiation of medical services in an emergency to a patient in an intensive care unit pending the arrival of a medical staff member are defined and documented;
 - 5. In addition to the requirements in R9-10-208(C), an intensive care unit is staffed:
 - a. With a minimum of one registered nurse for every three patients; and
 - b. According to an acuity plan as required in R9-10-208;
 - 6. If the medical services of an intensive care patient are reduced to a lesser level of care in the hospital, but the patient is not physically relocated, the nurse to patient ratio is based on the needs of the patient;
 - 7. Private duty staff do not provide medical services, nursing services, or health-related services in an intensive care unit;
 - 8. Nursing personnel assigned to an intensive care unit are qualified in advanced cardiopulmonary resuscitation specific to the age of the patients in the intensive care unit;
 - 9. Resuscitation, emergency, and other equipment are available at all times to meet the needs of a patient including:
 - a. Ventilatory assistance equipment;
 - b. Respiratory and cardiac monitoring equipment;
 - c. Suction equipment;

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- d. Portable radiologic equipment; and
- e. A patient weighing device for patients restricted to a bed;

10. An intensive care unit has at least one emergency cart that is maintained according to R9-10-217.

- C. A special hospital providing only psychiatric services and licensed according to A.R.S. Title 36, Chapters 4 and 5, is not subject to the requirements in this Section.

R9-10-223. Pharmaceutical services Pediatric Services

A. The hospital shall maintain pharmaceutical services which comply with A.R.S. Title 36, Chapter 9 and A.R.S. Title 32, Chapter 18 and all applicable regulations adopted by the Board of Pharmacy pursuant thereto.

B. There shall be a pharmacy and therapeutics committee composed of members of the medical staff, pharmacists, and other appropriate personnel.

C. Administration of drugs

- 1. Procedures shall be established to assure that drugs are administered only by persons authorized by state statutes and regulations.
- 2. Procedures shall be established to ensure that drugs are checked against physician's orders, that the patient is identified prior to administration of the drug, that each patient has an individual medication record, and that the dose of a drug administered to that patient is properly recorded therein by the person who administers the drug.
- 3. Drugs and biologicals shall be administered as soon as possible by a physician or the person who prepares them for administration. Preparation for administration shall not be interpreted as dispensing.

A. An administrator of a hospital that provides pediatric organized services shall require that:

- 1. Pediatric services are provided in a designated area under the direction of a medical staff member;
- 2. Consistent with the health and safety of a pediatric patient, arrangements are made for a parent or a guardian of a pediatric patient to stay overnight;
- 3. There are hospital policies and procedures for:
 - a. Infection control for shared toys, books, stuffed animals, and other items in a community playroom; and
 - b. Visitation of a pediatric patient, including age limits, if applicable.

B. An administrator of a hospital that provides pediatric intensive care services shall require that the pediatric intensive care services comply with intensive care services requirements in R9-10-220.

C. An administrator of a hospital that does not provide pediatric organized services may admit a pediatric patient only in an emergency and shall require that:

- 1. The pediatric patient is not placed in a patient room with an adult patient; and
- 2. Arrangements Consistent with the health and safety of a pediatric patient, arrangements are made for the pediatric patient's parent or guardian to stay overnight if the parent or guardian wishes to do so.

R9-10-228. Special Care Units Medical Records

If the hospital offers intensive care services or cardiac care services, the following provisions shall be met:

1. Administration

- a. A member of the medical staff, experienced in providing care to seriously ill patients, shall be responsible for direction of the special care services. He shall be a member of the appropriate special care committee.
- b. There shall be 1 or more multidisciplinary committees to review policies and procedures of special care services. These committees shall establish operational guidelines and nursing action plans for each special care unit.

2. Personnel requirements

- a. A registered nurse shall be in charge of each separate unit on each shift. This individual shall have completed an intensive care or cardiac care training course and shall have work experience in an intensive care or cardiac unit.
- b. There shall be 1 registered nurse for 3 or fewer patients in a special care unit. Nurses assigned to the unit shall have demonstrated proficiency in intensive or cardiac care and shall be competent in:
 - i. The recognition, interpretation, and recording of signs and symptoms in the critically ill patients,
 - ii. Arrhythmia interpretation,
 - iii. The initiation of cardiopulmonary resuscitation,
 - iv. The parenteral administration of electrolytes and fluids,
 - v. The effective and safe use of equipment in the unit,
 - vi. The performance of specialized nursing procedures peculiar to the needs of patients in the unit,
 - vii. The prevention of contamination and cross infection,
 - viii. The exercise of appropriate safety precautions in the use of electrical and electronic equipment, and
 - ix. The recognition of the need for psychological and social services for patients and their families.
- c. Private duty nurses shall not be permitted to function in intensive care or cardiac care units. For purposes of this Chapter nursing pool personnel employed temporarily as hospital staff are not considered private duty nurses.

3. Policies and procedures

- a. There shall be admission and discharge criteria.
- b. There shall be recommended diagnostic and treatment programs which include delineation of authority extended to the specially trained nursing staff to initiate individual emergency care pending the arrival of a physician.

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4. Equipment
 - a. Minimum monitoring equipment shall include:
 - i. Bedside electrocardiograph monitoring screens;
 - ii. Heart rate indicator with alarm at the nurses' station;
 - iii. Central monitor for display of each patient's electrocardiogram at the nurses' station;
 - iv. A direct writing electrocardiographic recorder as an integral part of the monitoring system. This requirement does not apply to an intensive care unit when this equipment is available in a separate cardiac care unit.
 - b. Resuscitative and other emergency equipment shall include:
 - i. One defibrillator in each unit and at least 1 additional defibrillator available within the hospital.
 - ii. A minimum of 2 transvenous pacemaker catheters in the unit for the first 2 beds, and 1 additional transvenous pacemaker for each additional 5 beds. One battery powered external demand pacemaker shall be available in the unit. At least 1 additional battery powered external demand pacemaker shall be available in the hospital.
 - iii. An emergency cart containing the drugs and emergency equipment required for the immediate care of emergencies. The emergency cart shall be inventoried on each shift, as well as after each use by a designated person, unless it is in a sealed unit and the seal is intact. Written documentation of this inventory shall be maintained.
 5. The special care unit shall be located to eliminate through traffic.
- A.** An administrator shall require that:
1. A medical record is established and maintained for each patient;
 2. An entry in a medical record is:
 - a. Recorded only by personnel authorized by hospital policies and procedures;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
 3. An order entered into a patient's medical record is:
 - a. Timed according to medical staff bylaws and dated when the order is entered in the medical record;
 - b. Authenticated by a medical staff member or the organized medical staff according to medical staff bylaws or hospital policies and procedures; and
 - c. Authenticated by the individual entering the order in the medical record if the order is an oral or telephone order;
 4. If a rubber-stamp signature or an electronic signature code is used to authenticate the order, the individual whose signature the stamp or electronic code represents is responsible for the use of the stamp or the electronic code;
 5. A medical record is available to personnel and medical staff members authorized by hospital policies and procedures;
 6. Information in a medical record is disclosed only with the written consent of a patient or the patient's representative or as permitted by law;
 7. Medical records are maintained under the direction of an individual:
 - a. Who is qualified according to hospital policies and procedures; or
 - b. Who consults with an individual qualified according to hospital policies and procedures;
 8. There are hospital policies and procedures that include:
 - a. The length of time a medical record is maintained on the hospital premises; and
 - b. The maximum time-frame to retrieve an onsite or offsite medical record at the request of a medical staff member or authorized personnel;
 9. A medical record of a patient is provided to the Department:
 - a. As soon as possible but not more than four hours from the time of the Department's request if the patient was discharged within 12 months from the date of the Department's request; or
 - b. Within 24 hours from the time of the Department's request if the patient was discharged more than 12 months from the date of the Department's request;
 10. A medical record is:
 - a. Protected from loss, damage, or unauthorized use; and
 - b. According to A.R.S. § 12-2297, maintained for seven years from the date of patient discharge unless the patient is a minor, in which case the record is maintained for three years after the patient's 18th birthday or at least seven years after the last date the child received hospital services, whichever date occurs last;
 11. Vital records and vital statistics are maintained for at least 10 years according to A.R.S. § 36-343;
 12. If a hospital discontinues hospital services, the Department is notified in writing, not less than 30 days before hospital services are discontinued, of the location where the medical records are stored.
- B.** If a hospital maintains medical records electronically, an administrator shall require that:
1. There are safeguards to prevent unauthorized access; and
 2. The date and time of an entry in a medical record is recorded by the computer's internal clock.
- C.** An administrator shall require that a hospital's medical record for an inpatient contains:
1. Patient information that includes:
 - a. The patient's name;

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- b. The patient's address;
 - c. The patient's date of birth;
 - d. A designated patient representative, if applicable; and
 - e. Any known allergy including medication or biological allergies or sensitivities;
 - 2. Medication information that includes:
 - a. The patient's weight;
 - b. A medication or biological ordered for the patient; and
 - c. A medication or biological administered to the patient including:
 - i. The date and time of administration;
 - ii. The name, strength, dosage, amount, and route of administration;
 - iii. The identification and authentication of the individual administering the medication or biological; and
 - iv. Any adverse reaction a patient has to the medication or biological;
 - 2-3. Documented consent for treatment by the patient or the patient's representative except in an emergency;
 - 3-4. A medical history and results of a physical examination or an interval note;
 - 4-5. If a patient provides a health care directive, the health care directive signed by the patient;
 - 5-6. An admitting diagnosis;
 - 6-7. Name of the admitting medical staff member and attending physician;
 - 7-8. All orders;
 - 8-9. All care plans;
 - 9-10. A record of medical services, nursing services, and health-related services provided to the patient;
 - 10-11. Notes by medical staff or nursing personnel;
 - 11-12. Disposition of the patient after discharge;
 - 12-13. Discharge instructions required in R9-10-211(B)(3);
 - 13-14. A discharge summary; and
 - 14-15. If applicable:
 - a. A medication record required in R9-10-217;
 - b-a. A laboratory report required in R9-10-218;
 - e-b. A radiologic report required in R9-10-219;
 - d-c. A diagnostic report;
 - e-d. Documentation of restraint; and
 - f-e. A consultation report;
- D.** An administrator shall require that a hospital's medical record for an outpatient contains:
- 1. Patient information that includes:
 - a. The patient's name;
 - b. The patient's address;
 - c. The patient's date of birth;
 - d. A designated patient representative, if applicable; and
 - e. Any known allergy including medication or biological allergies or sensitivities;
 - 2. Medication information that includes:
 - a. The patient's weight;
 - b. A medication or biological ordered for the patient; and
 - c. A medication or biological administered to the patient including:
 - i. The date and time of administration;
 - ii. The name, strength, dosage, amount, and route of administration;
 - iii. The identification and authentication of the individual administering the medication or biological; and
 - iv. Any adverse reaction a patient has to the medication or biological;
 - 23. Documented consent for treatment by the patient or the patient's representative, except in an emergency;
 - 3-4. A diagnosis or reason for outpatient medical services;
 - 4-5. All orders;
 - 5-6. A record of medical services, nursing services, and health-related services provided to the patient;
 - 6-7. If applicable:
 - a. A medication record required in R9-10-217;
 - b-a. A laboratory report required in R9-10-218;
 - e-b. A radiologic report required in R9-10-219;
 - d-c. A diagnostic report;
 - e-d. Documentation of restraint; and
 - f-e. A consultation report;
- E.** In addition to the requirements in subsection (D), an administrator shall require that the hospital's record of emergency services provided to a patient contains:
- 1. A record of treatment the patient received before arrival at the hospital, if available;

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2. The patient's medical history of disease or injury;
3. An assessment, including the name of the individual performing the assessment;
4. The patient's chief complaint;
5. The name of the individual who treated the patient in the emergency room, if applicable; and
6. The disposition of the patient after discharge.

R9-10-229. ~~Obstetrical services~~ Infection Control

In hospitals providing obstetrical services, the following shall apply:

1. ~~There shall be a registered nurse in charge of the delivery room and on duty there whenever patients are in the unit.~~
2. ~~There shall be policies and procedures adopted by the medical staff in accordance with the Standards for Obstetric-Gynecologic Hospital Services adopted by reference in A.A.C. R9-1-413(A) which provides for:~~
 - a. ~~Mixing of non-maternity patients with maternity patients.~~
 - b. ~~The use of operating rooms for delivery.~~
 - e. ~~Surgical procedures performed in the delivery room.~~
3. ~~Designated delivery rooms shall be provided with necessary supplies and equipment.~~
4. ~~Policies for the administration of oxytocic drugs, analgesics, and anesthetics shall be written.~~
5. ~~Equipment and supplies for anesthesia shall be readily available.~~
6. ~~Resuscitation equipment shall be available.~~
7. ~~A warming device that is free from fire or electrical hazards and capable of minimizing neonatal heat loss shall be available.~~
8. ~~Every newborn shall be identified by 2 reliable methods before removal from the delivery room other than in an emergency.~~
9. ~~A chronological register of deliveries and surgical procedures shall be maintained in the delivery area.~~
10. ~~Antepartum and postpartum care shall be under the supervision of a registered nurse.~~
11. ~~Newborn nursery~~
 - a. ~~the Department as required by 9 A.A.C. 6.~~
12. ~~Hospitals that do not provide obstetrical services but have only emergency obstetrical capabilities shall have:~~
 - a. ~~A designated area within the hospital where emergency obstetrical services may be performed.~~
 - b. ~~Necessary supplies and equipment to provide emergency obstetrical services.~~
 - e. ~~At least 1 Underwriter Laboratory approved isolette.~~

A. An administrator shall require that:

1. An infection control program is established under the direction of an individual qualified according to hospital policies and procedures;
2. There are hospital policies and procedures:
 - a. To prevent or minimize, identify, report, and investigate infections and communicable diseases that include:
 - i. Isolating a patient;
 - ii. Sterilizing equipment and supplies;
 - iii. Maintaining and storing sterile equipment and supplies;
 - iv. Disposing of biohazardous medical waste; and
 - v. Transporting and processing soiled linens and clothing;
 - b. That specify communicable diseases, medical conditions, or criteria that prevent an individual, personnel, or medical staff from:
 - i. Working in the hospital,
 - ii. Providing patient care, or
 - iii. Providing environmental services;
 - c. That establish criteria for determining whether a medical staff member is at an increased risk of exposure to infectious pulmonary tuberculosis based on:
 - i. The level of risk in the area of the hospital premises where the medical staff member practices, and
 - ii. The work that the medical staff member performs;
 - d. That establish the frequency of tuberculosis screening for an individual determined to be at an increased risk of exposure;
3. An infection control program includes an infection control risk assessment that is reviewed and updated at least every 12 months;
4. A tuberculosis screening is performed as follows:
 - a. For personnel, at least once every 12 months or more frequently as if determined by a risk assessment;
 - b. Except as required in subsection (4)(c), for medical staff members, at least once every 24 months; and
 - c. For those medical staff members at an increased risk of exposure based on the criteria in subsection (2)(c), at the frequency required by the hospital's policies and procedures, but no less frequently than every 24 months;
5. ~~Soiled linen and clothing are maintained in covered containers and in a separate area from clean linen and clothing;~~
5. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;

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- b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing;
 - 6. Personnel wash hands or use a hand disinfection product after each patient contact and after handling soiled linen, soiled clothing, or a potentially infectious material;
 - 7. An infection control program documents:
 - a. A chronological log of infections;
 - ~~b.a.~~ The collection and analysis of infection control data;
 - e-b. The actions taken relating to infections and communicable diseases; and
 - ~~d-c.~~ Reports of communicable diseases to the governing authority, and state and county health departments;
 - 8. Infection control documents are maintained in the hospital for two years and are provided to the Department for review as soon as possible but not more than four hours from the time of the Department's request;
 - 9. An infection control committee is established according to hospital policies and procedures that consists of:
 - a. At least one medical staff member;
 - b. The individual directing the infection control program; and
 - c. Other personnel identified in hospital policies and procedures;
 - 10. The infection control committee:
 - a. Develops a hospital-wide plan for preventing, tracking, and controlling infections;
 - b. Reviews the type and frequency of infections and develops recommendations for improvement;
 - c. Meets and provides a quarterly written report for review by the quality management program; and
 - d. Maintains a record of actions taken and minutes of meetings.
- B.** An administrator shall comply with communicable disease reporting requirements in 9 A.A.C. 6.

R9-10-230. ~~Pediatric services~~ Environmental Services

Hospitals with an organized pediatric department shall have distinct facilities for the care of children. There shall be facilities and procedures for the isolation of children with communicable diseases.

- 1. Policies shall be established to cover conditions under which parents may stay with their child.
- 2. The standards for the Care of Children in Hospitals adopted by reference in A.A.C. R9-1-413(C) are recommended as a guide for pediatric services in hospitals.

An administrator shall require that:

- 1. An individual providing environmental services who has the potential to transmit pulmonary tuberculosis to patients shall comply with the requirements in R9-10-206(3);
- ~~1-2.~~ The hospital premises and equipment are:
 - a. Cleaned according to policies and procedures designed to prevent or control illness or infection; and
 - b. Free from a condition or situation that may cause a patient or an individual to suffer physical injury;
- ~~2-3.~~ A pest control program is used to control insects and rodents;
- ~~3-4.~~ The hospital maintains a tobacco smoke-free environment;
- ~~4-5.~~ Biohazardous waste and hazardous waste are identified, stored, used, and disposed of according to A.A.C. R18-13-1401 and hospital policies and procedures;
- ~~5-6.~~ Equipment used to provide medical services, nursing services, or health-related services is:
 - a. Maintained in working order;
 - b. Tested and calibrated according to the manufacturer's recommendations or if there are no manufacturer's recommendations, as specified in hospital policies and procedures; and
 - c. Used according to the manufacturer's recommendations; and
- ~~6-7.~~ Documentation of equipment testing, calibration, and repair is maintained on the hospital premises for one year from the date of the testing, calibration, or repair and provided to the Department for review as soon as possible but not more than four hours from the time of the Department's request.
- ~~7-8.~~ Documentation of a fire drill or a disaster drill is maintained by the hospital for 12 months from the date of the drill and provided to the Department for review as soon as possible but not more than four hours from the time of the Department's request.

R9-10-232. ~~Hospital physical plant~~ Physical Plant Standards

A. ~~Physical plant — existing facilities~~

- 1. ~~The physical plant of all hospitals licensed prior to adoption of these regulations shall meet the requirements of the Sections applicable to existing hospitals in the Life Safety code adopted by reference in regulation A.A.C. R9-1-412(B).~~
- 2. ~~Appropriate drawings shall be submitted to the Department for any additions, alterations, or modifications, to the physical plant before work is undertaken.~~
- 3. ~~Alterations to the existing physical plant shall conform to new construction standards.~~

B. ~~Physical plant — new construction~~

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1. All new construction shall meet the minimum requirements of the applicable provisions of all codes and standards adopted by reference in A.A.C. R9-1-412 in accordance with their scope and applicability as specified in regulation A.A.C. R9-1-411.
2. Unless otherwise specified in this Section, patient rooms in newly constructed hospitals shall conform to the following minimum and maximum sizes:

Type of Accommodations	Minimum		Maximum*	
	(Sq. Ft.)	(Sq. M.)	(Sq. Ft.)	(Sq. M.)
Private	100	9.29	150	13.94
2 Bed	160	14.86	230	21.37
3 Bed	240	22.30	310	28.80
4 Bed	320	29.73	390	36.23

*Exception: Maximum areas may be exceeded if the number of beds is limited by the configuration of the room, and when approval has been obtained from the Department.

3. Capacity of patient rooms (excluding special care units) shall not exceed 4 beds.
 4. All patient room doors required to be self-closing by the Uniform Building Code adopted by reference in A.A.C. R9-1-412(A) shall be equipped with hold-open device. The device, upon activation of the fire alarm system, automatic fire extinguishing system and related products of combustion detectors, shall allow the door to close automatically.
- C.** All new and existing hospitals shall meet the following physical plant and safety factors:
1. Multi-bed rooms shall be designed and arranged to permit no more than 2 beds side by side parallel to the window wall with at least 3 feet (91 cm) between beds and 3 feet (91 cm) between bed and wall except at the head of the bed.
 2. All patient rooms other than in intensive care units shall be outside rooms. The window area in each patient room shall be at least 1/8 of the floor area. Suitable window shades or drapes shall be provided as a means of controlling light.
 3. Each bed shall have a nurse call system which conforms to the standard adopted by reference in A.A.C. R9-1-412(F).
 4. Each patient room shall be numbered. The Department shall be notified when room numbers are changed.
 5. Hospitals licensed prior to the adoption of these regulations shall have a minimum ratio of 1 toilet, 1 lavatory and 1 tub or shower for each 10 beds on each floor.
 6. All toilet rooms, bathrooms, utility rooms, and janitor's closets shall have mechanical ventilation providing a minimum number of air changes per hour as specified in the code adopted by reference in A.A.C. R9-1-412(F).
 7. There shall be adequate storage spaces or alcoves to store wheelchairs, walkers, and similar equipment when not in use. No corridors or stairwells shall be used for storing such equipment.
 8. There shall be adequate space for the preparation, cleaning, sterilization and storing of supplies and equipment.
 9. There shall be at least 1 room for isolation of patients with a communicable disease for each 100 beds or fraction thereof. The isolation room shall contain a private toilet and lavatory facilities.
 10. Separate adequate storage space for each patient shall be provided within the patient's room.
 11. Newborn nurseries shall have at least 24 square feet (2.23 sq. M) of floor space for each bassinet with 2 feet (61 cm) between bassinets.
 12. Pediatric nurseries shall have at least forty square feet (3.72 sq. M) of floor space for each bassinet.
 13. Pediatric beds shall have the same space requirement as adult patient beds.
 14. Items such as drinking fountains, telephone booths, vending machines, furniture, and medical equipment shall be located so that they do not reduce the required width of exit corridors.
 15. No door which is required to be fire-rated shall be held open except with a device approved by the codes adopted by reference in A.A.C. R9-1-412.
 16. Patient beds licensed after June 19, 1964 shall maintain the following minimum square footage per bed:
 - a. One bed rooms — 100 square feet (9.29 sq. M) per bed.
 - b. Multi-bed rooms — 80 square feet (7.43 sq. M) per bed.
 17. Multi-patient rooms licensed at 70 square feet (6.50 sq. M) per bed before and continuously since June 19, 1964 may retain the 70 square feet (6.50 sq. M) per bed.
- A.** An administrator shall require that:
1. A hospital is in compliance with:
 - a. Physical plant codes and standards incorporated by reference in A.A.C. R9-1-412 applicable at the time of licensure; and
 - b. The requirements in National Fire Protection Association 101, Existing Health Care Occupancies in the Life Safety Code, incorporated by reference in A.A.C. R9-1-412;

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2. Architectural plans and specifications for construction, modification, or change in licensed capacity or inpatient beds are submitted to the Department for approval;
 3. Construction, a modification, or a change in inpatient beds complies with the requirements of this Article and the physical plant codes and standards incorporated by reference in R9-1-412 in effect at the time the construction, modification or change in licensed capacity or inpatient beds is approved by the Department;
 4. Hospital premises, as defined in this Article, are used exclusively by the hospital and the hospital premises are not leased;
 4. Any part of the licensed hospital premises is not leased to or used by another person;
 5. A unit with inpatient beds is not used as a passageway to another health care institution; and
 6. Hospital premises are not licensed as more than one health care institution except as provided in R9-10-224.
- B.** An administrator shall provide to the Department for review as soon as possible but not more than four hours from the time of the Department's request, documentation of a current fire inspection conducted by a local jurisdiction.