NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected	Rulemaking Action
Article 2	Amend
R9-10-201	New Section
R9-10-202	New Section
R9-10-203	New Section
R9-10-204	New Section
R9-10-205	New Section
R9-10-206	New Section
R9-10-207	New Section
R9-10-208	New Section
R9-10-209	New Section
R9-10-210	New Section
R9-10-211	Repeal
R9-10-211	New Section
R9-10-212	Repeal
R9-10-212	New Section
R9-10-213	Repeal
R9-10-213	New Section
R9-10-214	Repeal
R9-10-214	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
R9-10-218	Repeal
R9-10-218	New Section
R9-10-219	Repeal
R9-10-219	New Section
R9-10-220	Repeal
R9-10-220	New Section
R9-10-221	Repeal
R9-10-221	New Section
R9-10-222	Repeal
R9-10-222	New Section
R9-10-223	Repeal
R9-10-223	New Section
R9-10-224	Repeal
R9-10-224	New Section
R9-10-225	Repeal
R9-10-225	New Section
R9-10-226	Repeal
R9-10-226	New Section

R9-10-227	Repeal
R9-10-227	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
R9-10-231	Repeal
R9-10-231	New Section
R9-10-232	Amend
R9-10-233	Repeal
R9-10-233	New Section
Article 3	Repeal
R9-10-311	Repeal
R9-10-312	Repeal
R9-10-313	Repeal
R9-10-314	Repeal
R9-10-315	Repeal
R9-10-316	Repeal
R9-10-317	Repeal
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R9-10-329	Repeal
R9-10-330	Repeal
R9-10-331	Repeal
R9-10-332	Repeal
R9-10-333	Repeal
Article 4	Repeal
R9-10-411	Repeal
R9-10-412	Repeal
R9-10-413	Repeal
R9-10-414	Repeal
R9-10-415	Repeal
R9-10-416	Repeal
R9-10-417	Repeal
R9-10-418	Repeal
R9-10-419	Repeal
R9-10-420	Repeal
R9-10-421	Repeal
R9-10-422	Repeal
R9-10-423	Repeal
R9-10-424	Repeal
R9-10-425	Repeal
R9-10-426	Repeal
R9-10-427	Repeal
R9-10-428	Repeal
R9-10-429	Repeal
R9-10-430	Repeal
R9-10-431	Repeal
R9-10-432	Repeal
R9-10-433	Repeal
R9-10-434	Repeal
R9-10-435	Repeal
R9-10-436	Repeal

R9-10-437	Repeal
R9-10-438	Repeal

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

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

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

3. The effective date of the rules:

October 1, 2002

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 1321, March 23, 2001

Notice of Proposed Rulemaking: 7 A.A.R. 4791, October 19, 2001

Notice of Supplemental Proposed Rulemaking: 8 A.A.R. 774, February 22, 2002

Notice of Public Information: 8 A.A.R. 1113, March 15, 2002

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

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6. 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 over 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.

7. A reference to any study that the agency relied on in its evaluation of or justification for the proposed rules and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

None

8. 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

9. The 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, 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 for hospitals.

The Department is requesting a delayed effective 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.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

A Notice of Rulemaking Docket Opening was published on March 23, 2001. A Notice of Proposed Rulemaking was published on October 19, 2001. The Department held oral proceedings on the proposed rules on December 4, 5, and 6, 2001, and received a number of written and oral comments. The Department made changes to address these comments and published a Notice of Supplemental Proposed Rulemaking on February 22, 2002. The Department held an oral proceeding on the supplemental proposed rules on March 27, 2002. The Department received no comments in response to the supplemental proposed rules. The Department has made technical and grammatical changes to the rules based on comments received from the Governor's Regulatory Review Council's staff. The Notice of Supplemental Proposed Rulemaking contained the following changes:

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. The rule has been modified for clarification purposes.

#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 practice. 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 understandable.

#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 notice.

#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. The rule 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 word "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 providing hospital services or volunteer service," from subsection (3), which clarifies that personnel must be TB tested before providing hospital services 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 appropriate 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 recredentialing, 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 5 years after it is maintained for one year in the emergency services area, has been changed to 4 years, for a total of 5 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 this Section. 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 a risk assessment may determine the frequency of the tuberculosis screening for personnel. 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 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 deleting (7)(a) but 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 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 R9-10-206. 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.

11. A summary of the principal comments and the agency response to them:

The following tables summarize the comments received by the Department in each comment period and provide the Department's response to each comment.

A. First Comment Period

Public Comment	ADHS Response
13 commenters expressed concern about mandatory overtime for nurses and request that the rules contain language to prohibit mandatory overtime.	The Department is not making changes in response to this comment. The Department has no evidence that mandatory overtime is a public health and safety issue in Arizona. The Department's Assistant Attorney General to the Office of Medical Facilities advised the Department that the Department has general statutory authority to protect public health and safety and could include the prohibition of mandatory overtime if evidence exists that it is a public health and safety issue in Arizona. Since the Department has not identified overtime as a health and safety issue, statutory authority to write rules for this is limited. Because evidence has not been presented to show a direct correlation between mandatory overtime and negative patient outcomes, the Department will not include language in the proposed rules. It appears that this may be a nursing issue, employer-employee issue, or a legislative issue rather than a rules issue. The Department has told interested persons that if evidence is provided to warrant further consideration, the Department will convene a small task force in the near future to consider the issue and, if necessary, develop a separate rulemaking that contains language acceptable to all parties involved.
12 commenters expressed opposition to the ICU nurse to patient ratio of 1:3 in R9-10-220 and asked that the rule be changed to 1:2.	The Department is not making changes in response to this comment. The Department considered this issue very carefully when drafting the proposed rules and specifically the impact to all types of hospitals. The requirement for a minimum nurse to patient ratio exists only in the intensive care service areas. The requirement is unchanged from the current rules. The nurse to patient ratio does not stand alone as a requirement but in conjunction with the requirement that hospitals establish and implement an acuity system to determine the type and level of nursing care necessary to provide care to meet patient's needs. The purpose of determining patient acuities and an acuity plan is to staff according to patient needs. By utilizing acuities, ICU's may determine that the appropriate nurse to patient ratio is 1:1 or even 2:1 in some cases. In most cases, the implementation of the acuity system will establish the ICU nurse to patient ratio at 1:2. General hospitals located in the rural areas may use a 1:3 ratio because the ICU patients in these settings typically do not require the same level of nursing care that urban general hospital ICU's do. Requiring a 1:2 ratio in rule would limit the hospital's ability to staff based on patient needs.
19 commenters expressed a variety of concerns about nurses' working conditions in general such as nurses are overworked, understaffed, have too many patients, are abused by physicians, and that there is a direct correlation between the working conditions and the nursing shortage.	The Department is not making changes in response to these comments. The Department does not have jurisdiction to regulate general nursing working conditions or establish rules to improve the recruitment and retention of nurses in an effort to resolve the current nursing shortage. The current nursing shortage is a nationwide problem.

Letter submitted by the Medical Staff Section Representative of the AMA supporting provisions of the proposed hospital rules, specifically, R9-10-207(A), R9-10-203(B), and definition of "medical staff bylaws".	The Department appreciates the support.
Letter from physician commending and supporting the Department in its efforts to improve the quality of patient care through improved hospital regulations. Specifically, the definition of "medical staff bylaws"; the direct accountability (for patient care) of the medical staff organization to the governing authority; the essential components of an effective quality management program and plan in the Quality Management rule R9-10-204(B).	The Department appreciates the support.
Letter from Arizona Citizen Action, a coalition concerned with public policies that affect the health and well-being of all Arizonans, supporting the Department's proposed rules and urging the Department to finalize sections R9-10-204 Quality Management, R9-10-207 Medical Staff, and R9-10-211 Discharge Planning, as they are proposed.	The Department appreciates the support.
Letter supporting the proposed rules pertaining to the medical staff, definition of "medical staff bylaws", and direct accountability of medical staff to the governing authority.	The Department appreciates the support.
Letter from a hospital Chief of Staff commending and supporting the proposed rules; specifically urging the Department to retain language relating to the medical staff organization's responsibilities (a) to oversee the quality of its members' patient care; (b) to establish a self-governing organization that collaborates with the hospital's administration and governing authority in ensuring responsible patient care; and (c) to be directly accountable to the governing authority for medical staff members' performance. This letter specifically supports the definitions of "attending physician", "medical staff bylaws", and "quality management program", and rules R9-10-203(A)(5), (6), and (7), R9-10-203(B)(3), R9-10-207(A), and R9-10-204.	The Department appreciates the support.
The Arizona State Board of Nursing submitted the following comments: R9-10-220(B)(2) - The requirement that a patient admitted to Intensive Care Services be under the care of a physician seems redundant and could be interpreted to mean that only a physician can admit patients to these services. R9-10-207(A)(7)(f) already specifies that an inpatient must have an attending physician. To further require that patients be under the care of a physician implies that only a physician may admit patients to intensive care services. This may be a threat to patient safety and cause delays in admitting patients to the ICU when a nurse practitioner is caring for a hospitalized patient. We would suggest that this subsection be deleted.	The Department is modifying R9-10-220(B)(2) by changing "under the care of" to "personally visited by a physician at least once every 24 hours" since the intent is that each patient be seen daily by a physician. R9-10-207(A)(7)(f) already requires that each patient have an attending physician. This change simply clarifies the requirement and avoids redundancy and misinterpretation. Other licensed practitioners with appropriate clinical privileges routinely admit and care for patients requiring Intensive Care Services, however, a physician must see the patient on a daily basis to direct the patient's overall care and treatment.
The Arizona State Board of Nursing and the Arizona Association of Nurse Anesthetists through DeMenna and Associates submitted the following comments: R9-10-215 - Delete references to "general" anesthesia and include all types of anesthesia performed in conjunction with surgical services as there are considerable risks to patients associated with other types of anesthesia. Recommend subsection (1) reads "Anesthesia services provided in conjunction with surgical services are provided as an organized service under the direction of a medical staff member." Change references from "certified registered nurse anesthetist" to "nurse anesthetist" to allow graduates of nurse anesthetist programs to provide anesthesia services prior to becoming certified. Continue to allow hospitals to determine the qualifications of anesthesia providers as part of the credentialing process. Recommend subsection (3) reads "An anesthesiologist or a nurse anesthetist performs, except in an emergency, a pre-anesthesia evaluation within 48 hours before anesthesia is administered in conjunction with surgical services."	The Department is modifying R9-10-215(1) to read "Anesthesia services provided in conjunction with surgical services are provided as an organized service under the direction of a medical staff member." The Department is changing references to "certified registered nurse anesthetist" to "nurse anesthetist". This change is less restrictive and allows the hospitals to grant privileges to the nurse anesthetists as the hospitals currently do through the credentialing process. Only those approved by the hospital's credentialing process will be allowed to administer anesthesia.

Define "nurse anesthetist" as "a registered nurse who meets the requirements of A.R.S. § 32-1661 and has been granted clinical privileges to administer anesthesia."	The Department is changing the term "certified registered nurse anesthetist" to "nurse anesthetist" and modifying the definition as suggested to provide consistency with A.R.S. § 32-1661. The new definition will read as follows: "means a registered nurse who meets the requirements of A.R.S. § 32-1661 and has been granted clinical privileges to administer anesthesia."
R9-10-207 use of the term "organized medical staff" which is defined in A.R.S. § 36-401(35) creates confusion with the term "medical staff member". The confusion created by use of the two terms, which includes other types of providers, could be eliminated by using the term "medical staff members" or "medical staff" in subsections (A)(1), (A)(2), (A)(3), (A)(4), (A)(5), (A)(7), (A)(7)(b), and (A)(8).	R9-10-207 – The Department agrees and has deleted the term "organized" when used in conjunction with "organized medical staff" as appropriate throughout this Section and the rules. The term "organized medical staff" is only being used where the requirement involves the 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.
Use of the term "medical services" as defined in A.R.S. § 36-401(30) implies that physicians are the only health care providers permitted to provide medical care. This concept is outdated and not consistent with current practice in hospitals through the state of Arizona. Specifically problematic is the use of the term in the definition of "order", "assessment", and "clinical privileges". It is requested that the term "medical services" be eliminated from the proposed rules and a term such as "medical care and treatment," which does not have an outdated statutory definition, be substituted.	The Department is not making changes in response to this comment. The term "medical services" as defined in A.R.S. § 36-401(30) means the services pertaining to medical care that are performed at the direction of a physician on behalf of patients by physicians, dentists, nurses and other professional and technical personnel. We do not believe that the definition is restrictive and implies that physicians are the only health care provider permitted to provide medical care. The definition specifically includes services pertaining to medical care performed at the direction of a physician by physicians, dentists, nurses and other professional and technical personnel. A physician is ultimately responsible for all care provided to a patient in a hospital. Nurse practitioners, physician assistants, nurses, technicians, etc. are permitted to perform services within the scope of professional practice at the direction of the physician. The term "direction" is also defined in A.R.S. § 36-401(17) as authoritative policy or procedural guidance. The Department believes this is clear and does not limit medical care to physicians. The Department does agree that the definition is outdated, however, it is a statutory definition, which would require statutory change.
Coppersmith, Gordon, Schermer, Owens & Nelson, PLC submitted the following comments on behalf of the Arizona Hospital and Healthcare Association (AzHHA): Prohibition on mandatory overtime for nurses – AzHHA worked diligently with the Arizona Nurses Association to resolve staffing issues. Given the enormous variations in staffing arrangements, any language would undoubtedly have the unintended consequence of prohibiting legitimate staffing arrangements. It would put the Department in the position of arbitrating what is acceptable in a rapidly changing field already governed by substantial federal and state employment laws. "Overtime" would have to be defined. While it is generally thought to be a work week of forty hours, the application of the prohibition to part-time personnel and those seeking flexible hours would create constant ambiguity and regulatory concern. This is particularly troubling when there is no evidence that Arizona hospitals are engaging in improper overtime arrangements. AzHHA believes that consideration of such a proposal will result in the lengthy and unnecessary delay in the publication of final rules.	Mandatory overtime – The Department is not making changes in response to comments concerning mandatory overtime. Please see the Department's response on page 13.
TB Testing: AzHHA maintains its position that the rule does not fulfill the public health issue it is intended to address and feels that TB testing for physicians and other licensed professionals is such an important public health goal that the appropriate professional licensing board should require TB testing as a condition of licensure. Hospitals agree that physicians should be tested for TB but that it extends beyond the hospital environment. Requiring hospitals to make sure that physicians are tested for TB will place a substantial financial and administrative burden on the hospital and will result in duplication of efforts since many physicians are on the staff of more than one hospital.	TB requirement – The Department is not making changes in response to comments concerning the TB requirements of medical staff. The existing hospital rules require that hospital personnel be screened annually for pulmonary tuberculosis (TB). The hospitals provide the TB skin test to personnel at no charge. Hospitals have not required medical staff members to be TB skin tested even though the Center for Disease Control and Prevention (CDC) recommends that all health care workers, including physicians, be screened annually or according to a risk assessment.

	The proposed rule specifically requires that medical staff members be TB screened. For the purposes of the rulemaking, a medical staff member is defined as a physician or other individual who has clinical privileges in a hospital. A number of hospitals recommend that their medical staff members be TB screened and provide the Mantoux skin test at no charge, but because it is only a recommendation, the hospitals do not monitor, track, follow-up, or document this information. For those hospitals that are already providing the TB screening to medical staff members, there may be a minimal to moderate increase in costs to test all staff members, but it is estimated that the administrative costs of monitoring, tracking, and documenting this information on each medical staff member will result in a substantial increase in costs to the hospitals. Most hospitals have over 1500 medical staff members. Many medical staff members have privileges at other hospitals. The non-medical staff personnel receive written documentation of the TB skin test result. In an effort to avoid duplication of skin tests for medical staff members, similar written documentation could be provided to the medical staff members for distribution to all hospitals where the medical staff member has clinical privileges. This would decrease the total number of TB skin tests administered to medical staff members. The Department does not agree with AzHHA that the appropriate place to gather evidence of physician TB testing is with the professional licensing boards. As the agency mandated to ensure the public health and safety of health care institutions, specifically licensing and regulating hospitals, the Department believes it is doing what it can within its authority to prevent the spread of TB by ensuring that all personnel employed by or providing services in a hospital are TB tested, including medical staff members. AzHHA, on behalf of most of Arizona's hospitals, urged the Department to consider a biennial requirement of TB testing for medical staff members instead of an annual requirement because of the estimated costs and administrative burdens for hospitals. AzHHA stated that hospitals indicated that although a biennial requirement would still impose substantial costs on the hospitals, an annual requirement for hospitals to track compliance would impose a much greater financial burden on the hospitals. After many hours of discussion and negotiation, the Department determined that hospital personnel would continue to be TB screened every 12 months, as has been the requirement for over 20 years and that the hospitals would monitor, document, and track TB skin testing for medical staff members on a biennial basis to coincide with the medical staff members' application for appointment or reappointment to the medical staff when hospital medical staff offices are already examining physician credentials. Those medical staff members identified by hospital infection control policies and procedures at an increased risk of exposure to TB will be tested at the frequency determined by those policies and procedures. These medical staff members determined to be at an increased risk may be tested every 6 months or every 12 months depending on the exposure risk and the work the medical staff member performs. AzHHA has verbally indicated its satisfaction with this resolution, and the Department's TB Control Office is in agreement with this approach as well.
R9-10-201(3), Definition of acuity. AzHHA requested confirmation that acuity includes the current widespread use of the matrix staffing system which is an evidence-based staffing plan by unit that allows for flexibility to add or delete staff based upon the acuity of the patient and the skill set of the nurse. National benchmarking information also is used. What traditionally is known as "acuity standards" are no longer used. While AzHHA believes the matrix staffing system is consistent with the "acuity plan" as it is broadly defined in the rules, AzHHA would like the Department to confirm that fact. If the matrix system is not consistent with the present definition of "acuity," AzHHA requests the Department to amend the definition to encompass this widespread practice.	Definition of acuity – The Department is not making changes in response to this comment. The Department has explained to AzHHA that any system or method of determining hospital staffing that uses the substantive requirements in the definition of "acuity" in these rules would be acceptable whether it is called benchmarking, matrix staffing system, or acuity. The critical component of this requirement is to ensure that the levels and numbers of nursing staff are based on the nursing needs of the patients.

Emergency services, R9-10-216(A)(8) requires hospitals to keep a chronological log in the emergency services area for 12 months, and then on the premises for an additional 5 years. To be consistent with federal EMTALA requirements, which requires retention for a total of 5 years, we recommend subsection (8)(b) be changed to "By the hospital for an additional 4 years."	Emergency services – The Department is modifying the rule for consistency with federal EMTALA requirements. R9-10-216(A)(8)(b) is changed to read "by the hospital for an additional 4 years." Additionally, R9-10-216()(8) contained a referencing error to (A)(8) which should have been (A)(7) and has now been corrected.
Department of Health Services Bureau of Epidemiology and Disease Control: R9-10-229 Infection Control: Suggest adding a requirement to (2) to report communicable diseases as specified in R9-6-201, R9-6-202, R9-6-203. Suggest revising (6) to "personnel wash hands or use an alcohol-based waterless antiseptic agent..." Suggest changing (7)(a) requiring "a chronological log of infections" to "a coordinated process to reduce the risk of endemic and epidemic nosocomial infections in patients and healthcare workers." Develop surveillance need depending on patient population and high-risk procedures as approved by the Infection Control committee.	R9-10-229 Infection Control - Communicable disease reporting – The Department is changing the rules in response to the Bureau's request. A new subsection (B) has been added requiring an administrator to comply with communicable disease reporting requirements in A.A.C. Title 9, Chapter 6. The addition of this language poses no additional burden on the hospitals since it is already in rule. Alcohol-based waterless antiseptic agent – The Department is not making changes in response to this request. The rules require that "personnel wash hands or use a hand disinfection product". The Department would like to leave the requirement broad enough to allow for future products or the possibility of using other products because of allergies. Using the recommended language would be restrictive. According to the Bureau's statement, this is based on a Center for Disease Control and Prevention draft guideline that may or may not be implemented. Chronological log of infections – The Department is modifying the rule by deleting the requirement in R9-10-229(7)(a) and relettering to conform. The Department received many comments from hospital infection control staff informing the Department that the requirement as listed would be extremely difficult to comply with, if not impossible. Hospitals are not currently documenting information in this manner. The information required in R9-10-229(7)(b),(c), and (d) would address the information in (a) without requiring an extensive log.
Letter from the Southern Arizona Nurses Coalition concerning changing 1:3 nurse-patient ratio in ICU to 1:2; add language to establish maximum number of patients per nurse in units other than ICU; require the development of statewide acuity standards by a committee of direct-care nurses; add language prohibiting floating of nurses unless they have been properly oriented to the unit in which they are floated to and have demonstrated and retained the competencies necessary to practice safely on that unit; insert language mandating that no employee of a healthcare facility can be required or forced to work more than a pre-determined schedule; change definitions of "adult" and "pediatric" to specifically define these terms rather than permitting hospitals to define these terms; add "and nursing" to the definition of "assessment"; add "and nursing" and "critically ill" to the definition of "intensive care services"; insert "medical, nursing, and" to the definition of "patient"; insert the phrase "medical, nursing, and" and "and nursing" to the definition of "patient care".	ICU Nurse to patient ratio – The Department is not making changes in response to this comment. Please see the Department's response to this comment on page 15. Nurse to patient ratios in other units: The Department is not addressing specific ratios in any other area of the hospital other than intensive care services. The rules currently in effect require that each nursing unit be staffed by at least 1 registered nurse; nursing units with more than 40 patients require an additional registered nurse. With the requirement in the proposed rules to provide sufficient personnel to meet the patient's needs based on the patient's acuities, an acuity system should be sufficient to determine staffing needs. Some nurses label this as a l:infinity staffing ratio. Again, an acuity system determines the staffing necessary to meet patient's needs. The 1:40 ratio in the current rules adopted over 20 years ago is outdated and no longer used. Units are not set up in this manner any longer. It would be difficult for the Department, if not impossible, to establish staffing ratios in each type of unit. Statewide acuity standards: The Department is not making changes in response to this comment. The development of statewide acuity standards would be a tremendous undertaking and a very lengthy process. In addition, it would not allow hospitals flexibility to meet patients' needs. Units are very diverse, and in theory, acuity standards would have to be developed for every type of medical condition and conceivable complication. Prohibit nurses floating to other units: The proposed rules state: "An administrator shall require that personnel assigned to provide medical services or nursing services demonstrate competency and proficiency according to criteria established in hospital policies and procedures." It is clear that this requirement would apply to situations where a nurse is floated to an unfamiliar area to provide nursing services. Furthermore, as a licensed professional, a nurse has the responsibility to inform the supervisor or manager of his or her concerns or inability to float to other areas because of the lack of proficiency or competency in that area. The nurse should then document the discussion. Working more than predetermined schedule: This is the mandatory overtime issue, which is discussed in detail on page 13 of this document.

	Definitions of adult and pediatric: The Department is not making changes in response to this comment. The terms "adult" and "pediatric" were specifically defined to allow hospitals flexibility. When the task force discussed this issue, it was decided to allow hospitals to determine at what age it would classify patients as pediatric patients or adult patients because one age limit does not work for all hospitals. Hospitals classify pediatric patients at varying ages depending on the community, the location of the hospital, the size or specialty of the hospital, etc. Add "and nursing" to the definitions of "assessment" and "intensive care services": The Department has replaced the term "medical services" with "hospital services" in both definitions to clarify that it includes medical services, nursing services, and health-related services. Add "critically ill" to the definition of intensive care services: The Department is not making changes in response to this comment at this time. The term "critically ill" would require defining in the rules. The Department will consider this for the next hospital rules task force meetings which are anticipated to begin soon after the current rulemaking is finalized.
Letter from a group of nurses from a local hospital recommending the following changes: Include direct care nurses' input into regulatory mandates.	Direct-care nurse input: The hospital rules task force that was established and met monthly for over two years included representation from the Arizona Nurses Association, the Organization of Nurse Executives, and a number of other registered nurses. The Department believed that nursing was well-represented throughout the rulemaking process, however, the Department has agreed that in the future it would ensure the inclusion of direct-care nurses in the task force.
R9-10-203 Administration - the term "accountable" should be used in place of the term "responsible".	R9-10-203 Administration: The Department is changing the term "responsible" to "accountable" in response to this comment.
R9-10-206(2) Personnel – Add the phrase "in conjunction with the scope of practice and legal authorization of each practice" at the end of the sentence.	R9-10-206(2) Personnel: The Department is not making a change to this comment. The recommended phrase is unnecessary because a professional license to practice already places limitations on the activities and scope of practice by law.
R9-10-208 Nursing Services – Change one registered nurse in the unit at all times to two registered nurses in the unit at all times. And change "registered nurse" to "direct-care nurse."	R9-10-208 Nursing Services: The Department is not making changes to these comments. The rules require that there are sufficient personnel at all times to meet the needs of the patients. Additionally, if there is more than one patient in a unit, there must be a registered nurse and one additional nursing personnel in the unit at all times. Requiring the second individual to be a registered nurse would be cost-prohibitive for many hospitals and unnecessary. Most hospitals have systems in place for calling additional RN's present in the hospital should the need arise. Hospitals are having difficulty staffing with RN's because of the current nursing shortage. During peak periods of the year, hospitals either close to new admissions or close units because they are unable to get the RN's to staff the beds. "Nurse" or "registered nurse" is the term that is used throughout the rules because these terms are used and defined in statutes and rules.
R9-10-216 Emergency Services – Add subsection (D): "A patient being held in the ED prior to transfer to the appropriate in house unit or transfer to the appropriate facility will be cared for at the nurse-patient ratio designated for the receiving unit."	R9-10-216 Emergency Services: The Department is not making changes in response to this comment. The only nurse to patient ratios requirement is in intensive care services. The explanation provided above in response to the comment in R9-10-208 applies to this Section as well as the explanation of acuity system described on pages 13-14 of this document.
R9-10-220 Intensive Care Services – (5): Change the nurse to patient ratio to 1:2 and require implementation of the acuity plan required in R9-10-208(C)(3). Add subsection (C): Ratio is to be maintained at all times including breaks and meal times. (6): Maintain the ratio at 1:2 at all times and not based on the needs of the patient.	R9-10-220 Intensive Care Services: The Department is not making changes in response to this comment. Please see the Department's response to this comment on pages 13-14 of this document.

Change the definitions as follows: Acuity means the measurement of the severity of patient illness or injury and the amount and complexity of nursing care required to meet the needs of the patient. Additionally, require the formation of an acuity development committee composed of a majority of direct-care nurses to formulate an acuity rating system. Assessment means an analysis of a patient's need for medical and nursing services within the scope of practice and legal authorization designated for each practice. Intensive Care Services means the medical and nursing services provided to an inpatient who requires the care of specialty trained direct-care nurses as well as other personnel as specified in hospital policy and procedures and as defined in their respective scope of practice and legal authorization. Monitor or Monitoring means evaluating a patient's condition through the use of direct observation and monitoring equipment on an intermittent or continuous basis. Patient means an individual receiving medical, nursing and other health related and/or preventative services, or who is under treatment or observation for illness, injury or care during pregnancy. Patient care means medical, nursing and health-related services provided to a patient including any unlicensed personnel who assist with simple nursing procedures.	Definitions: The Department is not making the changes to the definitions recommended. The changes are unnecessary or create ambiguity. The definitions of "patient" and "patient care" include the term "hospital services" instead of listing medical, nursing, and health-related services individually since "hospital services" already includes these in the definition.
R9-10-229(A)(2)(c): The comment concerns Infection Control, specifically, the TB requirement for medical staff members. Writer asks why the rules only address a medical staff member and not employed staff members as well. Recommends wording the TB risk assessment similar or same as OSHA's which bases risk of transmission as high, intermediate, low, very low, or minimal. R9-10-229(A)(5) Requiring soiled linen to be contained in covered containers is rigid. Recommends language requiring that soiled linen be "bagged at site of use" instead of stored in covered containers as recommended by the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC). Recommends deletion of (A)(7)(a) because the requirement is not clear and could be subject to multiple interpretations. Hospitals have performed focused surveillance for infections based on high-risk procedures. Total hospital-wide surveillance for all infections is inappropriate and does not lead to reduction of infection rates. Recommends consistency with CDC and APIC.	R9-10-229(A)(2)(c): The Department is not making changes to the rules as a result of this comment. The tuberculosis screening requirement for medical staff members is for all medical staff members. The rules do not differentiate between hospital-employed medical staff members and medical staff members who are not employed by the hospital. R9-10-229(A)(5): The Department agrees with this recommendation and has made changes to the requirements consistent with the Association for Professionals in Infection Control and Epidemiology, Inc., the organization that sets the standards in infection control. The requirement for soiled linen and clothing to be kept in covered containers has been deleted. R9-10-229(A)(7)(a): In response to comments received, the Department has deleted (7)(a), the requirement for a chronological log of infections. Hospitals do not document infection control information in that manner.
A letter received from the Association for Professionals in Infection Control and Epidemiology, Inc. reiterates the comments above concerning the deletion of R9-10-229(A)(7)(a). APIC recommends that TB testing for physicians belongs as a public function that should be required of all physicians, not only those with privileges at hospitals, and should not be the responsibility of the hospitals.	The Department has made changes to the infection control section as discussed above. As the agency responsible for licensing and regulating health care facilities and protecting the health and safety of Arizonans, the Department believes that the hospitals are the appropriate place for TB testing physicians. Hospitals have been TB testing all non-medical staff for more than 20 years. Please see additional discussion on pages 19-21.
Letter commenting on the definition of environmental services - should be reworded to remove ambiguity and the larger than intended scope. Recommends "means activities such as housekeeping, laundry, facility and equipment maintenance and excludes administrative, financial, and healthcare related activities." R9-10-202(A)(1)(a) – instead of requiring that a hospital provide the number of inpatient beds for each organized service, should list the nursing units for which the hospital must provide the number of inpatient beds and list all of the areas with licensed inpatient beds in the definition section.	The Department has modified the definition of "environmental services" by deleting the exclusions in the definition. The modified definition is more clear and concise, and reads "environmental services means activities such as housekeeping, laundry, facility and equipment maintenance". The Department is not making changes in response to this comment. A.R.S. § 36-401 defines licensed capacity and 9 A.A.C. 10, Article 1 describes the licensing process of all health care institutions. Application requirements specific only to a hospital license can be found in these rules under Application Requirements and specifies the number of inpatient beds requested in each organized service. The Department does not specify licensed bed categories because the categories often change which would render the rule obsolete.

Recommends amending R9-10-203(C)(6)(f). Believes it is unclear whether if patient informed consent is given, a pattern of failure to provide hospital services resulting in risk to a patient is acceptable.	The Department is not making any changes in response to this comment. The Department, the Department's Assistant Attorney General and attorneys representing the Hospital Association and various hospitals did not interpret this requirement as commenter suggested nor would the Department enforce it as such.
R9-10-206(3) the language in the current rule "prior to employment" was removed and not replaced with a time-frame so it is unclear whether personnel can work up to 12 months before submitting the evidence of freedom from infectious pulmonary TB required in R9-10-229(4).	The Department has modified the language in R9-10-206(3) by adding the phrase "before the initial date of work or volunteer service" to clarify when the time-frame begins.
R9-10-229(A)(4)(C) and (A)(2)(C). Believes these TB requirements for medical staff are difficult in that it is unclear whether a medical staff member who is at high risk for TB exposure at one facility and at low risk for TB exposure at another facility where he/she practices infrequently, would be required to be TB tested every 24 months at the facility with the low risk even though personnel are aware that he/she practices at another facility that is at high risk of exposure. Feels the burden of TB screening of medical staff should not be placed on the hospitals. Questions whether physicians practicing solely in an outpatient setting will be subject to TB screening and whether it would be better if all physicians, not just those practicing in hospitals, were screened for TB.	The Department is not making changes to this comment. The Department believes that it is not the responsibility of a hospital to monitor a medical staff member's risk of exposure while working at other hospitals. If the outpatient setting is part of a hospital, a physician practicing in this setting also is required to be TB screened. As new rules are written for classes and subclasses of health care institutions, this requirement will be included.
R9-10-229(A)(7) Infection Control. It is not possible to track all community-acquired infections that enter the hospital and the rule should require priority directed, site specific surveillance as recommended by the Centers for Disease Control and Prevention and the Association for Professionals in Infection Control and Epidemiology.	The Department has made a change in response to this comment. Please see the Department's comment on page 23 of this document.
R9-10-232(A)(4) is unclear and suggest "Hospital premises that are leased from another entity must be used exclusively by the licensee."	The Department has rewritten this requirement to read "Any part of the licensed hospital premises is not leased to or used by another person" to clarify that 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.

B. Second Comment Period – Supplemental Proposed Rulemaking

Public Comment	ADHS Response
A written comment was received after the Notice of Supplemental Proposed Rulemaking was published in the Arizona Administrative Register concerning the modification made to the proposed rules deleting the term "general" from anesthesia services in Section R9-10-215. The change from "general anesthesia" to "anesthesia" has significant implications. While only an anesthesiologist or nurse anesthetist performs general anesthesia, other forms of anesthesia are administered by other practitioners such as in the Emergency Department. The documentation requirements would be onerous for many forms of anesthesia such as locals. The requirements are no longer limited to the anesthesia provided in the operating room and would include anesthesia provided for any surgical service in the hospital.	The Department has made a change to the rules as a result of this comment. The Department's intent was to ensure that the requirements in the anesthesia services section applied only to anesthesia provided with surgical services performed in the operating room. If these requirements applied to all forms of anesthesia provided for surgical services in the hospital, the administrative burden and financial impact on hospitals would be tremendous. Therefore, the Department has added "performed in the operating room" to limit compliance to anesthesia services provided in the operating room and decrease the burden on hospitals.
A written comment was also received concerning the outpatient medical records requirements in R9-10-228(D). Specifically, not all outpatients are asked about allergies, sensitivities, or medications the outpatient may be taking if the outpatient services do not require the information.	The Department has made a change to the rules as a result of this comment. Specifically, the phrase "if necessary for treatment" has been added to subsection (D)(1)(e) which now reads "Any known allergy including medication or biological allergies or sensitivities, if necessary for treatment." In addition, the phrase "if necessary for treatment" has been added to subsection (D)(2) which now reads "If necessary for treatment, medication information that includes..." The addition of this phrase to the outpatient medical record requirements decreases the administrative requirements. The medication information is not necessary for many outpatient services. This information is necessary if a patient is required to ingest substances or receive substances topically or intravenously. For those patients that present for outpatient treatment such as a speech therapy assessment or a mammogram, the information about allergies, sensitivities, and medications is not necessary for treatment.

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

Not applicable

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

None

14. Was the rule previously made as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 2. ~~GENERAL~~ HOSPITALS

Section

R9-10-213. ~~Administration~~ Transfer
R9-10-214. ~~Medical Staff~~ Surgical Services
R9-10-215. ~~Nursing Services~~ Anesthesia Services
R9-10-216. ~~Surgical Services~~ Emergency Services
R9-10-217. ~~Dietetic Services~~ Pharmaceutical Services
R9-10-218. ~~Emergency Services~~ Clinical Laboratory Services and Pathology Services
R9-10-219. ~~Disaster Preparedness~~ Radiology Services and Diagnostic Imaging Services
R9-10-220. ~~Environmental Services~~ Intensive Care Services
R9-10-221. ~~Medical Records Services~~ Respiratory Care Services
R9-10-222. ~~Laboratory Services~~ Perinatal Services
R9-10-223. ~~Pharmaceutical Services~~ Pediatric Services
R9-10-224. ~~Rehabilitation Services~~ Psychiatric Services
R9-10-225. ~~Quality Assurance~~ Rehabilitation Services
R9-10-226. ~~Radiology Services~~ Social Services
R9-10-227. ~~Respiratory Care Services~~ Dietary Services
R9-10-228. ~~Special Care Units~~ Medical Records
R9-10-229. ~~Obstetrical Services~~ Infection Control
R9-10-230. ~~Pediatric Services~~ Environmental Services
R9-10-231. ~~Social Services~~ Disaster Management
R9-10-232. ~~Hospital Physical Plant~~ Physical Plant Standards
R9-10-233. ~~Rates and Charges~~ Effective Date

ARTICLE 3. ~~RURAL GENERAL HOSPITALS~~ REPEALED

Section
R9-10-311. ~~General~~ Repealed
R9-10-312. ~~Definitions~~ Repealed
R9-10-313. ~~Administration~~ Repealed
R9-10-314. ~~Medical staff~~ Repealed
R9-10-315. ~~Nursing services~~ Repealed
R9-10-316. ~~Surgical services~~ Repealed
R9-10-317. ~~Dietetic services~~ Repealed
R9-10-318. ~~Emergency services~~ Repealed
R9-10-319. ~~Disaster preparedness~~ Repealed
R9-10-320. ~~Environmental services~~ Repealed
R9-10-321. ~~Medical records services~~ Repealed
R9-10-322. ~~Laboratory services~~ Repealed
R9-10-323. ~~Pharmaceutical services~~ Repealed
R9-10-324. ~~Rehabilitation services~~ Repealed
R9-10-325. ~~Quality assurance~~ Repealed
R9-10-326. ~~Radiology services~~ Repealed
R9-10-327. ~~Respiratory care services~~ Repealed
R9-10-328. ~~Special care units~~ Repealed
R9-10-329. ~~Obstetrical services~~ Repealed
R9-10-330. ~~Pediatric services~~ Repealed
R9-10-331. ~~Social services~~ Repealed
R9-10-332. ~~Rural general hospital physical plant~~ Repealed
R9-10-333. ~~Rates and charges~~ Repealed

ARTICLE 4. ~~SPECIAL HOSPITALS~~ REPEALED

Section
R9-10-411. ~~General~~ Repealed
R9-10-412. ~~Definitions~~ Repealed
R9-10-413. ~~Administration~~ Repealed
R9-10-414. ~~Medical staff~~ Repealed
R9-10-415. ~~Nursing services~~ Repealed
R9-10-416. ~~Surgical services~~ Repealed
R9-10-417. ~~Dietetic services~~ Repealed
R9-10-418. ~~Emergency services~~ Repealed
R9-10-419. ~~Disaster preparedness~~ Repealed
R9-10-420. ~~Environmental services~~ Repealed

R9-10-421. ~~Medical records~~ Repealed
R9-10-422. ~~Laboratory services~~ Repealed
R9-10-423. ~~Pharmaceutical services~~ Repealed
R9-10-424. ~~Rehabilitation services~~ Repealed
R9-10-425. ~~Quality assurance~~ Repealed
R9-10-426. ~~Radiology services~~ Repealed
R9-10-427. ~~Respiratory care services~~ Repealed
R9-10-428. ~~Special care units~~ Repealed
R9-10-429. ~~Obstetrical services~~ Repealed
R9-10-430. ~~Pediatric services~~ Repealed
R9-10-431. ~~Social services~~ Repealed
R9-10-432. ~~Hospital physical plant~~ Repealed
R9-10-433. ~~Rates and charges~~ Repealed
R9-10-434. ~~License application~~ Repealed
R9-10-435. ~~Special hospitals that limit admission to patients requiring pain and stress services~~ Repealed
R9-10-436. ~~Special hospitals that limit admission to patients requiring psychiatric services~~ Repealed
R9-10-437. ~~Special hospitals limiting admissions to patients requiring services in rehabilitation medicine~~ Repealed
R9-10-438. ~~Special hospitals limiting admissions to patients requiring substance abuse services~~ Repealed

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, Chapter 10, Article 1, the following definitions apply in this Article:

1. "Accredited" has the same meaning as in A.R.S. § 36-422(I).
2. "Activities of daily living" means bathing, dressing, grooming, eating, ambulating, and 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 hospital services.
10. "Attending physician" means a physician with clinical privileges who is accountable 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 on the document or 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 in this Article.
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. "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 of a human being, or for the assessment of the health of a human being, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.

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.
18. "Communicable disease" has the same meaning as in A.A.C. R9-6-101.
19. "Consultation" means an evaluation of a patient requested by a medical staff member.
20. "Contracted services" means hospital services provided according to a written agreement between a hospital and the person providing the hospital services.
21. "Controlled substance" has the same meaning as in A.R.S. § 36-2501.
22. "Current" means up-to-date and extending to the present time.
23. "Device" has the same meaning as in A.R.S. § 32-1901.
24. "Diet" means food and drink provided to a patient.
25. "Diet manual" means a written compilation of diets.
26. "Dietary services" means providing food and drink to a patient according to an order.
27. "Disaster" means an unexpected adverse occurrence that affects a hospital's ability to provide hospital services.
28. "Discharge" means a hospital's termination of hospital services to an inpatient or an outpatient.
29. "Discharge instructions" means written information relevant to a patient's medical condition provided by a hospital to the patient at the time of discharge.
30. "Discharge planning" means a process of establishing goals and objectives for an inpatient in preparation for the inpatient's discharge.
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.
32. "Documentation" or "documented" means information in written, photographic, electronic, or other permanent form.
33. "Drill" means a response to a planned, simulated event.
34. "Drug" has the same meaning as in A.R.S. § 32-1901.
35. "Drug formulary" means a written compilation of medication developed according to R9-10-217.
36. "Electronic" has the same meaning as in A.R.S. § 44-7002.
37. "Electronic signature" has the same meaning as in A.R.S. § 44-7002.
38. "Emergency" means an immediate threat to the life or health of a patient.
39. "Emergency services" means unscheduled medical services provided in a designated area to an outpatient in an emergency.
40. "Environmental services" means activities such as housekeeping, laundry, and facility and equipment maintenance.
41. "Exploitation" has the same meaning as in A.R.S. § 46-451.
42. "General hospital" means a subclass of hospital that provides surgical services and emergency services.
43. "Gynecological services" means medical services for the diagnosis, treatment, and management of conditions or diseases of the female reproductive organs or breasts.
44. "Health care directive" has the same meaning as in A.R.S. § 36-3201.
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.
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.
47. "Hospital services" means medical services, nursing services, and other health-related services provided in a hospital.
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.
49. "Infection control risk assessment" means determining the risk for transmission of communicable diseases.
50. "Informed consent" means advising a patient of a proposed medical procedure, alternatives to the medical procedure, associated risks, and possible complications, and obtaining authorization of the patient or the patient's representative for the procedure.
51. "Inpatient" means an individual who:
    a. Is admitted to a hospital; or
    b. Receives hospital services for 24 consecutive hours or more.
52. "Inservice education" means organized instruction or information related to hospital services provided to a personnel member or a medical staff member.
53. "Intensive care services" means hospital services provided to an inpatient who requires the services of specially trained nursing and other personnel members as specified in hospital policies and procedures.
54. "Interval note" means documentation updating a patient's medical condition after a medical history and physical examination are performed.
55. "License" means 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.

56. "Manage" means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.
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.
58. "Medical record" has the same meaning as in A.R.S. § 12-2291.
59. "Medical staff member" means a physician or other licensed individual who has clinical privileges in a hospital.
60. "Medical staff bylaws" means standards, approved by the medical staff and governing authority, that provides the framework for the organization, responsibilities and self-governance of the medical staff.
61. "Medical staff regulations" means standards, approved by the medical staff, that govern the day-to-day conduct of the medical staff members.
62. "Medication" has the same meaning as drug.
63. "Monitor" or "monitoring" means observing a patient's medical condition.
64. "Neonate" means an individual:
    a. From birth until discharge following birth; or
    b. Who is designated as a neonate by hospital criteria.
65. "Nurse" has the same meaning as registered nurse or practical nurse as defined in A.R.S. § 32-1601.
66. "Nurse anesthetist" means a registered nurse who meets the requirements of A.R.S. § 32-1661 and who has clinical privileges to administer anesthesia.
67. "Nurse executive" means a registered nurse accountable for the direction of nursing services provided in a hospital.
68. "Nursery" means an area in a hospital designated only for neonates.
69. "Nurse supervisor" means a registered nurse accountable for managing nursing services provided in an organized service in a hospital.
70. "Nursing personnel" means an individual authorized by hospital policies and procedures to provide nursing services to a patient.
71. "Nutrition assessment" means a process for determining a patient's dietary needs using information contained in the patient's medical record.
72. "On call" means a time during which an individual is available and required to come to a hospital when requested by the hospital.
73. "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. "Organized service" means specific medical services, such as surgical services or emergency services, provided in an area of a hospital designated for the provision of those medical services.
75. "Orientation" means the initial instruction and information provided to an individual starting work in a hospital.
76. "Outpatient" means an individual who:
    a. Is not admitted to a hospital; or
    b. Receives hospital services for less than 24 consecutive hours.
77. "Pathology" means an examination of human tissue for the purpose of diagnosis or treatment of an illness or disease.
78. "Patient" means an individual receiving hospital services.
79. "Patient care" means hospital services provided to a patient by a personnel member or a medical staff member.
80. "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 as defined in A.R.S. § 36-3201.
81. "Pediatric" means pertaining to an individual designated by a hospital as a child based on the hospital's criteria.
82. "Perinatal services" means medical services for the treatment and management of obstetrical patients and neonates.
83. "Person" has the same meaning as in A.R.S. § 1-215 and includes governmental agencies.
84. "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. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.
86. "Physical examination" means to observe, test, or inspect an individual's body to evaluate health or determine cause of illness or disease.
87. "Postanesthesia care unit" means a designated area for monitoring a patient following a medical procedure for which anesthesia was administered to the patient.
88. "Private duty staff" means an individual, excluding a personnel member, compensated by a patient or the patient's representative.
89. "Psychiatric services" means the diagnosis, treatment, and management of mental illness.

90. "Quality management program" means activities designed and implemented by a hospital to improve the delivery of hospital services.
91. "Registered dietitian" means an individual approved to work as a dietitian by the American Dietetic Association's Commission on Dietetic Registration.
92. "Rehabilitation services" means medical services provided to a patient to restore or to optimize functional capability.
93. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.
94. "Respiratory care services" has the same meaning as practice of respiratory care as defined in A.R.S. § 32-3501.
95. "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. "Require" means to carry out an obligation imposed by this Article.
97. "Risk" means potential for an adverse outcome.
98. "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 that elects to be licensed as a rural general hospital rather than a general hospital.
99. "Satellite facility" has the same meaning as in A.R.S. § 36-422(I).
100. "Seclusion" means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.
101. "Shift" means the beginning and ending time of a work period established by hospital policies and procedures.
102. "Single group license" means a license that includes authorization to operate health care institutions according to A.R.S. § 36-422(F) and (G).
103. "Social services" means assistance, other than medical services, provided by a personnel member to a patient to meet the needs of the patient while in the hospital or the anticipated needs of the patient after discharge.
104. "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. "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. "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. "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. "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. "Telemedicine" has the same meaning as in A.R.S. § 36-3601.
110. "Transfer" means a hospital discharging a patient and sending the patient to another hospital for inpatient medical services without the intent that the patient will be returned to the sending hospital.
111. "Transfusion" means the introduction of blood or blood products from one individual into the body of another individual.
112. "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. "Treatment" means a procedure or method to cure, improve, or palliate an injury, an illness, or a disease.
114. "Unit" means a designated area of an organized service.
115. "Verification" means:
    a. A documented telephone call including the information obtained, the date, and the name of the documenting individual;
    b. A documented observation including the information observed, 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. "Vital records" has the same meaning as in A.R.S. § 36-301.
117. "Vital statistics" has the same meaning as in A.R.S. § 36-301.
118. "Volunteer" means an individual, except a student, authorized by a hospital to work in the hospital who does not receive compensation.
119. "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.

R9-10-202. ~~Reserved~~ Application Requirements

A. In addition to the license application requirements in A.R.S. § 36-422 and A.A.C. Title 9, Chapter 10, Article 1, a governing authority applying for an initial or renewal license shall submit the following to the Department:
1. For a hospital license:
   a. A statement on a form provided by the Department of the licensed capacity requested for the hospital, including the number of inpatient beds for each organized service, not including well-baby bassinets.
   b. A list on a form provided by the Department of medical staff specialties and subspecialties; and
   c. A copy of an accreditation report if the hospital is accredited and chooses to submit a copy of the report instead of receiving a license inspection by the Department in compliance with A.R.S. § 36-424(C).
2. For a single group license authorized in A.R.S. § 36-422(F) or (G):
   a. The items listed in subsection (A)(1); and
   b. A form provided by the Department that includes:
      i. The name, address, and telephone number of each accredited facility under the single group license;
      ii. The name of the administrator for each accredited facility; and
      iii. The specific times each accredited facility provides medical services.

B. An administrator shall:
1. Notify the Department when there is a change in administrator according to A.R.S. § 36-425(E);
2. Notify the Department at least 30 days before an accredited facility on a single group license terminates operations; and
3. Submit an application, according to the requirements in A.A.C. Title 9, Chapter 10, Article 1, at least 60 days but not more than 120 days before an accredited facility licensed under a single group license anticipates providing medical services under a license separate from the single group license.

R9-10-203. ~~Reserved~~ Administration

A. A governing authority shall:
1. Consist of one or more individuals accountable for the organization, operation, and administration of a hospital;
2. Determine which organized services are to be provided in the hospital;
3. Appoint an administrator in writing who has:
   a. A baccalaureate degree or a post-baccalaureate degree in a health care-related field; and
   b. At least three years of experience in health care administration;
4. Approve hospital policies and procedures or designate an individual to approve hospital policies and procedures;
5. Approve medical staff bylaws and medical staff regulations;
6. Approve contracted services or designate an individual to approve contracted services;
7. Grant, deny, suspend, or revoke a clinical privilege of a medical staff member or delegate authority to an individual to grant or suspend a clinical privilege for a limited time, according to medical staff bylaws;
8. Adopt a quality management program according to R9-10-204;
9. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
10. Appoint an acting administrator if the administrator is expected to be absent for more than 30 days;
11. Except if subsection (A)(10) applies, notify the Department in writing within five working days if there is a change of administrator and identify the name and qualifications of the new administrator;
12. For a health care institution under a single group license, comply with the applicable requirements in A.A.C. Title 9, Chapter 10 and Chapter 20 for the class or subclass of the health care institution; and
13. Comply with federal and state laws, rules, and local ordinances governing operations of a health care institution.

B. An administrator shall:
1. Be directly accountable to the governing authority for all hospital services and environmental services provided by a hospital;
2. Have the authority and responsibility to manage the hospital;
3. Act as a liaison between the governing authority and personnel; and
4. Designate, in writing, an individual who is available and accountable for hospital services and environmental services when the administrator is not available;

C. An administrator shall require that:
1. Hospital policies and procedures are established, documented, and implemented that:
   a. Include personnel job descriptions, duties, and qualifications;
   b. Cover orientation and inservice education for personnel, volunteers, and students;
   c. Include duties of volunteers and students;
   d. Cover cardiopulmonary resuscitation training required in R9-10-206(6) including:
      i. The method and content of cardiopulmonary resuscitation training;
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
      iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
      iv. The documentation that verifies personnel have received cardiopulmonary resuscitation training;

e. Cover use of private duty staff, if applicable;
f. Cover diversion, including:
i. The criteria for initiating diversion;
ii. The categories or levels of personnel or medical staff that may authorize or terminate diversion;
iii. The method for notifying emergency medical services providers of initiation of diversion, the type of diversion, and termination of diversion; and
iv. When the need for diversion will be reevaluated;
g. Include a method to identify a patient to ensure the patient receives medical services as ordered;
h. Cover patient rights;
i. Cover health care directives;
j. Cover medical records, including electronic medical records;
k. Cover quality management, including incident documentation;
l. Cover tissue and organ procurement and transplant; and
m. Cover hospital visitation, including visitations to a nursery, if applicable;
2. Hospital policies and procedures for hospital services are established, documented, and implemented that:
a. Cover patient admission, transport, transfer, discharge planning, and discharge;
b. Cover acuity;
c. Include when informed consent is required;
d. Include the age criteria for providing hospital services to pediatric patients;
e. Cover dispensing, administering, and disposing of medication and biologicals;
f. Cover infection control;
g. Cover restraints that require an order, including the frequency of monitoring and assessing the restraint;
h. Cover seclusion of a patient including:
i. The requirements for an order, and
ii. The frequency of monitoring and assessing a patient in seclusion;
i. Cover telemedicine, if applicable; and
j. Cover environmental services that affect patient care;
3. Hospital policies and procedures are reviewed at least once every 36 months and updated as needed;
4. Hospital policies and procedures are available to personnel and medical staff;
5. Licensed capacity in an organized service is not exceeded except for an emergency admission of a patient. If the licensed capacity of an organized service is exceeded:
a. A medical staff member reviews the medical history of a patient scheduled to be admitted to the organized service to determine whether the admission is an emergency; and
b. A patient is not admitted to the organized service except in an emergency;
6. A patient is free from:
a. The intentional infliction of physical, mental, or emotional pain unrelated to the patient's medical condition;
b. Exploitation;
c. Seclusion or restraint if not medically indicated or necessary to prevent harm to self or others;
d. Sexual abuse according to A.R.S. § 13-1404;
e. Sexual assault according to A.R.S. § 13-1406; and
f. A pattern of failure to provide hospital services without the informed consent of the patient or the patient's representative that results or may result in risk to the health and safety of the patient as determined by:
i. The number of incidents;
ii. How the incidents are related to each other;
iii. When the incidents occurred; and
iv. The amount of time between the incidents.

D. An administrator of a special hospital shall require that:
1. Medical services are available to an inpatient in an emergency based on the inpatient's medical conditions and the type of medical services provided by the special hospital; and
2. A physician or a nurse, qualified in cardiopulmonary resuscitation, is on the hospital premises at all times.

R9-10-204. ~~Reserved~~ Quality Management

A. A governing authority shall require that an ongoing quality management program is established that:
1. Complies with the requirements in A.R.S. § 36-445; and
2. Evaluates the quality of hospital services and environmental services related to patient care, including contracted services.

B. An administrator shall require that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate hospital services and environmental services related to patient care;
   c. A method to evaluate the data collected to identify a concern about the delivery of hospital services;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of hospital services; and
   e. The frequency of submitting a documented report required in subsection (B)(2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern; and
   b. Any changes made or actions taken as a result of the identification of a concern;
3. The report required in subsection (B)(2) and the supporting documentation for the report are:
   a. Maintained on the hospital premises for 12 months from the date the report is submitted to the governing authority; and
   b. Except for information or documents that are confidential under federal or state law, provided to the Department for review as soon as possible after a Department request but not more than four hours from the time of the request.

R9-10-205. ~~Reserved~~ Contracted Services

An administrator shall require that:
1. Contracted services are provided according to the requirements in this Article;
2. A contract includes the responsibilities of each contractor;
3. A documented list of current contracted services is maintained at the hospital that includes a description of the contracted services provided; and
4. A contract and the list of contracted services required in subsection (3) is provided to the Department for review as soon as possible after a Department request but not more than four hours from the time of the request.

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 providing hospital services or volunteer service, a personnel member submits one of the following as evidence of freedom from infectious pulmonary tuberculosis according to the requirements in R9-10-229(A)(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 for the position held by the personnel member;
   b. The personnel member's starting date;
   c. Verification of a personnel member's certification, license, or education, if necessary for the position held;
   d. Verification of current cardiopulmonary resuscitation qualifications, if necessary for the position held; 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 for at least two years after the last date the personnel member worked; and
11. Personnel records and inservice education documentation are provided upon request to the Department for review:
    a. For a current personnel member, as soon as possible but not more than four hours from the time of the Department's request; and
    b. For a personnel member who is 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 a patient in a hospital;
2. The medical staff bylaws and medical staff regulations are approved according to the medical staff bylaws and governing authority requirements;
3. A medical staff member complies with medical staff bylaws and medical staff regulations;
4. The medical staff of 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 medical staff of 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 a committee according to subsection (A)(7)(c);
6. A medical staff member is available to direct patient care;
7. Medical staff bylaws or 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 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;
   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 for medical staff members; 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 of and, if applicable, the adverse reaction to an investigational medication or device;
8. The organized medical staff reviews the medical staff bylaws and the medical staff regulations at least once every 36 months and updates the bylaws and regulations as needed.

B. An administrator shall require that:
1. By October 1, 2003, 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(A)(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 under subsection (B)(2) 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.

R9-10-208. ~~Reserved~~ Nursing Services

A. An administrator shall:
1. Require that nursing services are provided 24 hours a day; and
2. Appoint a nurse executive who is qualified according to the requirements specified in the hospital's policies and procedures.

B. A nurse executive shall designate a registered nurse who is present in the hospital to be accountable for managing the nursing services when the nurse executive is not present in the hospital.

C. A nurse executive shall require that:
1. Policies and procedures for nursing services are established, documented, and implemented;
2. An acuity plan is established and documented to determine the types and numbers of nursing personnel necessary to provide nursing services to meet the needs of the patients;
3. The acuity plan in subsection (C)(2) is implemented;
4. There is a minimum of one registered nurse on duty in a hospital at all times whether or not there is a patient;
5. A general hospital has two registered nurses on duty at all times when there is more than one patient;
6. A special hospital that is licensed to provide behavioral health services complies with the staffing requirements in A.A.C. Title 9, Chapters 10 and 20;
7. A special hospital offering emergency services or obstetrical services has two registered nurses on duty at all times when there is more than one patient;
8. A special hospital not offering emergency services or obstetrical services has at least one registered nurse and one other nurse on duty at all times when there is more than one patient;
9. A rural general hospital with more than one patient has one registered nurse and at least one other nursing personnel on duty at all times. If there is only one registered nurse in the hospital, an additional registered nurse is on call who is able to be present in the hospital within 15 minutes of being called;
10. If a hospital has a patient in a unit, there is a minimum of one registered nurse in the unit at all times;
11. If a hospital has more than one patient in a unit, there is a minimum of one registered nurse and one additional nursing personnel in the unit at all times;
12. At least one registered nurse is present and accountable for the nursing services provided to a patient:
    a. During the delivery of a neonate,
    b. In an operating room, and
    c. In a postanesthesia care unit;
13. Nursing personnel work schedules are planned, reviewed, adjusted, and documented to meet patient needs and emergencies;
14. A registered nurse assesses, plans, directs, and evaluates nursing services provided to a patient;
15. There is a care plan for each inpatient based on the inpatient's need for nursing services; and
16. Nursing personnel document nursing services in a patient's medical record.

R9-10-209. ~~Reserved~~ Patient Rights

An administrator shall require that:
1. A patient:
   a. Is treated with consideration, respect, and dignity, and receives privacy in treatment and activities of daily living; and
   b. Has access to a telephone;
2. A patient or the patient's representative:
   a. Either consents to or refuses treatment, if capable of doing so;
   b. May refuse examination, or withdraw consent for treatment before treatment is initiated;
   c. May submit grievances without retaliation;

d. Is informed of:
   i. The hospital's health care directives policies and procedures;
   ii. How to obtain a schedule of hospital rates and charges required in A.R.S. § 36-436.01(B);
   iii. The hospital's patient grievance policies and procedures, including the telephone number of hospital personnel to contact about grievances, and the Department's telephone number if the hospital is unable to resolve the patient's grievance;
   iv. Except as authorized by the Health Insurance Portability and Accountability Act of 1996, proposed involvement of the patient in research, experimentation, or education, if applicable; and
   v. Proposed medical procedures, alternatives to the medical procedures, associated risks, and possible complications;

3. There are hospital policies and procedures that include:
   a. How and when a patient or the patient's representative is informed of patient rights in subsections (1) and (2); and
   b. Where patient rights are posted in the hospital;
4. A patient or the patient's representative receives a written statement of patient's rights; and
5. Medical record information is disclosed only with the written consent of a patient or the patient's representative or as permitted by law.

R9-10-210. ~~Reserved~~ Admission

An administrator shall require that:

1. A patient is admitted on the order of a medical staff member;
2. An individual, authorized by hospital policies and procedures, is available at all times to accept a patient for admission;
3. Except in an emergency, informed consent is obtained from a patient or the patient's representative before or at the time of admission;
4. The informed consent obtained in subsection (3) or the lack of consent in an emergency is documented in the patient's medical record;
5. A physician or other medical staff member performs a medical history and physical examination on a patient within 30 days before admission or within 48 hours after admission and documents the medical history and physical examination in the patient's medical record within 48 hours of admission;
6. If a physician or a medical staff member performs a medical history and physical examination on a patient before admission, the physician or the medical staff member enters an interval note into the patient's medical record at the time of admission.

R9-10-211. ~~General~~ Discharge Planning; Discharge

~~**A.** General hospitals to which these requirements apply shall be subject to inspection by personnel of the Department as provided in A.R.S. §§ 36-406 and 36-424. Department personnel are prohibited by A.R.S. § 36-404 from disclosing patient records or any information from which a patient or his family might be identified, or sources of information which cause the Department to believe that an inspection is needed to determine whether an institution is in compliance with the provisions of this Chapter and the regulations thereunder.~~

~~**B.** When a service has been contracted for, the hospital administration shall assure that the supplier is meeting the same standards of quality the hospital would have to meet if services were provided by the hospital.~~

~~**C.** Regulations contained in this Article shall not be construed to compel any patient to submit to any examination or treatment, however, all requirements for the control of communicable disease and sanitation must be met.~~

A. For an inpatient, an administrator shall require that discharge planning:
1. Identifies the specific needs of the patient after discharge, if applicable;
2. Includes the participation of the patient or the patient's representative;
3. Is completed before discharge occurs;
4. Provides the patient or the patient's representative with written information identifying classes or subclasses of health care institutions and the level of care that the health care institutions provide that may meet the patient's assessed and anticipated needs after discharge, if applicable; and
5. Is documented in the patient's medical record.

B. For an inpatient discharge, an administrator shall require that:
1. There is a discharge summary that includes:
   a. A description of the patient's medical condition and the medical services provided to the patient; and
   b. The signature of the patient's attending physician or the attending physician's designee;
2. There is a documented discharge order by an attending physician or the attending physician's designee before discharge unless the patient leaves the hospital against a medical staff member's advice; and

3. If the patient is discharged to any location other than a health care institution:
   a. There are documented discharge instructions; and
   b. The patient or the patient's representative is provided with a copy of the discharge instructions;

C. Except as provided in subsection (D), an administrator shall require that an outpatient is discharged according to hospital policies and procedures.

D. For a discharge of an outpatient receiving emergency services, an administrator shall require:
1. A discharge order is documented by an attending physician or the attending physician's designee before the patient is discharged unless the patient leaves against a medical staff member's advice; and
2. Discharge instructions are documented and provided to the patient or the patient's representative before the patient is discharged unless the patient leaves the hospital against a medical staff member's advice.

E. A patient transferred to another hospital is exempt from the requirements in this Section. An administrator shall require that a transfer of a patient to another hospital complies with the requirements in R9-10-213.

R9-10-212. ~~Definitions~~ Transport

~~Unless the context otherwise requires:~~

~~1. "Ancillary nursing personnel" means persons employed to assist registered nurses or licensed practical nurses in the care of patients.~~
~~2. "Anesthesiologist" means a physician whose specialized training and experience qualify him to administer anesthetic agents and to monitor patients under the influence of these agents.~~
~~3. "Anesthetist" means a physician or dentist qualified by experience to administer anesthetic agents or a registered nurse who meets the requirements of A.R.S. § 32-1661.~~
~~4. "Audiologist" means a person who has been granted a Certificate of Clinical Competence in audiology by the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who has completed the academic program and is in the process of accumulating the supervised work experience required to qualify for such a certificate.~~
~~5. "Audiology services" means those diagnostic, screening, preventive or other services provided by or under the supervision of an audiologist within the scope of practice of his profession.~~
~~6. "Chief executive officer" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the hospital.~~
~~7. "Dentist" means a person so licensed under the provisions of A.R.S. Title 32, Chapter 11.~~
~~8. "Dietitian" means a person who meets the standards and qualifications established by the Commission on Dietetic Registration under the requirements in effect March 9, 1976.~~
~~9. "Department" means Department of Health Services.~~
~~10. "Direct nursing care" means the provision of preventative, curative, rehabilitative and health-related services directly to patients on a nursing unit by nursing personnel under the supervision of a registered nurse.~~
~~11. "Direction" means authoritative policy or procedural guidance for the accomplishment of a function or activity.~~
~~12. "Director" means the Director of the Department of Health Services.~~
~~13. "Director of nursing" means a registered nurse with supervisory and administrative ability who is responsible to the chief executive officer for supervision of nursing service for the entire facility for all shifts.~~
~~14. "Food service director" means a person who is a dietitian or a graduate of a dietetic technician, dietetic assistant or food service supervisor training program, correspondence school or classroom, approved by the American Dietetic Association; or who has training and experience in food service supervision and management equivalent to 1 of these programs.~~
~~15. "General hospital" means a subclass of hospital which provides inpatient beds and other hospital services, both surgical and non-surgical, to patients who have any of a variety of medical conditions.~~
~~16. "Governing authority" means the individual, agency or group or corporation appointed, elected or otherwise designated in which the ultimate authority and responsibility for the conduct of the hospital is vested.~~
~~17. "Hospital" means a class of health care institution which provides, through an organized medical or professional staff, services that include, but are not limited to, inpatient beds, medical services and continuous nursing services for the diagnosis and treatment of patients.~~
~~18. "Infirmary" is a subclass of hospital having fewer than 50 inpatient beds providing limited hospital services to a distinct population such as an entire isolated community, the staff and students of a school, the members of an association or wards of a public agency.~~
~~19. "Licensed bed" means an individual patient care unit including a bed, nurse call system and related furniture, equipment and space as specified in these regulations.~~
~~20. "Licensed bed capacity" means the number of adult and pediatric beds specified on the hospital's license, and does not include bassinets, labor or recovery beds.~~
~~21. "Licensed nursing personnel" means registered and licensed practical nurses.~~
~~22. "Licensed practical nurse" means a person so licensed under the provisions of A.R.S. Title 32, Chapter 15.~~

~~23. "Medical staff" means physicians, dentists and other practitioners of the healing arts who are privileged by agreement with the hospital as defined in the hospital's medical staff by-laws to attend patients.~~
~~24. "New construction" means new buildings, addition to existing buildings, conversion of existing buildings or portions thereof or portions of buildings undergoing modification other than repair.~~
~~25. "Nurse practitioner" means a registered nurse certified by the Arizona State Board of Nursing to function as a nurse practitioner in the extended role under the provisions of A.R.S. Title 32, Chapter 15.~~
~~26. "Nursing unit" means an organized jurisdiction of nursing services such as nurses' station, special care unit, or outpatient clinic providing services to patients.~~
~~27. "Occupational therapist" means a person who is registered by or meets the requirements for registration by the American Occupational Therapy Association.~~
~~28. "Occupational therapy services" means those services provided by or under the supervision of an occupational therapist within the scope of the practice of his profession.~~
~~29. "Outpatient surgical center" is a subclass of outpatient treatment center with facilities and limited hospital services for the diagnosis or treatment of patients by surgery whose recovery, in the concurring opinion of the surgeon and the anesthesiologist, will not require inpatient care.~~
~~30. "Patients room" is a room designated and designed for 1 or more licensed beds, meeting the requirements of these regulations.~~
~~31. "Patient" means a person admitted to or receiving treatment in the hospital.~~
~~32. "Pharmacist" means a person registered under the provisions of A.R.S. Title 32, Chapter 18.~~
~~33. "Physical therapist" means a person registered under the provisions of A.R.S. Title 32, Chapter 19.~~
~~34. "Physical therapy services" means those services provided by or under the supervision of a physical therapist within the scope of the practice of his profession as defined by A.R.S. Title 32, Chapter 19.~~
~~35. "Physician" means a person licensed under the provision of A.R.S. Title 32, Chapter 13 or 17.~~
~~36. "Physician's assistant" means a person certified under the provisions of A.R.S. Title 32, Chapter 25.~~
~~37. "Private duty nurse" is a registered nurse or licensed practical nurse in the employ of the patient or his representative.~~
~~38. "Qualified person" when used in connection with an occupation or position, means a person:~~
~~a. Who is licensed or has certification, registration or other professional recognition, or, if there are no such requirements or standards,~~
~~b. Who has appropriate training, education, or relevant experience and demonstrates through job performance to the satisfaction of the chief executive officer the ability to perform the required functions.~~
~~39. "Registered nurse" means a person so licensed under the provisions of A.R.S. Title 32, Chapter 15.~~
~~40. "Social worker" means a person who has received a baccalaureate degree and has met the requirements of a two-year curriculum in a school of social work that is accredited by the Council on Social Work Education, or has the equivalent of such education and training.~~
~~41. "Special care unit" means a designated area in which there are concentrated qualified and specially trained nursing and ancillary nursing personnel together with the necessary diagnostic, monitoring and special therapeutic equipment needed to provide optimal medical care for critically ill patients.~~
~~42. "Special hospital" is a subclass of hospital which provides hospital services for persons having a specialized medical condition; and which limits admission, care and services to those patients appropriate to the specialties for which it has qualified for licensure.~~
~~43. "Speech therapist" means a person who has been granted the Certificate of Clinical Competence in speech therapy by the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience required for such a certificate, or who has completed the academic program and is in the process of accumulating the supervised work experience required for such a certificate.~~
~~44. "Speech therapy services" means those diagnostic, screening, preventive or other corrective services provided by or under the supervision of a speech therapist within the scope of the practice of his profession.~~
~~45. "Supervision" means direct overseeing and inspection of the act of accomplishing a function or activity.~~
~~46. "Therapist" means a person who is appropriately qualified by training, experience, or both, to apply diagnostic or treatment techniques and procedures for patients under the direction of a physician. Such persons who are required to have an Arizona license to practice their profession shall have the appropriate license.~~
~~47. "Treatment" is the medical, surgical or psychiatric management of a patient or procedure for the cure or amelioration of a disease or pathological condition.~~

A. For a transport of a patient, the administrator of a sending hospital shall require that:
1. Hospital policies and procedures:
   a. Specify the process by which the sending hospital personnel members coordinate the transport and the medical services provided to a patient to protect the health and safety of the patient;
   b. Require an assessment of the patient by a registered nurse or a medical staff member before transporting the patient and after the patient's return;

c. Specify the sending hospital's patient medical records that are required to accompany the patient, which shall include the medical records related to the medical services to be provided to the patient at the receiving health care institution; and
d. Specify how the sending hospital personnel members communicate patient medical record information that the sending hospital does not provide at the time of transport but is requested by the receiving health care institution; and
e. Specify how a medical staff member explains the risks and benefits of transport and obtains consent from the patient or the patient's representative based on the:
i. Patient's medical condition, and
ii. Mode of transport; and

2. Documentation in the patient's medical record includes:
a. The acceptance of the patient by and communication with an individual at the receiving health care institution;
b. The date and the time of the transport to the receiving health care institution;
c. The date and time of the patient's return to the sending hospital, if applicable;
d. The mode of transportation; and
e. The type of professional assisting in the transport if an order requires that a patient be assisted during transport.

B. For a transport of a patient to a receiving hospital, the administrator of the receiving hospital shall require that:

1. Hospital policies and procedures:
a. Specify the process by which the receiving hospital personnel members coordinate the transport and the medical services provided to a patient to protect the health and safety of the patient;
b. Require an assessment of the patient by a registered nurse or a medical staff member upon arrival of the patient and before the patient is returned to the sending hospital;
c. Specify the receiving hospital's patient medical records required to accompany the patient when the patient is returned to the sending hospital, if applicable; and
d. Specify how the receiving hospital personnel members communicate patient medical record information to the sending hospital that is not provided at the time of the patient's return; and

2. Documentation in the patient's medical record includes:
a. The date and time the patient arrives at the receiving hospital;
b. The medical services provided to the patient at the receiving hospital;
c. Any adverse reaction or negative outcome the patient experiences at the receiving hospital, if applicable;
d. The date and time the receiving hospital returns the patient to the sending hospital, if applicable;
e. The mode of transportation to return the patient to the sending hospital, if applicable; and
f. The type of professional assisting in the transport if an order requires that a patient be assisted during transport.

C. A sending hospital and a receiving hospital that are licensed at separate locations and have the same Medicare number issued by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services are exempt from subsections (A)(1)(d), (B)(1)(c), and (B)(1)(d).

R9-10-213. ~~Administration~~ Transfer

~~**A.** Governing authority: The governing authority shall adopt bylaws which identify the purposes of the hospital and the methods of fulfilling them. The governing authority shall appoint a chief executive officer who shall be appropriately qualified for the management of the facility. The chief executive officer shall have authority and responsibility for the operation of the hospital.~~

~~**B.** The chief executive officer shall be directly responsible to the governing authority for the management and operation of the hospital and shall provide liaison between the governing authority and the medical staff.~~

~~1. The chief executive officer shall maintain written definitions of the hospital organization, authority, responsibility and relationships, to provide the hospital with administrative direction.~~
~~2. When there is a planned change of the chief executive officer or ownership, the governing authority of the hospital shall notify the Department at least 30 days prior to the effective date of change. Such changes that cannot be planned in advance shall be reported in writing to the Department immediately.~~
~~3. The admitting office shall have written admission and discharge policies which are consistent with the established purposes of the hospital.~~
~~4. There shall be available at all times an employee authorized to accept patients for admission and to make administrative decisions concerning their disposition.~~
~~5. Inpatients shall be provided, at the time of their admission, a suitable device or method for identification.~~
~~6. Records and reports: The following documents, or copies shall be available in the hospital:~~
~~a. Bylaws of the governing body,~~
~~b. Bylaws and rules and regulations of the medical staff,~~
~~c. Policies and procedures for all established hospital services,~~
~~d. Reports of all inspections and reviews related to licensure for the preceding 5 years together with corrective actions taken,~~

~~e. Contracts and agreements related to licensure to which the hospital is bound,~~
~~f. Appropriate documents evidencing control and ownership,~~
~~g. A current copy of Title 9 Health Care Regulations available from the Office of the Secretary of State:~~

~~Chapter 1, Article 4,~~	~~Codes and Standards referenced~~
~~Chapter 8, Article 1,~~	~~Food and Drink~~
~~Chapter 9, Articles 1,2,3,~~	~~Health Care Institutions: Establishment and Modification~~
~~Chapter 10, Article 1,~~	~~Health Care Institutions: Licensure~~
~~Chapter 11, Articles 1,2,3~~	~~Health Care Institutions: Rates and Charges~~

~~7. The Department recognizes that emergency situations do occur in which a general hospital may temporarily need to exceed its licensed capacity. The medical need to admit patients in excess of licensed bed capacity as indicated by service category as shown on the then current license shall be determined by a committee or other organizational structure of the medical staff. During any period in which the hospital's census exceeds its licensed bed capacity by category of service, it shall suspend all elective admissions to that service until its census is reduced to less than licensed bed capacity of that service category. The exception afforded by this subsection does not exempt a hospital from any other requirement of this Chapter.~~
~~8. Personnel~~
~~a. Personnel records:~~
~~i. A record of each employee shall be maintained which includes the following:~~
~~(1) Employee's identification, including name, address and next of kin,~~
~~(2) Resume of education and work experience,~~
~~(3) Verification of valid license if required, education and training.~~
~~ii. Payroll and attendance records for the preceding 12-month period shall be available for review by Department personnel.~~
~~iii. Every position shall have a written description which describes the duties of the position.~~
~~b. Orientation: New employees shall receive orientation to familiarize them with the facility, its policies, and the responsibilities of the new employee.~~
~~c. In-service training: An in-service training program shall be conducted on a continuing basis for all nursing and dietary personnel. Records shall be maintained that include at least subject matter, attendance and date of training.~~
~~d. An employee whose duties during his normal work shift require him to be awake while on the job, shall not be scheduled to work consecutive shifts.~~
~~e. Health examinations: Prior to employment each employee shall have a general physical examination. An appropriate tuberculosis screening test shall be performed prior to employment and annually or as otherwise appropriate.~~
~~9. Miscellaneous~~
~~a. Pets: There shall be no pets allowed in the patient care and food service areas of the hospital. For the purpose of these regulations, seeing eye dogs are not considered pets.~~
~~b. Telephones: Unless bedside telephones are provided, patients shall have access to a public telephone.~~
~~c. Keys: The person on duty and in charge of the hospital shall have reasonable access to all areas related to patient care and operation of the physical plant.~~
~~d. Privacy: Reasonable privacy shall be provided for all patients.~~

A. For a transfer of a patient, the administrator of a sending hospital shall require that:
1. Hospital policies and procedures:
   a. Specify the process by which the sending hospital personnel members coordinate the transfer and the medical services provided to a patient to protect the health and safety of the patient during the transfer;
   b. Require an assessment of the patient by a registered nurse or a medical staff member of the sending hospital before the patient is transferred;
   c. Specify how the sending hospital personnel members communicate medical record information that is not provided at the time of the transfer;
2. Except in an emergency, a medical staff member obtains informed consent for the transfer;
3. In an emergency, documentation of informed consent or why informed consent could not be obtained is included in the medical record;
4. One of the following accompanies the patient during transfer to the receiving hospital:
   a. A copy of the patient's medical record for the current inpatient admission; or
   b. All of the following for the current inpatient admission:
      i. A medical staff member's summary of medical services provided to the patient;
      ii. A care plan containing up-to-date information;

iii. Consultation reports;
iv. Laboratory and radiology reports;
v. A record of medications administered to the patient for the seven days before the date of transfer;
vi. Medical staff member's orders in effect at the time of transfer; and
vii. Any known allergy; and

5. Documentation in the patient's medical record includes:
   a. The acceptance of the patient by and communication with an individual at the receiving hospital;
   b. The date and the time of the transfer to the receiving hospital;
   c. The mode of transportation; and
   d. The type of professional assisting in the transfer if an order requires that a patient be assisted during transfer.

B. A sending hospital and a receiving hospital that are licensed at separate locations and have the same Medicare number issued by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services are exempt from subsections (A)(1)(c), (A)(4) and (A)(5)(a).

R9-10-214. ~~Medical staff~~ Surgical Services

~~**A.** The hospital shall have an organized medical staff responsible to the governing authority for the quality of medical care provided to patients and for the ethical and professional practices of its members.~~
~~**B.** Patients shall be admitted to the hospital by a member of the medical staff in accordance with medical staff bylaws, and shall be under the general care of a physician.~~
~~**C.** The medical staff of a general hospital shall consist of 2 or more physicians.~~
~~**D.** The medical staff, subject to final action by the governing authority, shall adopt bylaws, rules and policies for the proper conduct of its activities. The medical staff shall recommend to the governing authority, physicians and other licensed practitioners considered eligible for new and continued membership on the medical staff, as delineated in medical staff bylaws. Clinical privileges of each medical staff member shall be delineated in writing.~~
~~**E.** The bylaws shall state the type, purpose, composition and organization of standing committees.~~
~~**F.** The medical staff shall be responsible to assure the availability of inpatient and outpatient physician services in the event of an emergency.~~

A. An administrator of a general hospital shall require that:
1. There is an organized service that provides surgical services under the direction of a medical staff member;
2. There is a designated area for providing surgical services as an organized service;
3. The area of the hospital designated for surgical services is managed by a registered nurse or a physician;
4. Documentation is available in the surgical services area that specifies each medical staff member's clinical privileges to perform surgical procedures in the surgical services area;
5. Postoperative orders are documented in the patient's medical record;
6. There is a chronological log of surgical procedures performed in the surgical services area that contains:
   a. The date of the surgical procedure;
   b. The patient's name;
   c. The type of surgical procedure;
   d. The time in and time out of the operating room;
   e. The name and title of each individual performing or assisting in the surgical procedure;
   f. The type of anesthesia used;
   g. An identification of the operating room used; and
   h. The disposition of the patient after the surgical procedure;
7. The chronological log required in subsection (A)(6) is maintained in the surgical services area for a minimum of 12 months from the date of the surgical procedure and then maintained by the hospital for an additional 12 months;
8. The medical staff designate in writing the surgical procedures that may be performed in areas other than the surgical services area;
9. The hospital has the medical staff members, personnel members, and equipment to provide the surgical procedures offered in the surgical services area;
10. A patient and the surgical procedure to be performed on the patient are identified before initiating the surgical procedure;
11. Except in an emergency, a medical staff member or a surgeon performs a medical history and physical examination within 30 days before performing a surgical procedure on a patient;
12. Except in an emergency, a medical staff member or a surgeon enters an interval note in the patient's medical record before performing a surgical procedure;
13. Except in an emergency, the following are documented in a patient's medical record before a surgical procedure:
    a. A preoperative diagnosis;
    b. Each diagnostic test performed in the hospital;
    c. A medical history and physical examination as required in subsection (A)(11) and an interval note as required in subsection (A)(12);

d. A consent or refusal for blood or blood products signed by the patient or the patient's representative, if applicable; and
e. Informed consent according to hospital policies and procedures; and

14. Within 24 hours after a surgical procedure is completed:
a. The surgeon performing the surgery documents the surgical technique, findings, and tissue removed or altered, if applicable; and
b. The individual performing the postoperative follow-up examination completes a postoperative follow-up report.

B. An administrator of a rural general hospital or a special hospital that provides surgical services shall comply with subsection (A).

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.~~
~~c. 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:

1. Anesthesia services provided in conjunction with surgical services performed in the operating room 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. Except in an emergency, an anesthesiologist or a nurse anesthetist performs a pre-anesthesia evaluation within 48 hours before anesthesia is administered in conjunction with surgical services;
4. Anesthesia administration is documented in a patient's medical record and 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. Post-anesthesia documentation by the individual performing the post-anesthesia evaluation that includes the information required by the medical staff bylaws and medical staff regulations; and
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 risk to the patient 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; and
8. The chronological log required in subsection (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 four 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 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.~~
~~**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 members 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 ordering 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 a pharmacist's absence, personnel members 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 of 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 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; and
15. Hospital policies and procedures specify a process for review through the quality management program of:
    a. A medication administration error;
    b. An adverse reaction to a medication; and
    c. A pharmacy medication dispensing error.

R9-10-218. ~~Emergency services~~ Clinical Laboratory Services and Pathology Services

~~**A.** A general hospital is not required to staff or equip a full-time emergency department, but necessary emergency medical services shall be provided in a designated area of the hospital. The hospital shall have procedures whereby the ill or injured person will be assessed and treated or referred to an appropriate facility.~~

~~**B.** Emergency services shall be provided to any person in need of them. If the hospital offers only a partial range of services and elects to transfer the patient for further care, essential lifesaving measures and emergency procedures shall be instituted that will minimize aggravation of the condition during transportation. A patient shall be transferred only to a receiving institution that has consented to accept that patient. A record of the immediate medical problem and treatment provided shall accompany the patient.~~

~~**C.** There shall be written policies approved by the medical staff and adopted by the governing authority establishing the extent of treatment to be carried out by the emergency service. These written policies shall provide for transfer to facilities offering specialized care.~~

~~**D.** There shall be a physician responsible for the overall medical direction of emergency services.~~

~~**E.** The emergency services of a general hospital shall maintain the following minimum staffing requirements:~~

~~1. A current roster of physicians on call.~~
~~2. A registered nurse immediately available within the hospital.~~
~~3. A laboratory technician on call.~~
~~4. A radiologic technician on call.~~

An administrator shall require that:

1. Clinical laboratory services and pathology services are provided by a hospital through a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
2. A copy of the certificate of accreditation or compliance in subsection (1) is provided to the Department for review upon the Department's request;
3. A general hospital or a rural general hospital provides clinical laboratory services 24 hours a day within the hospital to meet the needs of a patient in an emergency;
4. A special hospital whose patients' diagnoses or treatment requires clinical laboratory services provides the services within the special hospital 24 hours a day;
5. A hospital that provides clinical laboratory services 24 hours a day has on duty or on call at all times laboratory personnel authorized by hospital policies and procedures to perform testing;
6. A hospital that offers surgical services shall provide pathology services within the hospital or by contract to meet the needs of a patient;

7. Clinical laboratory and pathology test results are:
   a. Available to the medical staff:
      i. Within 24 hours after the test is completed if the test is performed at a laboratory on the hospital premises; or
      ii. Within 24 hours after the test result is received if the test is performed at a laboratory outside of the hospital premises; and
   b. Documented in a patient's medical record;
8. If a test result is obtained that indicates a patient may have an emergency medical condition, as defined by medical staff, laboratory personnel notify the ordering medical staff member or a registered nurse in the patient's assigned unit;
9. If a clinical laboratory report, a pathology report, or an autopsy report is completed on a patient, a copy of the report is included in the patient's medical record;
10. There are hospital policies and procedures for:
    a. Procuring, storing, transfusing, and disposing of blood and blood products;
    b. Blood typing, antibody detection, and blood compatibility testing; and
    c. Investigating transfusion adverse reactions that specify a process for review through the quality management program;
11. If blood and blood products are provided by contract, the contract includes:
    a. The availability of blood and blood products from the contractor; and
    b. The process for delivery of blood and blood products from the contractor; and
12. Expired laboratory supplies are discarded according to hospital policies and procedures.

R9-10-219. ~~Disaster preparedness~~ Radiology Services and Diagnostic Imaging Services

~~**A.** Disaster plan: There shall be a written plan of operation with procedures to be followed in the event of a disaster. The plan shall be developed in 2 phases:~~

~~1. Phase one -- Internal disasters such as fire, gas explosion, etc. Policies and procedures shall include:~~
   ~~a. Notification of personnel and assignment of responsibilities.~~
   ~~b. Instructions regarding the location and use of fire alarm systems and fire fighting equipment.~~
   ~~c. Provision for each type of internal disaster (fire, bomb scare, etc.).~~
   ~~d. Provisions for evacuation, including priorities for evacuation and disposition.~~
   ~~e. Management of casualties.~~
   ~~f. Emergency feeding plan.~~
~~2. Phase two -- External disasters such as mine explosion, bus accidents, flood, earthquakes, etc. Policies and procedures shall include:~~
   ~~a. Notification of personnel and assignment of responsibilities.~~
   ~~b. Communications with other facilities.~~
   ~~c. Unified medical command.~~
   ~~d. Establishment of a triage unit and its location.~~
   ~~e. Transfer of patients.~~
   ~~f. Method of identifying patients.~~
   ~~g. Establishment of an emergency treatment record.~~
   ~~h. Public information center.~~
   ~~i. Security.~~
   ~~j. Method to obtain necessities (water, food, etc.).~~
   ~~k. Determination of availability of beds, blood, medical supplies, etc.~~
   ~~l. Emergency feeding plan.~~

~~**B.** Disaster and fire drills: At least 12 fire drills shall be held each year. They shall be conducted at irregular intervals and at least 4 times on each shift. At least 1 disaster drill shall be held on each shift each year. Fire and disaster drills may be combined and may accommodate more than 1 shift.~~

A. An administrator shall require that:
1. Radiology services and diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and A.A.C. Title 12, Chapter 1;
2. A copy of a certificate documenting compliance with subsection (1) is provided to the Department for review upon the Department's request;
3. A general hospital or a rural general hospital provides radiology services 24 hours a day within the hospital to meet the emergency needs of a patient;
4. A general hospital or a rural general hospital has a radiologic technologist on duty or on call at all times; and
5. A special hospital whose patients' diagnoses or treatment requires radiology services and diagnostic imaging services is able to provide the services or has a documented plan to provide the services to meet the needs of a patient.

B. An administrator of a hospital that provides radiology services and diagnostic imaging services in the hospital shall require that:
1. Radiology services and diagnostic imaging services are provided:
   a. Under the direction of a medical staff member; and
   b. According to an order that includes:
      i. The patient's name;
      ii. The name of the ordering individual;
      iii. The radiological or diagnostic imaging procedure ordered; and
      iv. The reason for the procedure;
2. A medical staff member or radiologist interprets the radiologic or diagnostic image;
3. A radiologist prepares a documented radiologic or diagnostic imaging patient report that includes:
   a. The patient's name;
   b. The date of the procedure;
   c. A radiologist's interpretation of the image;
   d. The type and amount of radiopharmaceutical used, if applicable; and
   e. The adverse reaction to the radiopharmaceutical, if any;
4. A radiologic or diagnostic imaging patient report is included in the patient's medical record; and
5. A radiologic or diagnostic image is maintained by the hospital for at least 12 months from the date of the imaging.

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 personally visited by a physician at least once every 24 hours;

3. Admission and discharge criteria for intensive care services are established;
4. A personnel member's 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 in hospital policies and procedures;
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 hospital 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;
   d. Portable radiologic equipment; and
   e. A patient weighing device for patients restricted to a bed; and
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.

R9-10-221. ~~Medical records services~~ Respiratory Care Services

~~A.~~ ~~There shall be a medical records department under the direction of a qualified person and with adequate staff and facilities to perform all required functions.~~

~~B.~~ ~~A medical record shall be established and maintained for every person receiving treatment as an inpatient, outpatient, or on an emergency basis in any unit of the hospital. The records shall be available to other units engaged in care and treatment of the patient.~~

~~C.~~ ~~Only authorized personnel shall have access to the records.~~

~~D.~~ ~~Medical record information shall be released only with the written consent of the patient, the legal guardian, or in accordance with law.~~

~~E.~~ ~~In hospitals that have designated psychiatric or substance abuse units confidentiality of medical records shall be maintained as required by A.R.S. § 36-509 and applicable Regulations.~~

~~F.~~ ~~For licensing purposes medical records shall be readily retrievable for a period of not less than 3 years, except that A.R.S. § 36-343 requires retention of vital records and statistics for 10 years.~~

~~G.~~ ~~The original or signed copy of all clinical reports shall be filed in the medical record.~~

~~H.~~ ~~Medical records shall be indexed to facilitate continuity of care, acquisition of statistical medical information and retrieval of records for research or administrative action.~~

~~I.~~ ~~Within 48 hours of admission a current or updated history and physical examination shall be in the record.~~

~~J.~~ ~~When a patient is readmitted within thirty days for the same problem, there shall be at least a reference to the previous history by an interval note.~~

~~K.~~ ~~Histories and physicals shall be written by members of the medical or the house staff. When authorized by medical staff bylaws, physicians assistants and nurse practitioners may write or dictate medical histories and results of physical examinations; such entries shall be counter-signed by the attending physician. A physician's signature shall be required on each page of the record which bears his notation or a notation made by a physician assistant or nurse practitioner under his direction.~~

~~L.~~ ~~The person responsible for each entry shall be identified by initials or signature. If initials are used the person's signature must appear on the page.~~

~~M.~~ ~~Medical records of discharged patients shall be completed within the time limit established by the medical staff.~~

~~N.~~ ~~Inpatient medical records shall contain the following information if applicable:~~

~~1. Patients identification sheet, including name, address, date of birth, sex, next of kin and a unique identifying number,~~
~~2. History and physical examination,~~
~~3. Physicians' orders, and progress notes,~~
~~4. Laboratory and diagnostic reports,~~
~~5. Nursing notes,~~
~~6. Nursing care plans,~~
~~7. Medication and treatment record,~~
~~8. Admitting diagnosis,~~
~~9. Disposition and discharge diagnosis,~~
~~10. Record of informed consent,~~

~~11. Discharge summary.~~

~~**O.** The outpatient's medical record shall be accessible.~~

~~1. In outpatient departments that are organized by clinics, the following information shall be available:~~

~~a. Patient's identification sheet,~~

~~b. History and physical examination,~~

~~c. Physician's orders,~~

~~d. Any laboratory and other diagnostic tests, diagnosis and treatment,~~

~~e. Disposition.~~

~~2. If outpatient services are provided in other than an organized outpatient clinic, the following information shall be available:~~

~~a. Patient's identification,~~

~~b. That information pertaining to the patient's chief complaint including, but not limited to, physician's orders, treatment or service provided, and disposition.~~

~~**P.** The emergency services record shall contain the following:~~

~~1. Patient identification,~~

~~2. Record of any treatment patient received prior to arrival,~~

~~3. History of disease or injury,~~

~~4. Physical findings,~~

~~5. Laboratory and x-ray reports, if applicable,~~

~~6. Diagnosis,~~

~~7. Record of treatment,~~

~~8. Disposition,~~

~~9. Name of physician who saw patient in the emergency room.~~

~~**Q.** All deaths, abortional acts, post-mortem procedures and births shall be reported in accordance with 9 A.A.C. 19.~~

~~**R.** If a facility ceases operation, there shall be an arrangement for preservation of records to ensure compliance with these regulations. The Department shall be notified, in writing, concerning the arrangements.~~

~~**S.** Symbols or abbreviations used in the medical record shall be approved by the medical staff and a current copy maintained at each nursing unit and in the medical record department.~~

An administrator of a hospital that provides respiratory care services shall require that:

1. Respiratory care services are provided under the direction of a medical staff member;
2. Respiratory care services are provided according to an order that includes:
   a. The patient's name;
   b. The name and signature of the ordering individual;
   c. The type, frequency, and if applicable, duration of treatment;
   d. The type and dosage of medication and diluent; and
   e. The oxygen concentration or oxygen liter flow and method of administration;
3. Respiratory care services provided to a patient are documented in the patient's medical record and include:
   a. The date and time of administration;
   b. The type of respiratory care services;
   c. The effect of respiratory care services;
   d. The adverse reaction to respiratory care services, if any; and
   e. The authentication of the individual providing the respiratory care services; and
4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-218.

R9-10-222. ~~Laboratory services~~ Perinatal Services

~~**A.** Minimum capability~~

~~1. There shall be within the hospital the capability of providing clinical laboratory services required to support emergency services.~~

~~2. There shall be arrangements for the provision of clinical and anatomical pathology services necessary to meet the needs of hospitalized patients.~~

~~3. Clinical laboratory services, may be provided by another hospital laboratory, an independent clinical laboratory or an out-of-state laboratory providing the following conditions are met:~~

~~a. The contracting laboratory is licensed by the Department or, in the case of out of state clinical laboratories, is licensed by the United States Government, to perform the contracted laboratory services.~~

~~b. The conditions, procedures and type of examinations performed by the contracting laboratory or hospital shall be in writing and available in the hospital.~~

~~**B.** Administration~~

~~1. Clinical laboratory services shall be under the direction of a physician with training and experience in clinical laboratory services, or a person who holds a doctoral degree from an accredited institution with a chemical, physical or bio-~~

~~logical science as his major subject and who is qualified to perform at least 1 of the technical services provided by the laboratory. Anatomical pathology service shall be provided by a pathologist.~~

~~2. A qualified person shall be appointed to be in charge of the laboratory in the absence of the Director.~~

~~3. At least 1 qualified laboratory technician shall be on duty or on call at all times.~~

~~C.~~ ~~Examination of specimens, written requests, reports of results, retention of test records.~~

~~1. Except as otherwise provided, laboratory personnel shall examine specimens only at the request of a physician authorized to practice medicine and surgery or other persons permitted by law to use the findings of laboratory examinations or at the request of the Department for the purpose of quality control and proficiency testing.~~

~~2. Results of tests shall be reported to the physician and entered in the patient's chart. No clinical interpretation, diagnosis, prognosis or suggested treatment shall appear on the laboratory report form except that a report made by a physician may include such information.~~

~~3. All specimens received by the laboratory shall be tested on the premises, or may be forwarded for analysis to another laboratory licensed under A.R.S. Title 36, Chapter 4.1, Article 2, or licensed as part of a general hospital or exempted by A.R.S. § 36-461(4). Specimens submitted for proficiency testing shall be analyzed on the premises by regularly assigned personnel using the laboratory's routine methods.~~

~~4. When the laboratory performing the analysis is other than the laboratory which initially received the specimen, the report shall include the name, address and name of the director of the laboratory actually performing the analysis.~~

~~D.~~ ~~Quality control program~~

~~1. Each laboratory director shall establish and file with the Department a detailed description of the services to be provided by the laboratory and of a quality control program that is acceptable to the Department and meets the standard specified in R9-14-108. It is the responsibility of the laboratory director to assure that the laboratory is operated in accordance with its approved quality control program.~~

~~2. Each laboratory shall participate successfully in a proficiency testing program provided by the American Association of Bioanalysts or the College of American Pathologists for each authorized specialty and subspecialty. Records of such testing shall be kept for 2 years and shall be available for examination by representatives of the Department. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the proficiency testing service.~~

~~3. Each laboratory shall participate successfully in a Department operated proficiency testing program if the laboratory seeks authorization in a specialty or subspecialty for which proficiency testing is not available under subsection (D)(2) or if the Department needs additional assurance of the laboratory's proficiency. Such testing may be carried out during onsite inspections or by submittal of specimens by mail. Regularly assigned personnel shall examine samples using the laboratory's routine methods. The laboratory will be tested only in specialties or subspecialties for which an authorization has been issued by the Department. Proficiency test samples shall be tested within the time required under conditions of normal laboratory operation. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the Department.~~

~~E.~~ ~~Sanitation and safety requirements. All laboratories shall be maintained and operated in a manner which prevents undue physical, chemical and biological hazards to hospital patients, employees or other members of the community and in accordance with standards specified in R9-14-109.~~

~~F.~~ ~~Maintenance, availability, retention of records~~

~~1. Records of observations shall be made concurrently with the performance of each step in the examination of specimens. The actual results of all control procedures shall be recorded.~~

~~2. Records shall identify the individual performing the examination. Such records as well as duplicate copies of laboratory reports shall be retained in the laboratory area for a period of at least 1 year after the date the results are reported.~~

~~3. A.R.S. § 25-103.06 requires that copies of premarital serology results be retained for 5 years.~~

~~G.~~ ~~Blood services. Hospitals shall have facilities adequate for the procurement, storage and transfusion of blood and blood components. Records of the donor and recipient of all blood handled shall be available. All transfusion reactions occurring in the hospital shall be investigated by the medical staff and an incident report shall be prepared.~~

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

1. Perinatal services are provided in a designated area under the direction of a medical staff member;
2. Only medical and surgical procedures approved by the medical staff are performed in the perinatal services unit;
3. The perinatal services unit has the capability to initiate an emergency cesarean delivery within the time-frame established by the medical staff and documented in hospital policies and procedures;
4. Only a patient in need of perinatal services or gynecological services receives perinatal services or gynecological services in the perinatal services unit;
5. A patient receiving gynecological services does not share a room with a patient receiving perinatal services;
6. A chronological log of perinatal services is maintained that includes:
   a. The patient's name;
   b. The date, time, and mode of the patient's arrival;
   c. The disposition of the patient including discharge, transfer, or admission time; and

d. The following information for a delivery of a neonate:
   i. The neonate's name or other identifier;
   ii. The name of the medical staff member who delivered the neonate;
   iii. The delivery time and date; and
   iv. Complications of delivery, if any;

7. The chronological log required in subsection (A)(6) is maintained by the hospital in the perinatal services unit for a minimum of 12 months from the date the perinatal services are provided and then maintained by the hospital for an additional 12 months;
8. The perinatal services unit provides fetal monitoring;
9. The perinatal services unit has ultrasound capability;
10. Except in an emergency, a neonate is identified as required by hospital policies and procedures before moving the neonate from a delivery area;
11. There are hospital policies and procedures that specify:
    a. Security measures to prevent neonatal abduction, and
    b. How the hospital determines to whom a neonate may be discharged;
12. A neonate is discharged only to an individual who is:
    a. Authorized according to subsection (A)(11), and
    b. Provides identification;
13. A neonate's medical record identifies the individual to whom the neonate is discharged;
14. A patient or the individual to whom the neonate is discharged receives perinatal education, discharge instructions, and a referral for follow-up care for a neonate in addition to the discharge planning requirements in R9-10-211;
15. Intensive care services for neonates comply with the requirements in R9-10-220;
16. A minimum of one registered nurse is on duty at all times when there is a neonate in a nursery;
17. Equipment and supplies are available to a nursery, labor-delivery-recovery room, or labor-delivery-recovery-postpartum room to meet the needs of each neonate; and
18. In a nursery, only a neonate's bed or bassinet is used for changing diapers, bathing, or dressing the neonate.

B. An administrator of a hospital that does not provide perinatal organized services shall comply with the requirements in R9-10-216(C).

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; and
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. 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.

R9-10-224. ~~Rehabilitation services~~ Psychiatric Services

~~A.~~ ~~For purposes of this Section rehabilitation services include physical therapy, occupational therapy, speech therapy and audiology services.~~

~~**B.** The following provisions shall be met in hospitals that provide rehabilitation services:~~
~~1. Rehabilitation services shall be provided by a qualified therapist only when ordered by a physician. Rehabilitation services may be provided by qualified aides and assistants only when under the direct supervision of qualified therapists.~~
~~2. There shall be written administrative and patient care policies and procedures for each of the rehabilitation services offered.~~
~~3. There shall be a written plan for each patient indicating the modality or type of treatment provided and the frequency of treatment. This plan shall be based on the written order of a physician.~~
~~4. There shall be written documentation in the patient's medical record of the rehabilitation services provided.~~

An administrator of a hospital that provides psychiatric organized services shall require that the hospital is in compliance with A.R.S. Title 36, Chapters 4 and 5, A.A.C. Title 9, Chapter 20, and this Chapter.

R9-10-225. ~~Quality assurance~~ Rehabilitation Services

~~**A.** Each hospital shall have a quality assurance program conducted in accordance with A.R.S. § 36-445. A record of such activities shall be maintained.~~
~~**B.** A discharge planning program shall be established to provide for the transfer of information between hospital and other health facilities or agencies to facilitate continuity of care. Periodic review and evaluation of the program shall be conducted by a committee established for this purpose.~~

An administrator shall require that:
1. If rehabilitation services are provided as an organized service, the rehabilitation services are provided under the direction of an individual qualified according to hospital policies and procedures;
2. Rehabilitation services are provided according to an order; and
3. The medical record of a patient receiving rehabilitation services includes:
   a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis;
   b. A documented care plan that is developed in coordination with the ordering individual and the individual providing the rehabilitation services;
   c. The rehabilitation services provided;
   d. The patient's response to the rehabilitation services; and
   e. The authentication of the individual providing the rehabilitation services.

R9-10-226. ~~Radiology services~~ Social Services

~~**A.** A hospital shall have within the hospital as a minimum the capability of providing emergency diagnostic radiology services.~~
~~**B.** A physician shall be responsible for the medical direction of the Department.~~
~~**C.** A radiologic technician shall be on duty or on call at all times.~~
~~**D.** There shall be a radiologic procedure manual available to radiology services personnel.~~
~~**E.** X-ray examinations shall be performed only when ordered by a member of the medical staff. The order shall contain a concise statement of the reason for the examination.~~
~~**F.** The radiology department shall be staffed, equipped and operated in accordance with A.R.S. Title 30, Chapter 4 and regulations adopted thereunder.~~

An administrator of a hospital that provides social services shall require that:
1. A social worker or a registered nurse designated by the administrator coordinates social services;
2. A medical staff member, nurse, patient, patient's representative or a member of the patient's family may request social services;
3. A personnel member providing social services participates in discharge planning as necessary to meet the needs of a patient;
4. The patient has privacy when communicating with a personnel member providing social services; and
5. Social services provided to a patient are documented in the patient's medical record and the entries are authenticated by the individual providing the social services.

R9-10-227. ~~Respiratory care services~~ Dietary Services

~~Hospitals that provide respiratory care services shall meet the following provisions:~~
~~1. Respiratory care services shall include therapeutic procedures and may include diagnostic procedures.~~
~~2. A physician shall be responsible for the medical direction of the respiratory care unit or department.~~
~~3. Respiratory care services shall be provided in accordance with the written order of a physician. The order shall state the modality to be used, the type, frequency and duration of treatment and type and dose of medication including dilution ratio.~~
~~4. Reports of respiratory care services shall be made a part of the patient's medical record.~~
~~5. Respiratory therapy shall be administered by qualified personnel.~~

An administrator shall require that:
1. Dietary services are provided according to A.A.C. Title 9, Chapter 8, Article 1;

2. A copy of the hospital's food establishment license under A.A.C. Title 9, Chapter 8, Article 1, is provided to the Department for review upon the Department's request;
3. For a hospital that contracts with a food establishment to prepare and deliver food to the hospital, a copy of the contracted food establishment's license under A.A.C. Title 9, Chapter 8, Article 1, is:
   a. Maintained on the hospital premises, and
   b. Provided to the Department for review upon the Department's request;
4. If a hospital contracts with a food establishment to prepare and deliver food to the hospital, the hospital is able to store, refrigerate, and reheat food to meet the dietary needs of a patient;
5. Dietary services are provided under the direction of an individual qualified to direct the provision of dietary services according to hospital policies and procedures;
6. There are personnel members on duty to meet the dietary needs of all patients;
7. Personnel members providing dietary services are qualified to provide dietary services according to hospital policies and procedures;
8. A nutrition assessment of a patient is:
   a. Performed according to hospital policies and procedures; and
   b. Communicated to the attending physician or the attending physician's designee if the nutrition assessment reveals a specific dietary need;
9. A medical staff member documents an order for a diet for each patient in the patient's medical record;
10. A current diet manual approved by a registered dietitian is available to personnel members and medical staff members; and
11. A patient's dietary needs are met 24 hours a day.

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 commit tees 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.~~
~~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 a personnel member authorized by hospital policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the medical record and includes the time of the order if required by medical staff bylaws;
   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 an order, the individual whose signature the stamp or electronic code represents is accountable for the use of the stamp or the electronic code;
5. A medical record is available to personnel members and medical staff members authorized by hospital policies and procedures to access the medical record;
6. Information in a medical record is disclosed to an individual not authorized under subsection (5) only with the written consent of a patient or the patient's representative or as permitted by law;
7. A medical record is maintained under the direction of an individual:
   a. Who is qualified to maintain the medical record 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 off-site medical record at the request of a medical staff member or authorized personnel member;
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 less than 18 years of age, 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; and
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;
   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 the patient has to the medication or biological;

3. Documented informed consent for treatment by the patient or the patient's representative except in an emergency;
4. A medical history and results of a physical examination or an interval note;
5. If the patient provides a health care directive, the health care directive signed by the patient;
6. An admitting diagnosis;
7. Names of the admitting medical staff member and attending physician;
8. All orders;
9. All care plans;
10. A record of hospital services provided to the patient;
11. Notes by medical staff members, nursing or other personnel members;
12. Disposition of the patient after discharge;
13. Discharge instructions required in R9-10-211(B)(3);
14. A discharge summary; and
15. If applicable:
    a. A laboratory report required in R9-10-218;
    b. A radiologic report required in R9-10-219;
    c. A diagnostic report;
    d. Documented of restraint; and
    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. If necessary for treatment, any known allergy including medication or biological allergies or sensitivities;
2. If necessary for treatment, 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 the patient has to the medication or biological;
3. Documented informed consent by the patient or the patient's representative, except in an emergency;
4. A diagnosis or reason for outpatient medical services;
5. All orders;
6. A record of hospital services provided to the patient; and
7. If applicable:
    a. A laboratory report required in R9-10-218;
    b. A radiologic report required in R9-10-219;
    c. A diagnostic report;
    d. Documented of restraint; and
    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;
2. The patient's medical history;
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.~~
~~c. 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. A registered nurse shall be in charge of the nursery at all times.~~
~~b. A nursery shall be provided for the care of newborns and shall not be used for any other purpose.~~
~~c. A room in which "rooming-in" is practiced shall not be considered a nursery unless more than 2 mothers are accommodated in which case all requirements for newborn nurseries shall apply.~~
~~d. An individual bassinet shall be provided for each newborn and each newborn shall have separate equipment and supplies.~~
~~e. The use of common bathing or dressing areas is prohibited. All bathing, diaper changing, and treatments shall be carried out in the bassinet or on the newborn's individual shelf or drawer.~~
~~f. Accurate scales shall be provided.~~
~~g. Any newborn born outside of the hospital and any newborn suspected of having an infection or who has been exposed to actual or potential infection shall be properly isolated. The decision to transfer a newborn from the main nursery to isolation may be made by the nurse in charge of the main nursery in an emergency.~~
~~h. Only persons, specified by hospital rules and regulations, shall be admitted to any nursery.~~
~~i. Containers shall be provided for soiled diapers to ensure proper disposal.~~
~~j. Underwriters Laboratory-approved isolettes shall be available.~~
~~k. The use of a rack or bassinet stand which holds more than 1 bassinet is prohibited.~~
~~l. Oxygen, oxygen equipment and suction equipment adapted to the use of newborn infants shall be available. An oxygen analyzer shall be available.~~
~~m. Formula shall be prepared in an appropriate isolated area.~~
~~n. Traffic in the nursery shall be closely supervised by the registered nurse in charge.~~
~~o. Sanitized nursery linens or disposable linens shall be used.~~
~~p. Whenever 2 or more infants in a nursery exhibit symptoms of a communicable illness, the incident shall be reported to 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.~~
~~c. At least 1 Underwriter Laboratory-approved isolette.~~

A. An administrator shall require that:
1. An infection control program that meets the requirements of this Section 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, a personnel member, or a medical staff member 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; and
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 a personnel member, at least once every 12 months or more frequently if determined by an infection control risk assessment;
   b. Except as required in subsection (A)(4)(c), for a medical staff member, at least once every 24 months; and
   c. For a medical staff member at an increased risk of exposure based on the criteria in subsection (A)(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:
   a. Collected in a manner to minimize or prevent contamination,
   b. Bagged at the site of use, and
   c. Maintained separate from clean linen and clothing;
6. A personnel member washes hands or uses a hand disinfection product after each patient contact and after handling soiled linen, soiled clothing, or potentially infectious material;
7. An infection control program has a procedure for documenting:
   a. The collection and analysis of infection control data;
   b. The actions taken relating to infections and communicable diseases; and
   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 after a Department request but not more than four hours from the time of the 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; and
10. The infection control committee:
   a. Develops a 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 inclusion 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 A.A.C. Title 9, Chapter 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 as determined by the infection control risk assessment shall comply with the requirements in R9-10-206(3);
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 other individual to suffer physical injury;
3. A pest control program is used to control insects and rodents;
4. The hospital maintains a tobacco smoke-free environment;
5. Biohazardous waste and hazardous waste are identified, stored, used, and disposed of according to A.A.C. Title 18, Chapter 13, Article 14 and hospital policies and procedures;
6. Equipment used to provide hospital 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;

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 after a Department request but not more than four hours from the time of the request.

R9-10-231. ~~Social services~~ Disaster Management

~~When a hospital has an organized social service department the following conditions shall be met:~~

~~1. There shall be policies and procedures relating to the staff and functions of the department.~~
~~2. Personnel~~
~~a. The social service department shall be under the direction of a social worker and shall have adequate staff and facilities to perform all required functions; or~~
~~b. Social services shall be provided by a designated person who shall receive consultation from a social worker in accordance with a written agreement; or~~
~~c. Social services shall be provided by referral, based on established written procedures, to appropriate social agencies.~~
~~3. Social services to patients shall be initiated by physician referral, or by request of patient, family member or guardian.~~
~~4. Social services information shall be recorded. Policies and procedures shall be established by the department with approval of the medical staff which specify the type and extent of this information to be placed in the medical record.~~
~~5. Facilities shall be provided which are accessible to patients and staff and which assure privacy for interviews.~~

An administrator shall require that:

1. A disaster plan is developed and documented that includes:
   a. Procedures for protecting the health and safety of patients and other individuals;
   b. Assigned personnel responsibilities; and
   c. Instructions for the evacuation, transport, or transfer of patients, maintenance of medical records, and arrangements to provide any other hospital services to meet the patients' needs;
2. A plan exists for back-up power and water supply;
3. A fire drill is performed on each shift at least once every three months;
4. A disaster drill is performed on each shift at least once every 12 months;
5. Documentation of a fire drill required in subsection (3) and a disaster drill required in subsection (4) includes:
   a. The date and time of the drill;
   b. A critique of the drill; and
   c. Recommendations for improvement, if applicable; and
6. 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 after a Department request but not more than four hours from the time of the 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~~
~~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 complies with the physical plant health and safety codes and standards that are incorporated by reference in A.A.C. R9-1-412 at the time the hospital is licensed;
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 health and safety codes and standards incorporated by reference in R9-1-412 at the time the construction, modification, or change in licensed capacity or inpatient beds is approved by the Department;
4. The licensed hospital premises or 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 A.R.S. Title 36, Chapters 4 and 5, and A.A.C. Title 9, Chapter 20.

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.

R9-10-233. ~~Rates and charges~~ Effective Date

~~The current schedule of rates and charges shall be posted in accordance with R9-11-114(H), and R9-10-1734.~~
The effective date of this Article is October 1, 2002.

ARTICLE 3. ~~RURAL GENERAL HOSPITALS~~ REPEALED

R9-10-311. ~~General~~ Repealed

~~A.~~ ~~Rural general hospitals to which these requirements apply are subject to inspection as provided in A.R.S. §§ 36-406 and 36-424. Department personnel are prohibited by A.R.S. § 36-404 from disclosing patient records or any information from which a patient or his family might be identified, or sources of information which cause the Department to believe that an~~

~~inspection is needed to determine whether an institution is in compliance with the provisions of this Chapter and the regulations thereunder.~~

~~**B.** The rural general hospital administration shall assure that contract suppliers meet the same standards of quality the hospital would have to meet if services were provided by the hospital.~~

~~**C.** Regulations contained in this Article shall not be construed to compel any patient to submit to any examination or treatment provided all requirements for the control of communicable disease and sanitation are met.~~

~~**D.** It is not the intent of this regulation to require a general hospital having fewer than 50 inpatient beds to apply for licensure as a rural general hospital. It shall be the prerogative of the governing authority to determine the type of licensure for which it will apply.~~

R9-10-312. ~~Definitions~~ Repealed

~~Unless the context otherwise requires:~~

1. ~~"Anesthesiologist" means a physician whose specialized training and experience qualify him to administer anesthetic agents and to monitor patients under the influence of these agents.~~
2. ~~"Anesthetist" means a physician or dentist qualified by experience to administer anesthetic agents or a registered nurse who meets the requirements of A.R.S. § 32-1661.~~
3. ~~"Chief executive officer" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the hospital.~~
4. ~~"Direct nursing care" means the provision of preventative, curative, rehabilitative and health-related services directly to patients on a nursing unit by nursing personnel under the supervision of a registered nurse.~~
5. ~~"Food service director" means a person who is a dietitian or a graduate of a dietetic technician, dietetic assistant or food service supervisor training program, correspondence school or classroom, approved by the American Dietetic Association, or who has training and experience in food service supervision and management equivalent to 1 of these programs.~~
6. ~~"General hospital" means a subclass of hospital which provides inpatient beds and other hospital services, both surgical and non-surgical, to patients who have any of a variety of medical conditions.~~
7. ~~"Hospital" means a class of health care institution which provides, through an organized medical or professional staff, services that include, but are not limited to, inpatient beds, medical services and continuous nursing services for the diagnosis and treatment of patients.~~
8. ~~"Licensed bed capacity" means the number of adult and pediatric beds specified on the rural general hospital's license, and does not include bassinets, labor or recovery beds.~~
9. ~~"Rural general hospital" means a subclass of hospital having 50 or fewer inpatient beds serving an area located not less than 20 surface miles from another general or rural general hospital and which provides hospital services.~~
10. ~~"Social worker" means a person who has received a baccalaureate degree and has met the requirements of a two-year curriculum in a school of social work that is accredited by the Council on Social Work Education, or has the equivalent of such education and training.~~
11. ~~"Therapist" means a person who is appropriately qualified by training, experience, or both, to apply diagnostic or treatment techniques and procedures for patients under the direction of a physician. Such persons who are required to have an Arizona license to practice their profession shall have the appropriate license.~~

R9-10-313. ~~Administration~~ Repealed

~~**A.** Governing authority: The governing authority shall adopt bylaws which identify the purposes of the rural general hospital and the methods of fulfilling them. The governing authority shall appoint a chief executive officer who shall be appropriately qualified for the management of the facility. The chief executive officer shall have authority and responsibility for the operation of the rural general hospital.~~

~~**B.** The chief executive officer shall be directly responsible for the management and operation of the rural general hospital and shall provide liaison between the governing authority and the medical staff.~~

1. ~~The chief executive officer shall maintain written definitions of the rural general hospital organization, authority, responsibility and relationships, to provide the rural general hospital with administrative direction.~~
2. ~~When there is a planned change of the chief executive officer or ownership, the governing authority shall notify the Department at least thirty days prior to the effective date of change. Such changes that cannot be planned in advance shall be reported in writing to the Department immediately.~~
3. ~~Written admission and discharge policies which are consistent with the established purposes of the rural general hospital shall be maintained in the admitting office.~~
4. ~~An employee authorized to accept patients for admission and to make administrative decisions concerning their disposition shall be available at all times.~~
5. ~~Upon admission, inpatients shall be provided a suitable device or method for identification.~~
6. ~~The following documents or copies shall be available in the rural general hospital:~~
   a. ~~Bylaws of the governing body.~~
   b. ~~Bylaws and rules and regulations of the medical staff.~~

c. Policies and procedures for established rural general hospital services.
d. Reports of inspections and reviews related to licensure for the preceding 5 years together with corrective actions taken.
e. Contracts related to licensure to which the rural general hospital is bound.
f. Appropriate documents evidencing control and ownership.
g. A current copy of Title 9 Health Care Regulations available from the Office of the Secretary of State, which includes:

Chapter 1, Article 4	Codes and Standards Referenced
Chapter 8, Article 1	Food and Drink
Chapter 9, Articles 1,2,3	Health Care Institutions: Establishment and Modification
Chapter 10, Article 1	Health Care Institutions: Licensure
Chapter 10, Article 3	Rural General Hospital
Chapter 11, Articles 1,2	Health Care Institutions: Rates and Charges

7. Personnel
   a. Personnel records:
      i. A record of each employee shall be maintained which includes the following:
         (1) Employee's identification, including name, address and person to be notified in an emergency.
         (2) Resume of education and work experience.
         (3) Verification of valid license if required, education and training.
      ii. Payroll and attendance records for the preceding 12 month period shall be available for review by Department personnel.
      iii. Every position shall have a written description of the duties of the position.
   b. New employees shall receive orientation to familiarize them with the facility, its policies, and the responsibilities of the new employee.
   c. Continuing education programs shall be regularly provided for all nursing and dietary personnel to prepare them for their specific duties and responsibilities in the hospital. Records shall be maintained that include at least subject matter, attendance date, and location of the education program.
   d. An employee whose duties during his normal work shift require him to be awake while on the job, shall not be scheduled to work consecutive shifts.
   e. Pre-employment and annual medical screenings shall be conducted; these shall include a medical history and an appropriate tuberculosis screening test. A physical examination shall be accomplished of those persons whose medical screening indicates such need.
8. Miscellaneous
   a. There shall be no pets allowed in the patient care and food service areas of the rural general hospital. For the purposes of these regulations, seeing eye and hearing ear dogs are not considered pets.
   b. Unless bedside telephones are provided, patients shall have access to a public telephone.
   c. The person on duty and in charge of the hospital shall have reasonable access to all areas of the hospital.
   d. Reasonable privacy shall be provided for all patients.

C. The Department recognizes that emergency situations do occur in which a rural general hospital may temporarily need to exceed its licensed capacity. The medical need to admit patients in excess of licensed bed capacity as indicated by service category as shown on the then current license shall be determined by a committee or other organizational structure of the medical staff. During any period in which the hospital's census exceeds its licensed bed capacity by category of service, it shall suspend all elective admissions to that service category. The exception afforded by this subsection does not exempt a rural general hospital from any other requirement of this Chapter.

D. Licensed nursing personnel shall be prepared, through appropriate education or training, for their responsibilities in the provision of nursing care. This training shall include:
1. Cardiopulmonary resuscitation training
2. Basic recognition of EKG arrhythmias
3. Use of emergency equipment

R9-10-314. ~~Medical staff~~ Repealed

A. The rural general hospital shall have a medical staff responsible to the governing authority for the quality of medical care provided to patients and for the ethical and professional practices of its members.

B. Patients shall be admitted to the rural general hospital by a member of the medical staff in accordance with medical staff bylaws, and shall be under the general care of a physician.

C. A rural general hospital shall have at least 1 physician as an active medical staff member and at least 1 other physician as consultant or as courtesy staff who shall be active in committee functions.

~~**D.** The medical staff, subject to final action by the governing authority, shall adopt bylaws, rules and regulations, and policies for the proper conduct of its activities. The medical staff shall recommend to the governing authority, physicians and other licensed practitioners considered eligible for new and continued membership on the medical staff, as delineated in medical staff bylaws. Clinical privileges of each medical staff member shall be delineated in writing.~~

~~**E.** The bylaws shall state the type, purpose, composition and organization of standing committees.~~

~~**F.** The medical staff shall be responsible to assure the availability of inpatient and outpatient physician services in the event of an emergency.~~

R9-10-315. ~~Nursing services~~ Repealed

~~**A.** Organization~~

~~1. The rural general 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 procedures 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 on duty and in charge of the nursing service at all times.~~

~~b. There shall be at least 1 registered nurse and at least 1 other licensed nurse or ancillary nursing personnel on duty at all times when there are inpatients.~~

~~c. Each nursing unit shall be staffed by at least 1 registered nurse on each shift, nursing units with 25 patients or more shall have an additional licensed nurse on each shift.~~

~~d. When there is only 1 registered nurse on duty, a registered nurse shall be on call and available to the rural general hospital within fifteen minutes.~~

~~2. A general staffing plan shall be maintained which includes individual staffing patterns for each nursing unit, and for the surgical, obstetrical, outpatient, and emergency services.~~

~~**C.** Patient care plans: There shall be a written patient care plan developed for each patient which is consistent with the patient's medical plan of care. Development of the plan shall be coordinated with the total health team. The plan shall reference the patient's problems and needs as well as the approaches to achieve treatment goals. The plan shall be available to all members of the patient's health team.~~

R9-10-316. ~~Surgical services~~ Repealed

~~**A.** Rural general hospitals are not required to provide surgical services.~~

~~**B.** Rural general hospitals that provide surgical services shall meet the following requirements:~~

~~1. The rural general hospital shall have at least 1 operating room.~~

~~2. A roster specifying the surgical privileges of each physician shall be kept in the operating room or suite.~~

~~3. The medical staff shall establish policies specifying the surgical procedures which will require a second physician as assistant in surgery.~~

~~4. A chronological register of surgical operations performed shall be maintained in the surgical suite.~~

~~5. Except in a documented emergency, a history shall be taken and physical examination shall be performed on every patient prior to surgery.~~

~~6. There shall be policies and procedures for the immediate post-operative care.~~

~~7. The surgical suite shall be supervised by a registered nurse.~~

~~8. The operating room(s) and support services shall be located to prevent through traffic.~~

~~9. General anesthesia shall be administered by an anesthesiologist or an anesthetist.~~

~~10. The recovery room shall be supervised by a registered nurse who may be the surgical services supervisor.~~

~~11. There shall be available a current listing of all types of surgical procedures offered in the hospital. The current edition of the American Medical Association Procedural Terminology shall be used as a guide when preparing this list.~~

~~12. Policies shall be adopted regarding the content of, and timing for, anesthetic follow-up notes.~~

~~13. When surgical procedures are scheduled to be performed under general anesthesia, at least 1 other physician shall be on call and available to the rural general hospital within 20 minutes.~~

R9-10-317. ~~Dietetic services~~ Repealed

~~**A.** Organization~~

~~1. The rural general hospital shall have an organized dietetic service under the direction of a qualified food service director who has authority and accountability for the dietetic services.~~

~~2. Each rural general 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.~~

~~**B.** Staffing~~

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

~~**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 physicians, nursing and food service 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 contained in 9 A.A.C. 8, Article 1, "Food and Drink".~~

R9-10-318. ~~Emergency services~~ Repealed

~~**A.** A rural general hospital is not required to staff or equip a full-time emergency department, but necessary emergency medical services shall be provided in a designated area of the rural general hospital. The rural general hospital shall have procedures whereby the ill or injured person will be assessed and treated or referred to an appropriate facility.~~

~~**B.** Emergency services shall be provided to any person in need of them. If the hospital offers only a partial range of services and elects to transfer the patient for further care, essential lifesaving measures and emergency procedures shall be instituted that will minimize aggravation of the condition during transportation. A patient shall be transferred only to a receiving institution that has consented to accept the patient. A record of the immediate medical problem and treatment provided shall accompany the patient.~~

~~**C.** There shall be written policies approved by the medical staff and adopted by the governing authority establishing the type of treatment to be carried out by the emergency service. These written policies shall provide for transfer to facilities offering specialized care.~~

~~**D.** There shall be a physician responsible for the overall medical direction of emergency services.~~

~~**E.** The emergency services of a rural general hospital shall maintain the following minimum staffing requirements:~~

1. ~~A current roster of physicians on call.~~
2. ~~A registered nurse available to the rural general hospital within 15 minutes.~~
3. ~~A laboratory technician on call.~~
4. ~~A radiologic technician on call.~~

~~**F.** Resuscitative and monitoring equipment and supplies shall be readily available for emergency services.~~

~~**G.** An emergency cart containing the drugs and emergency equipment required for the immediate care of emergencies shall be readily available. 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.~~

R9-10-319. ~~Disaster preparedness~~ Repealed

~~**A.** Disaster plan: There shall be a written plan of operation with procedures to be followed in the event of a disaster. The plan shall be developed in 2 phases:~~

1. ~~Phase one -- Internal disasters such as fire, gas explosion, etc. Policies and procedures shall include:~~
   a. ~~Notification of personnel and assignment of responsibilities.~~
   b. ~~Instructions regarding the location and use of fire alarm systems and fire fighting equipment.~~
   c. ~~Provision for each type of internal disaster (fire, bomb scare, etc.).~~
   d. ~~Provisions for evacuation, including priorities for evacuation and disposition.~~
   e. ~~Management of casualties.~~
   f. ~~Emergency feeding plan.~~
2. ~~Phase two -- External disasters such as mine explosion, bus accidents, flood, earthquakes, etc. Policies and procedures shall include:~~
   a. ~~Notification of personnel and assignment of responsibilities.~~
   b. ~~Communications with other facilities.~~
   c. ~~Unified medical command.~~
   d. ~~Establishment of a triage unit and its location.~~
   e. ~~Transfer of patients.~~
   f. ~~Method of identifying patients.~~
   g. ~~Establishment of an emergency treatment record.~~
   h. ~~Public information center.~~
   i. ~~Security.~~
   j. ~~Method to obtain necessities (water, food, etc.).~~
   k. ~~Determination of availability of beds, blood, medical supplies, etc.~~

l. ~~Emergency feeding plan.~~

~~B.~~ ~~Disaster and fire drills: As required by A.A.C. R9-1-412(3), Life Safety Code, at least 12 fire drills shall be held each year. They shall be conducted at irregular intervals and at least 4 times on each shift. At least 1 disaster drill shall be held on each shift each year. Fire and disaster drills may be combined and may accommodate more than 1 shift.~~

~~C.~~ ~~Policies shall be established for obtaining sufficient personnel to staff the rural general hospital during post-emergency or disaster periods.~~

R9-10-320. ~~Environmental services~~ Repealed

~~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 rural general 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 rural general 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 rural general 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 disposable 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. If only 1 autoclave is available and an incinerator is not available, the waste shall be double bagged, clearly marked and shall be taken to a Department approved landfill. The operator of the landfill shall be notified and immediate burial assured. 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.~~

~~J.~~ ~~Sewage systems shall be in accordance with the Department's regulations contained in 9 A.A.C. 8, Article 3.~~

R9-10-321. ~~Medical records services~~ Repealed

~~A.~~ ~~There shall be a medical records service under the direction of a designated person and with adequate staff and facilities to perform all required functions. If the designated person is not qualified in medical records management, he shall receive consultation from a qualified person.~~

~~B.~~ ~~A medical record shall be established and maintained for every person receiving treatment as an inpatient, outpatient, or on an emergency basis in any unit of the rural general hospital. The records shall be available to other units engaged in care and treatment of the patient.~~

~~C.~~ ~~Only authorized personnel shall have access to the records.~~

~~D.~~ ~~Medical record information shall be released only with the written consent of the patient, the legal guardian, or in accordance with law.~~

~~E.~~ ~~In rural general hospitals that have designated psychiatric or substance abuse units, confidentiality of medical records shall be maintained as required by A.R.S. § 36-509 and applicable regulations.~~

~~F.~~ ~~For licensing purposes medical records shall be readily retrievable for a period of not less than 3 years, except that A.R.S. § 36-343 requires retention of vital records and statistics for 10 years.~~

~~**G.** The original or signed copy of all clinical reports shall be filed in the medical record.~~
~~**H.** Medical records shall be indexed to facilitate continuity of care, acquisition of statistical medical information and retrieval of records for research or administrative action.~~
~~**I.** Within 48 hours of admission, a current or updated history and physical examination shall be in the record.~~
~~**J.** When a patient is re-admitted within 30 days for the same problem, there shall be at least a reference to the previous history by an interval note.~~
~~**K.** Histories and physicals shall be written by members of the medical or the house staff. When authorized by medical staff bylaws, physician assistants and nurse practitioners may write or dictate medical histories and results of physical examinations. A physician's signature shall be required on each page of the record which bears a notation made by a physician assistant or nurse practitioner under his direction.~~
~~**L.** All entries in the record must be dated and signed or initialed by the person making the entry. If initials are used, a method must be established to identify authorship.~~
~~**M.** Medical records of discharged patients shall be completed within the time limit established by the medical staff.~~
~~**N.** Inpatient medical records shall contain the following information, if applicable:~~
~~1. Patient's identification sheet, including name, address, date of birth, sex, person to be notified in an emergency, and an unique identifying number.~~
~~2. History and physical examination.~~
~~3. Physician's orders and progress notes.~~
~~4. Laboratory and diagnostic reports.~~
~~5. Nursing notes.~~
~~6. Patient care plans.~~
~~7. Medication and treatment record.~~
~~8. Admitting diagnosis.~~
~~9. Disposition and discharge diagnosis.~~
~~10. Record of informed consent.~~
~~11. Discharge summary.~~
~~**O.** The outpatient's medical record shall be accessible:~~
~~1. In outpatient departments that are organized by clinics, the following information shall be available:~~
~~a. Patient's identification sheet.~~
~~b. History and physical examination.~~
~~c. Physician's orders.~~
~~d. Any laboratory and other diagnostic tests, diagnosis and treatment.~~
~~e. Disposition.~~
~~2. If outpatient services are provided in other than an organized outpatient clinic, the following information shall be available:~~
~~a. Patient's identification.~~
~~b. That information pertaining to the patient's chief complaint including, but not limited to, physician's orders, treatment or service provided, and disposition.~~
~~**P.** The emergency services record shall contain the following:~~
~~1. Patient's identification.~~
~~2. Record of any treatment patient received prior to arrival.~~
~~3. History of disease or injury.~~
~~4. Physical findings.~~
~~5. Laboratory and x-ray reports, if applicable.~~
~~6. Diagnosis.~~
~~7. Record of treatment.~~
~~8. Disposition.~~
~~9. Name of physician who ordered emergency treatments.~~
~~**Q.** All deaths, abortional acts, post-mortem procedures, and births shall be reported in accordance with 9 A.A.C. 19.~~
~~**R.** If a facility ceases operation, there shall be an arrangement for preservation of records to ensure compliance with these regulations. The Department shall be notified, in writing, concerning the arrangements.~~
~~**S.** Symbols or abbreviations used in the medical record shall be approved by the medical staff and a current copy maintained at each nursing unit and in the medical record department.~~

R9-10-322. ~~Laboratory services~~ Repealed

~~**A.** Minimum capability:~~
~~1. There shall be within the rural general hospital the capability of providing clinical laboratory services required to support emergency services.~~
~~2. There shall be arrangements for the provision of clinical and anatomical pathology services necessary to meet the needs of hospitalized patients.~~

3. ~~Clinical laboratory services may be provided by another hospital laboratory, an independent clinical laboratory or an out-of-state laboratory providing the following conditions are met:~~
   a. ~~The contracting laboratory is licensed by the Department or, in the case of out-of-state clinical laboratories, licensed by the United States Government, to perform the contracted laboratory services.~~
   b. ~~The conditions, procedures and type of examinations performed by the contracting laboratory or hospital for the rural general hospital shall be in writing and available in the rural general hospital.~~

B. ~~Administration~~
1. ~~Clinical laboratory services shall be under the medical direction of a physician with training and experience in clinical laboratory services, or a person who holds a doctoral degree from an accredited institution with a chemical, physical or biological science as his major subject and who is qualified to perform at least 1 of the technical services provided by the laboratory. Anatomical pathology service shall be provided by a pathologist.~~
2. ~~A qualified person shall be appointed to be in charge of the laboratory in the absence of the director.~~
3. ~~At least 1 qualified laboratory technician or technologist shall be on duty or on call at all times.~~

C. ~~Examination of specimens, written requests, reports of results, retention of test records:~~
1. ~~Except as otherwise provided, laboratory personnel shall examine specimens only at the request of a physician authorized to practice medicine and surgery or other persons permitted by law to use the findings of laboratory examinations or at the request of the Department for the purpose of quality control and proficiency testing.~~
2. ~~Results of tests shall be reported to the physician and entered in the patient's chart. No clinical interpretation, diagnosis, prognosis or suggested treatment shall appear on the laboratory report form except that a report made by a physician may include such information.~~
3. ~~All specimens received by the laboratory shall be tested on the premises or may be forwarded for analysis to another laboratory licensed under A.R.S. Title 36, Chapter 4.1, Article 2 or licensed as part of a rural general hospital or exempted by A.R.S. § 36-461(4). Specimens submitted for proficiency testing shall be analyzed on the premises by regularly assigned personnel using the laboratory's routine methods.~~
4. ~~When the laboratory performing the analysis is other than the laboratory which initially received the specimen, the report shall include the name, address, and name of the director of the laboratory actually performing the analysis.~~

D. ~~Quality control program:~~
1. ~~Each laboratory director shall establish and file with the Department a detailed description of the services to be provided by the laboratory and of a quality control program that is acceptable to the Department and meets the standard specified in R9-14-108. It is the responsibility of the laboratory director to assure that the laboratory is operated in accordance with its approved quality control program.~~
2. ~~Each laboratory shall participate successfully in a proficiency testing program provided by the American Association of Bioanalysts or the College of American Pathologists for each authorized specialty and subspecialty. Records of such testing shall be kept for 2 years and shall be available for examination by representatives of the Department. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the proficiency testing service.~~
3. ~~Each laboratory shall participate successfully in a Department operated proficiency testing program if the laboratory seeks authorization in a specialty or subspecialty for which proficiency testing is not available under subsection (D)(2) or if the Department needs additional assurance of the laboratory's proficiency. Such testing may be carried out during onsite inspections or by submittal of specimens by mail. Regularly assigned personnel shall examine samples using the laboratory's routine methods. The laboratory will be tested only in specialties or subspecialities for which an authorization has been issued by the Department. Proficiency test samples shall be tested within the time required under conditions of normal laboratory operation. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the Department.~~

E. ~~Sanitation and safety requirements: All laboratories shall be maintained and operated in a manner which prevents undue physical, chemical and biological hazards to hospital patients, employees or other members of the community and in accordance with standards specified in R9-14-109.~~

F. ~~Maintenance, availability, retention of records:~~
1. ~~Records of observations shall be made concurrently with the performance of each step in the examination of specimens. The actual results of all control procedures shall be recorded.~~
2. ~~Records shall identify the individual performing the examination. Such records as well as duplicate copies of laboratory reports shall be retained in the laboratory area for a period of at least 1 year after the date the results are reported.~~
3. ~~A.R.S. § 25-103.06 requires that copies of premarital serology results be retained for 5 years.~~

G. ~~Blood services: Hospitals shall have facilities adequate for the procurement, storage and transfusion of blood and blood components. Records of the donor and recipient of all blood handled shall be available. All transfusion reactions occurring in the hospital shall be investigated by the medical staff and an incident report shall be prepared.~~

R9-10-323. ~~Pharmaceutical services~~ Repealed

A. ~~The rural general 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 a member of the medical staff, a pharmacist, 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 a licensed nurse. Preparation for administration shall not be interpreted as dispensing.~~

R9-10-324. ~~Rehabilitation services~~ Repealed

~~**A.** For purposes of this Section rehabilitation services include physical therapy, occupational therapy, speech therapy or audiology services.~~

~~**B.** The following provisions shall be met in rural general hospitals that provide rehabilitation services:~~

~~1. Rehabilitation services shall be provided by a qualified therapist only when ordered or upon referral by a physician. Rehabilitation services may be provided by qualified aides and assistants only when a qualified therapist is on the premises.~~

~~2. There shall be written administrative and patient care policies and procedures for each of the rehabilitation services offered.~~

~~3. There shall be a written plan for each patient indicating the modality or type of treatment provided and the frequency of treatment. This plan shall be based on the written order of a physician.~~

~~4. There shall be written documentation in the patient's medical record of the rehabilitation services provided.~~

R9-10-325. ~~Quality assurance~~ Repealed

~~**A.** Each rural general hospital shall have a quality assurance program conducted in accordance with A.R.S. § 36-445. A record of such activities shall be maintained.~~

~~**B.** A discharge planning program shall be established to provide for the transfer of information between hospital and other health facilities or agencies to facilitate continuity of care. Periodic review and evaluation of the program shall be conducted by a committee established for this purpose.~~

R9-10-326. ~~Radiology services~~ Repealed

~~**A.** A rural general hospital shall have within the hospital as a minimum the capability of providing emergency diagnostic radiology services.~~

~~**B.** A physician shall be responsible for the medical direction of the radiology department.~~

~~**C.** A radiologic technician shall be on duty or on call at all times.~~

~~**D.** There shall be a radiologic procedure manual available to radiology services personnel.~~

~~**E.** X-ray examinations shall be performed only when ordered by a person authorized by law. Request for x-ray shall contain a concise statement of the reason for the examination.~~

~~**F.** The radiology department shall be staffed, equipped and operated in accordance with A.R.S. Title 30, Chapter 4 and regulations adopted thereunder.~~

R9-10-327. ~~Respiratory care services~~ Repealed

~~Rural general hospitals that provide respiratory care services shall meet the following provisions:~~

~~1. Respiratory care services shall include therapeutic procedures and may include diagnostic procedures.~~

~~2. A physician shall be responsible for the medical direction of the respiratory care unit or department.~~

~~3. Respiratory care services shall be provided in accordance with the written order of a physician. The order shall state the modality to be used, the type, frequency and duration of treatment and type and dose of medication including dilution ratio.~~

~~4. Reports of respiratory care services shall be made a part of the patient's medical record.~~

~~5. Respiratory therapy shall be administered by qualified personnel.~~

R9-10-328. ~~Special care units~~ Repealed

~~Rural general hospitals shall not have intensive care or cardiac care units.~~

R9-10-329. ~~Obstetrical services~~ Repealed

~~In rural general 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.~~

c. ~~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 delivery room record shall be maintained.~~
10. ~~Antepartum and postpartum care shall be under the supervision of a registered nurse.~~
11. ~~Newborn nursery~~
    a. ~~Policies and procedures shall be adopted in accordance with the standards and recommendations for Hospital Care of Newborn Infants adopted by reference in A.A.C. R9-1-413(B).~~
    b. ~~A registered nurse shall be in charge of the nursery at all times.~~
    c. ~~A nursery shall be provided for the care of newborns and shall not be used for any other purpose.~~
    d. ~~A room in which "rooming in" is practiced shall not be considered a nursery unless more than 2 mothers are accommodated in which case all requirements for newborn nurseries shall apply.~~
    e. ~~An individual bassinet shall be provided for each newborn and each newborn shall have separate equipment and supplies.~~
    f. ~~The use of common bathing or dressing areas is prohibited. All bathing, diaper changing, and treatments shall be carried out in the bassinet or on the newborn's individual shelf or drawer.~~
    g. ~~Accurate scales shall be provided.~~
    h. ~~Any newborn born outside of the hospital and any newborn suspected of having an infection or who has been exposed to actual or potential infection shall be properly isolated. The decision to transfer a newborn from the main nursery to isolation may be made by the nurse in charge of the main nursery in an emergency.~~
    i. ~~Only persons specified by hospital rules and regulations shall be admitted to any nursery.~~
    j. ~~Containers shall be provided for soiled diapers to ensure proper disposal.~~
    k. ~~Underwriters Laboratory approved isolettes shall be available.~~
    l. ~~The use of a rack or bassinet stand which holds more than 1 bassinet is prohibited.~~
    m. ~~Oxygen, oxygen equipment and suction equipment adapted to the use of newborn infants shall be available. An oxygen analyzer shall be available.~~
    n. ~~Formula shall be prepared in an appropriate isolated area.~~
    o. ~~Traffic in the nursery shall be closely supervised by the registered nurse in charge.~~
    p. ~~Sanitized nursery linens or disposable linens shall be used.~~
    q. ~~Whenever 2 or more infants in a nursery exhibit symptoms of a communicable illness, the incident shall be reported to 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.~~
    c. ~~At least 1 Underwriter Laboratory approved isolette.~~

R9-10-330. ~~Pediatric services~~ Repealed

~~Rural general hospitals with a designated pediatric unit 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 or guardians 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.~~

R9-10-331. ~~Social services~~ Repealed

~~When a rural general hospital provides social services the following conditions shall be met:~~

1. ~~There shall be policies and procedures relating to the staff and functions of the department.~~
2. ~~Personnel~~
    a. ~~The social service department shall be under the direction of a social worker and shall have adequate staff and facilities to perform all required functions; or~~
    b. ~~Social services shall be provided by a designated person who shall receive consultation from a social worker in accordance with a written agreement; or~~
    c. ~~Social services shall be provided by referral, based on established written procedures, to appropriate social agencies.~~
3. ~~Social services to patients shall be initiated by physician referral or by request of patient, family member or guardian.~~

4. ~~Social services information shall be recorded. Policies and procedures shall be established by the Department with approval of the medical staff which specify the type and extent of this information to be placed in the medical record.~~
5. ~~Facilities shall be provided which are accessible to patients and staff and which assure privacy for interviews.~~

R9-10-332. ~~Rural general hospital physical plant~~ Repealed

~~A.~~ ~~Physical plant -- existing facilities~~
1. ~~The physical plant of all rural general 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~~
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 rural general 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 a 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 rural general 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 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. ~~Rural general 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 isolation room for isolation of patients, with a communicable disease, for each 100 beds or fraction thereof. The isolation room shall contain a private toilet, shower/tub 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 40 square feet (3.72 sq. M) of floor space for each bassinet.~~
13. ~~Pediatric beds shall have the same space requirements 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 doors.~~
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 (9.23 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.~~

R9-10-333. ~~Rates and charges~~ Repealed

~~The current schedule of rates and charges shall be posted in accordance with R9-11-114(H) and R9-10-1734.~~

ARTICLE 4. ~~SPECIAL HOSPITALS~~ REPEALED

R9-10-411. ~~General~~ Repealed

~~A.~~ ~~Special hospitals shall observe R9-10-211.~~

~~B.~~ ~~Special hospitals include but are not limited to:~~
1. ~~Hospitals limiting admissions to patients requiring care or treatment for substance abuse.~~
2. ~~Hospitals limiting admissions to patients requiring services for the terminally ill.~~
3. ~~Hospitals limiting admissions to patients requiring psychiatric services.~~
4. ~~Hospitals limiting admissions to patients requiring reconstructive surgery or services in rehabilitation medicine.~~
5. ~~Hospitals limiting admissions to patients requiring obstetrical or gynecological services.~~
6. ~~Hospitals limiting admissions to patients requiring services for the treatment of pain or stress.~~

~~C.~~ ~~Special hospitals under common ownership with a general hospital shall not be required to maintain independent services or functions if such services or functions are provided by the general hospital.~~

R9-10-412. ~~Definitions~~ Repealed

~~Section R9-10-212 is adopted with the following additions:~~
1. ~~"Detoxification" means the systematic reduction of physical dependence upon alcohol or other drugs (excluding dependence on methadone or other maintenance drugs) by use of therapeutic procedures, which may include medication, rest, diet, counseling, or medical supervision.~~
2. ~~"Drug administration" means the giving of a single dose of medication to a specific patient as a result of an order of a physician or other authorized medical practitioner.~~
3. ~~"Drug dispensing" means the issuing of 1 or more doses of a medication in a suitable container, with appropriate label for subsequent administration to or use by a patient.~~
4. ~~"Gynecologist" means a physician specialist for the diagnosis and treatment of the female generative organs. He may also be an obstetrician.~~
5. ~~"Obstetrician" means a physician specialist for treatment of women during pre-natal, natal, and post-natal periods. He may also be a gynecologist.~~
6. ~~"Patient activity program" means a level of therapeutic revitalization and assessment of needs, interests, and activities for the re-enforcement and maintenance of health and well-being of the patient.~~
7. ~~"Physiatrist" means a physician specialist for physical medicine and rehabilitation.~~
8. ~~"Physician specialist" means a physician who,~~
    a. ~~Is a diplomate of the appropriate American Board or Osteopathic Board, or~~
    b. ~~Is a fellow of the appropriate American Specialty College or a member of the Osteopathic Specialist College, or~~
    c. ~~Has been notified of the admissibility for examination by the appropriate American Board or Osteopathic Board, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or the American Osteopathic Association and has not lost his eligibility for admissibility to the examination.~~
9. ~~"Psychiatric services" means the management, evaluation, diagnosis, treatment and prevention of mental illness.~~
10. ~~"Psychiatrist" means a physician specialist for the diagnosis and treatment of mental diseases and disorders.~~
11. ~~"Psychologist" means a person certified under provision of A.R.S. Title 32, Chapter 19.1.~~
12. ~~"Services for the terminally ill" means a program of palliative care for patients with terminal illness and treatment of the patient's concurrent medical conditions on an inpatient, day care or outpatient basis and may involve emotionally supportive care to the patient and his family, home health services and other social and health related services.~~
13. ~~"Substance abuse" means the chronic, habitual or compulsive use of alcohol, prescription or non-prescription drugs or intermittent or extended use of alcohol or such drugs resulting in impairment to physical health, mental faculties, social or economic functioning of the individual.~~

R9-10-413. ~~Administration~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-213. In addition, special hospitals that limit admissions to patients requiring services for the terminally ill shall be exempt from R9-10-213(B)(9)(a); however, pets shall not be allowed in the food service area.~~

R9-10-414. ~~Medical staff~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-214 with the following additions:~~

1. ~~Physical examinations are required at least annually for patients residing in special hospitals for more than 12 months.~~
2. ~~Special hospitals limiting admissions to patients requiring obstetrical and gynecological services shall have at least 1 medical staff member qualified as a physician specialist in obstetrics or gynecology.~~
3. ~~Special hospitals limiting admissions to patients requiring psychiatric services shall have at least a majority of the active medical staff members qualified as physician specialists in psychiatry.~~
4. ~~Special hospitals limiting admissions to patients requiring services in rehabilitation medicine shall have at least 1 medical staff member qualified as a physician specialist in rehabilitation medicine.~~
5. ~~Special hospitals limiting admissions to patients requiring services for the terminally ill shall have a medical director who is responsible for the overall coordination of the medical care to ensure the adequacy and appropriateness of the medical services provided to patients and the implementation of a program providing ongoing emotional support to staff and volunteers.~~
6. ~~The medical staff of special hospitals shall consist of 2 or more physicians.~~

R9-10-415. ~~Nursing services~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-215 except that:~~

1. ~~The director of nurses shall have education and experience in the special services provided by the hospital.~~
2. ~~In special hospitals not offering emergency or obstetrical services, there shall be at least 1 registered nurse and at least 1 other ancillary nursing personnel on duty at all times when there are inpatients.~~

R9-10-416. ~~Surgical services~~ Repealed

~~Special hospitals that provide surgical services shall comply with the requirements of R9-10-216.~~

R9-10-417. ~~Dietetic services~~ Repealed

~~**A.** Special hospitals shall comply with the requirements of R9-10-217 with the following additions.~~

~~**B.** Special hospitals limiting admissions to terminally ill patients shall meet the following requirements:~~

1. ~~Each patient's nutritional needs and wants shall be evaluated on a daily basis.~~
2. ~~A selective menu shall be available to patients.~~
3. ~~Between meal snacks and bedtime nourishment shall be available to patients.~~

R9-10-418. ~~Emergency services~~ Repealed

~~**A.** There shall be written policies for the provision of emergency care to patients receiving treatment within the hospital.~~

~~**B.** Special hospitals that provide outpatient emergency services shall comply with the requirements of R9-10-218.~~

R9-10-419. ~~Disaster preparedness~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-219.~~

R9-10-420. ~~Environmental services~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-220.~~

R9-10-421. ~~Medical records~~ Repealed

~~In addition to the requirements of R9-10-221 special hospitals shall comply with the following:~~

1. ~~Special hospitals limiting admissions to patients requiring psychiatric services shall include in the medical record:~~
   a. ~~A treatment plan shall include patient goals, treatment goals, treatment to be provided, and time intervals in which treatment is to be reviewed. The plan shall be annotated to reflect the results of treatment.~~
   b. ~~A report of neurological examination.~~
   c. ~~A report of a psychiatric evaluation.~~
   d. ~~A report of social services, if any.~~
   e. ~~A report of required physical examinations.~~
2. ~~Special hospitals that limit admissions to patients requiring reconstructive surgery or services in rehabilitation medicine shall include the following information in the medical record:~~
   a. ~~A treatment plan including patient goals, treatment goals, treatment to be provided, time intervals in which treatment is reviewed, and measures to be used to assess the effects of the treatment.~~
   b. ~~Report of an evaluation by a physiatrist or other properly qualified physician specialist.~~
   c. ~~Prosthetic or orthotic evaluation and reports, if applicable.~~
3. ~~Special hospitals that limit admission to patients requiring services for the terminally ill shall include the following information in the medical record:~~
   a. ~~Record of home care treatment, if applicable.~~
   b. ~~Record of day care treatment, if applicable.~~
   c. ~~Record of services provided to family, if applicable.~~
   d. ~~Social service reports.~~

e. ~~Activities plan.~~

4. ~~Special hospitals that limit admission to patients requiring obstetrical and gynecological services shall include the following information in the medical record:~~
   a. ~~A copy of the pre-natal record, if available.~~
   b. ~~A pre-natal examination updated within 24 hours of admission may substitute for the required physical examination.~~

R9-10-422. ~~Laboratory services~~ Repealed

~~A.~~ ~~Special hospitals that provide outpatient emergency services, obstetrical services, or surgical services shall comply with the requirements of R9-10-222.~~

~~B.~~ ~~Special hospitals that do not provide emergency, obstetrical or surgical services shall provide laboratory services on the premises or by agreement with a licensed laboratory. The laboratory service available by agreement shall be appropriate to meet the needs of hospitalized patients.~~

R9-10-423. ~~Pharmaceutical services~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-223.~~

R9-10-424. ~~Rehabilitation services~~ Repealed

~~Special hospitals that elect to provide rehabilitation services shall comply with the requirements of R9-10-224.~~

1. ~~Special hospitals limiting admissions to patients requiring psychiatric services shall provide occupational therapy and a patient activity program.~~
2. ~~Special hospitals limiting admission to patients with terminal illness shall provide physical therapy and a patient activity program.~~
3. ~~Special hospitals that limit admission to patients requiring reconstructive surgery or services in rehabilitation medicine shall provide rehabilitation services and comply with R9-10-224.~~

R9-10-425. ~~Quality assurance~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-225.~~

R9-10-426. ~~Radiology services~~ Repealed

~~A.~~ ~~Special hospitals that provide outpatient emergency or surgical services shall comply with the requirements of R9-10-226.~~

~~B.~~ ~~Special hospitals that do not provide emergency or surgical services shall nevertheless have radiologic services available on the premises or by agreement.~~

R9-10-427. ~~Respiratory care services~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-227.~~

R9-10-428. ~~Special care units~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-228.~~

R9-10-429. ~~Obstetrical services~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-229.~~

R9-10-430. ~~Pediatric services~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-230.~~

R9-10-431. ~~Social services~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-231. In addition, social services shall be provided in special hospitals which limit their admissions to patients requiring pain and stress services, reconstructive surgery or services in rehabilitation medicine, psychiatric services, substance abuse services, and services for the terminally ill.~~

R9-10-432. ~~Hospital physical plant~~ Repealed

~~Special hospitals shall comply with the requirements of R9-10-232 with the following additions and exceptions:~~

1. ~~New construction in special hospitals which limit admissions to patients requiring psychiatric services may, notwithstanding the provisions in the standards adopted by reference in A.A.C. R9-1-412(A) and (B), have exit corridors of a minimum width of 6 feet (1.82 meters) in lieu of 8 feet (2.43 meters) if alcoves opening onto the corridors are provided. The alcoves, suitable for temporary parking of linen carts, food carts, cleaning carts, and other equipment, shall have a minimum of 20 square feet (1.85 square meters) and be spaced no farther apart than 40 linear feet (12.2 meters) of corridor length or fraction thereof. New construction in these special hospitals shall conform to the requirements listed in the chapter for Long-term Care of the standard adopted by reference in A.A.C. R9-1-412(F) except that:~~
   a. ~~The examination and treatment room may be omitted.~~
   b. ~~Parking space for stretchers and wheelchairs may be omitted.~~

c. ~~Combined inpatient dining and recreation areas shall be increased to 40 square feet (3.71 square meters) per bed, for the first 100 beds and 30 square feet (2.78 square meters) for all beds in excess of 100.~~
d. ~~In addition to inpatient's dining and recreation space an additional 40 square feet (3.71 square meters) shall be provided for each day care patient if a day care program is provided.~~
e. ~~The nurse call system may be omitted.~~
f. ~~Physical therapy facilities may be omitted.~~
g. ~~General storage rooms may be reduced in size to 5 square feet (.46 square meters) per bed.~~
h. ~~Seclusion rooms, i.e., those rooms not assigned as patient rooms and used only as holding rooms, will not be counted as licensed beds.~~
i. ~~Hospital type elevators may be omitted.~~
j. ~~Doors to patient rooms may be a minimum of 3 feet (91 centimeters) clear width.~~
k. ~~Bed pan washers are not required in patient bath rooms.~~
l. ~~Toilet training rooms may be omitted.~~
m. ~~Emergency generators may be omitted; however, emergency power to provide lighting to means of egress and exit signs and power to alarm systems, smoke detection systems, sprinkler alarm systems, and magnetic hold-open devices on doors shall be provided.~~

2. ~~New construction for special hospitals limiting admissions to terminally ill patients shall conform to the requirements listed in the chapter for Long-term Care of the standard adopted by reference in A.A.C. R9-1-412(F), except that:~~
   a. ~~An examination room is not required.~~
   b. ~~In addition to inpatient's dining and recreation space an additional 40 square feet (3.71 square meters) shall be provided for each day care patient if a day care program is provided.~~
   c. ~~If a personal care room (beauty parlor or barber shop) is not provided within the facility, provision shall be made for outside services~~.
   d. ~~An attractive outdoor recreation area, suitable for lounging shall be provided.~~
   e. ~~A room suitable for storing and dispensing all necessary patient medication shall be provided.~~
   f. ~~In the event the facility for terminally ill patients is a separately licensed component of a general hospital, separate dining and recreational spaces shall be provided.~~
3. ~~New construction for special hospitals limiting admissions to patients requiring treatment of pain and stress shall conform to the requirements listed in the chapter for Hospitals of the standard adopted by reference in A.A.C. R9-1-412(F), except that:~~
   a. ~~Rooms for disturbed patients are not required.~~
   b. ~~Psychiatric nursing units are not required.~~
   c. ~~Surgical facilities are not required within the facility.~~
   d. ~~Radiology facilities are not required within the facility.~~
   e. ~~Laboratory facilities are not required within the facility.~~
   f. ~~A group therapy room or rooms shall be provided at a rate of 50 square feet (4.6 square meters) per patient.~~
   g. ~~Hospital type elevators may be omitted.~~
   h. ~~Doors to patients' rooms may be a minimum of 3 feet (91 centimeters) clear width.~~
   i. ~~Bed pan washers are not required in patient bath rooms.~~
   j. ~~Toilet training rooms may be omitted.~~
   k. ~~Emergency generators may be omitted; however, emergency power to provide lighting to means of egress and exit signs, and power to alarm systems, smoke detection systems, sprinkler alarm systems, and magnetic hold-open devices on doors shall be provided.~~
   l. ~~Nurse call systems may be omitted.~~
   m. ~~The width of exit access corridors may be a minimum of 6 feet (1.82 meters) in lieu of 8 feet (2.43 meters) if alcoves opening onto the corridors are provided. The alcoves, suitable for temporary parking of linen carts, food carts, cleaning carts, and other equipment, shall have a minimum of 20 square feet (1.85 square meters) and be spaced no farther apart than 40 linear feet (12.2 meters) of corridor length or fraction thereof.~~
4. ~~New construction for special hospitals limiting admissions to patients requiring treatment for substance abuse shall conform to the requirements listed in the chapter for Long-term Care of the standard adopted by reference in A.A.C. R9-1-412(F), except that:~~
   a. ~~Physical therapy and occupational therapy facilities are not required.~~
   b. ~~Parking space for stretchers and wheelchairs may be omitted.~~
   c. ~~Hospital type elevators may be omitted.~~
   d. ~~Door to patients' rooms may be a minimum of 3 feet (91 centimeters) clear width.~~
   e. ~~Bed pan washers are not required in patient bath rooms.~~
   f. ~~Toilet training rooms may be omitted.~~

g. Emergency generators may be omitted; however, emergency power to lighting to means of egress, exit signs, and power to alarm systems, smoke detection systems, sprinkler alarm systems, and magnetic hold-open devices on doors shall be provided.
h. General storage rooms may be reduced in size to 5 square feet (.46 square meters) per bed.
i. The width of exit access corridors may be a minimum of 6 feet (1.82 meters) in lieu of 8 feet (2.43 meters) if alcoves opening onto the corridors are provided. The alcoves, suitable for temporary parking of linen carts, food carts, cleaning carts, and other equipment, shall have a minimum of 20 square feet (1.85 square meters) and be spaced no farther apart than 40 linear feet (12.2 meters) of corridor length or fraction thereof.
j. Nurse call systems may be omitted.

5. New construction for special hospitals limiting admissions to patients requiring reconstructive surgery or services in rehabilitation medicine shall conform to the requirements listed in the chapter for Hospitals of the standard adopted by reference in A.A.C. R9-1-412(F), except that:
a. Patient rooms exclusively for the use of the pediatric patient may have a maximum capacity of 8 patients for no more than 50% of the total pediatric beds.
b. Pediatric patient rooms with more than 4 beds shall contain a nursing desk positioned to allow the staff constant visual observation of the patients.
c. In addition, all patient toilet rooms shall be designed in accordance with provisions for the handicapped person as required by the standard adopted by reference in A.A.C. R9-1-412(I); however, toilet heights shall be established as required by the service offered and type of patient served by the hospital.
d. The number of parking spaces designed in accordance with provisions for the handicapped person as required by the standard adopted by reference in A.A.C. R9-1-412(I) shall be provided for new construction at a rate of 1 space per 10 beds; however, based on the services offered, the Hospital may be excused from the above handicapped parking space requirement with prior approval from the Department.
6. Special hospitals limiting admissions to patients requiring treatment for obstetrical and gynecological services may exceed the maximum patient room square footage for patient rooms when used as birthing rooms for labor, delivery, and postpartum care by adding additional space usually allotted to bassinet space in the nursery.

R9-10-433. ~~Rates and charges~~ Repealed
~~Special hospitals shall comply with the requirements of R9-10-233.~~

R9-10-434. ~~License application~~ Repealed
~~Application for licensure for special hospitals shall include a statement describing the type of services the hospital will offer.~~

R9-10-435. ~~Special hospitals that limit admission to patients requiring pain and stress services~~ Repealed
~~There shall be written policies and procedures concerning the provision of special treatments such as:~~
1. ~~Drug therapy.~~
2. ~~Biofeedback and autogenic training.~~
3. ~~Transcutaneous and neural stimulation.~~

R9-10-436. ~~Special hospitals that limit admissions to patients requiring psychiatric services~~ Repealed
~~A.~~ ~~Psychological services~~
1. ~~Psychological services shall be available to meet the needs of patients.~~
2. ~~There shall be a written plan describing the organization of psychology services or arrangements for provisions for such services.~~
3. ~~There shall be sufficient number of appropriately qualified staff to provide psychological services.~~
4. ~~The psychology staff shall participate in development of the treatment plan for each patient.~~
5. ~~There shall be documentation of psychological services provided.~~
6. ~~There shall be written procedures for the referral of patients for evaluation and treatment not available in the hospital.~~

~~B.~~ ~~Social services~~
1. ~~There shall be adequate staff to meet the specific needs of individual patients and their families.~~
2. ~~There shall be a written plan describing the organization of social services.~~
3. ~~Social work services shall be under the supervision of a qualified social worker.~~

~~C.~~ ~~Patient activities program~~
1. ~~There shall be adequate, suitable area available for patient activities including a patient lounge.~~
2. ~~There shall be a written patient activities plan suitable to the needs of each patient. Activities shall encourage independence and self-care consistent with patient's condition.~~
3. ~~Patient activities shall be supervised by a patient's activity director or an employee of the hospital who shall receive consultation from a qualified consultant. Records shall be maintained of patient attendance, services rendered, patient's response, and recommendations made by the consultant.~~
4. ~~A schedule of patient activities shall be posted in a prominent place in an area of the hospital readily available to all patients.~~

~~5. Activities shall be available to bedfast patients.~~

R9-10-437. ~~Special hospitals limiting admissions to patients requiring services in rehabilitation medicine~~ Repealed

~~**A.** Organization. Rehabilitation services shall be under the medical direction of a physician specializing in rehabilitation medicine.~~

~~**B.** Services. In addition to physical therapy, occupational therapy, speech therapy, and audiology services as required by R9-10-224(A), prosthetic and orthotic, psychology, vocational and social services shall be available.~~

~~**C.** Facilities, supplies, equipment. There shall be:~~

~~1. Adequate facilities available for the provision of therapy, including suitable space and equipment, for teaching activities of daily living.~~

~~2. Physical and occupational therapy areas that include a reception area, treatment area, office space for therapy staff, storage space for supplies and equipment, and adequate appropriate equipment as determined by professional staff to meet the requirements for treatment of patients.~~

~~3. Suitable space and equipment for speech therapy, sensory testing and evaluation within the facility or through arrangements with an existing community facility.~~

~~4. Adequate office space for patient vocational counseling and evaluation.~~

~~5. Adequate space shall be provided for fitting and adjustment of prosthetic and orthotic devices.~~

~~**D.** Outpatient services. When outpatient services are offered, the equipment shall be adequate to provide safe, prompt services to the number and types of patients served.~~

R9-10-438. ~~Special hospitals limiting admissions to patients requiring substance abuse services~~ Repealed

~~**A.** Services. The following shall be available:~~

~~1. Detoxification.~~

~~2. Substance abuse rehabilitation.~~

~~a. Substance abuse rehabilitation service which includes physical, psychological, education and socio-cultural aspects of rehabilitation.~~

~~b. Social and recreational activities suited to the needs of the patients shall be available.~~

~~c. Patients may participate in facility tasks, household chores, and general duties when these are included in the plan of treatment.~~

~~3. Outpatient services shall be provided in the hospital or by written agreement for outside services.~~

~~4. Family services. Counseling and information services shall be available to families of patients.~~

~~**B.** Staffing~~

~~1. There shall be sufficient staff to assure the safety and welfare of the patients, and to achieve the objectives of the program.~~

~~2. The substance abuse rehabilitation program in hospitals treating alcoholism shall be staffed by qualified persons at a rate of not fewer than 1 per 10 patients undergoing alcoholism treatment.~~

~~3. Psychologists, social workers, and physical therapists shall be available as required to meet the needs of patients.~~