DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hospital Licensing Requirements

2) Code Citation: 77 Ill. Adm. Code 250

3)

Section Numbers:	Proposed Action:
250.160	Amend
250.330	Amend
250.1510	Amend
250.1810	Amend
250.1820	Amend
250.1830	Amend
250.1845	New
250.1850	Amend
250.1860	Repeal
250.1870	Amend

4) Statutory Authority: Hospital Licensing Requirements [210 ILCS 85]

5) A Complete Description of the Subjects and Issues Involved: The Hospital Licensing Requirements regulate hospitals, including all aspects of obstetric and neonatal care.

This rulemaking updates Subpart O of the Hospital Licensing Requirements that contains the Sections on obstetric and neonatal care and obstetric departments. The amendments update the requirements to reflect current industry and regulatory standards. Additionally, a new Section 250.1845, containing minimum requirements for caesarean births, is being added, and Section 250.1860 (Special Programs) is being repealed. Section 250.160 (Incorporated and Referenced Materials) is being amended to incorporate new industry standards and to add professional association standards, federal regulations and relevant State statutes and rules.

In other amendments, Section 250.330 (Orders for Medications and Treatments) is being amended to add a 72-hour deadline for signing telephone orders, and Section 250. 11510 (Medical Records) is being amended to clarify who may authenticate telephone orders.

The economic effect of this proposed rulemaking is unknown. Therefore, the Department requests any information that would assist in calculating this effect.

The Department anticipates adoption of this rulemaking approximately six to nine months after publication of the Notice in the *Illinois Register*.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any mergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? s

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objective: This rulemaking does not create a State Mandate.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning this rulemaking within 45 days after this issue of the Illinois Register to:

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 West Jefferson St., 5th Floor
Springfield, Illinois 62761

217/782-2043
e-mail: dph.rules@illinois.gov

13) Initial Regulatory Flexibility Analysis:

A) Type of small businesses, small municipalities and not-for-profit corporations affected: Hospitals

B) Reporting, bookkeeping or other procedures required for compliance: Yes

C) Types of professional skills necessary for compliance: Nursing, medical

14) Regulatory Agenda on which this rulemaking was summarized:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

July 2010

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES

PART 250
HOSPITAL LICENSING REQUIREMENTS

SUBPART A: GENERAL

Section

SUBPART B: ADMINISTRATION AND PLANNING

Section

SUBPART C: THE MEDICAL STAFF

Section

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

SUBPART D: PERSONNEL SERVICE

SUBPART E: LABORATORY

SUBPART F: RADIOLOGICAL SERVICES

SUBPART G: GENERAL HOSPITAL EMERGENCY SERVICE

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SUBPART N: HOUSEKEEPING AND LAUNDRY SERVICES

SUBPART O: OBSTETRICMATERNITY AND NEONATAL SERVICE

SUBPART P: ENGINEERING AND MAINTENANCE OF THE PHYSICAL PLANT, SITE, EQUIPMENT, AND SYSTEMS – HEATING, COOLING, ELECTRICAL, VENTILATION, PLUMBING, WATER, SEWER, AND SOLID WASTE DISPOSAL

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

SUBPART Q: CHRONIC DISEASE HOSPITALS

SUBPART R: PHARMACY OR DRUG AND MEDICINE SERVICE

SUBPART S: PSYCHIATRIC SERVICES

SUBPART T: DESIGN AND CONSTRUCTION STANDARDS

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

SUBPART U: CONSTRUCTION STANDARDS FOR EXISTING HOSPITALS

SUBPART V: SPECIAL CARE AND/OR SPECIAL SERVICE UNITS

SUBPART W: ALCOHOLISM AND INTOXICATION TREATMENT SERVICES

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

250.2880 Client Legal and Human Rights

250.APPENDIX A Codes and Standards (Repealed)
250.EXHIBIT A Codes (Repealed)
250.EXHIBIT B Standards (Repealed)
250.EXHIBIT C Addresses of Sources (Repealed)
250.ILLUSTRATION A Seismic Zone Map
250.TABLE A Measurements Essential for Level I, II, III Hospitals
250.TABLE B Sound Transmission Limitations in General Hospitals
250.TABLE C Filter Efficiencies for Central Ventilation and Air Conditioning Systems in General Hospitals (Repealed)
250.TABLE D General Pressure Relationships and Ventilation of Certain Hospital Areas (Repealed)
250.TABLE E Piping Locations for Oxygen, Vacuum and Medical Compressed Air
250.TABLE F General Pressure Relationships and Ventilation of Certain Hospital Areas
250.TABLE G Insulation/Building Perimeter

AUTHORITY: Implementing and authorized by the Hospital Licensing Act [210 ILCS 85].

SOURCE: Rules repealed and new rules adopted August 27, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 21, p. 49, effective May 16, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 45, p. 85, effective November 6, 1978; amended at 3 Ill. Reg. 17, p. 88, effective April 22, 1979; amended at 4 Ill. Reg. 22, p. 233, effective May 20, 1980; amended at 4 Ill. Reg. 25, p. 138, effective June 6, 1980; amended at 5 Ill. Reg. 507, effective December 29, 1980; amended at 6 Ill. Reg. 575, effective December 30, 1981; amended at 6 Ill. Reg. 1655, effective January 27, 1982; amended at 6 Ill. Reg. 3296, effective March 15, 1982; amended at 6 Ill. Reg. 7835 and 7838, effective June 17, 1982; amended at 7 Ill. Reg. 962, effective January 6, 1983; amended at 7 Ill. Reg. 5218 and 5221, effective April 4, 1983 and April 5, 1983; amended at 7 Ill. Reg. 6964, effective May 17, 1983; amended at 7 Ill. Reg. 8546, effective July 12, 1983; amended at 7 Ill. Reg. 9610, effective August 2, 1983; codified at 8 Ill. Reg. 19752; amended at 8 Ill. Reg. 24148, effective November 29, 1984; amended at 9 Ill. Reg. 4802, effective April 1, 1985; amended at 10 Ill. Reg. 11931, effective September 1, 1986; amended at 11 Ill. Reg. 10283, effective July 1, 1987; amended at 11 Ill. Reg. 10642, effective July 1, 1987; amended at 12 Ill. Reg. 15080, effective October 1, 1988; amended at 12 Ill. Reg. 16760, effective October 1, 1988; amended at 13 Ill. Reg. 13232, effective September 1, 1989; amended at 14 Ill. Reg. 2342, effective February 15, 1990; amended at 14 Ill. Reg. 13824, effective September 1, 1990; amended at 15 Ill. Reg. 5328, effective May 1, 1991; amended at 15 Ill. Reg. 13811, effective October 1, 1991; amended at 17

Ill. Reg. 1614, effective January 25, 1993; amended at 17 Ill. Reg. 17225, effective October 1, 1993; amended at 18 Ill. Reg. 11945, effective July 22, 1994; amended at 18 Ill. Reg. 15390, effective October 10, 1994; amended at 19 Ill. Reg. 13355, effective September 15, 1995; emergency amendment at 20 Ill. Reg. 474, effective January 1, 1996, for a maximum of 150 days; emergency expired May 29, 1996; amended at 20 Ill. Reg. 3234, effective February 15, 1996; amended at 20 Ill. Reg. 10009, effective July 15, 1996; amended at 22 Ill. Reg. 3932, effective February 13, 1998; amended at 22 Ill. Reg. 9342, effective May 20, 1998; amended at 23 Ill. Reg. 1007, effective January 15, 1999; emergency amendment at 23 Ill. Reg. 3508, effective March 4, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9513, effective August 1, 1999; amended at 23 Ill. Reg. 13913, effective November 15, 1999; amended at 24 Ill. Reg. 6572, effective April 11, 2000; amended at 24 Ill. Reg. 17196, effective November 1, 2000; amended at 25 Ill. Reg. 3241, effective February 15, 2001; amended at 27 Ill. Reg. 1547, effective January 15, 2003; amended at 27 Ill. Reg. 13467, effective July 25, 2003; amended at 28 Ill. Reg. 5880, effective March 29, 2004; amended at 28 Ill. Reg. 6579, effective April 15, 2004; amended at 29 Ill. Reg. 12489, effective July 27, 2005; amended at 31 Ill. Reg. 4245, effective February 20, 2007; amended at 31 Ill. Reg. 14530, effective October 3, 2007; amended at 32 Ill. Reg. 3756, effective February 27, 2008; amended at 32 Ill. Reg. 4213, effective March 10, 2008; amended at 32 Ill. Reg. 7932, effective May 12, 2008; amended at 32 Ill. Reg. 14336, effective August 12, 2008; amended at 33 Ill. Reg. 8306, effective June 2, 2009; amended at 34 Ill. Reg. 2528, effective January 27, 2010; amended at 34 Ill. Reg. 3331, effective February 24, 2010; amended at 34 Ill. Reg. 19031, effective November 17, 2010; amended at 34 Ill. Reg. 19158, effective November 23, 2010; amended at 35 Ill. Reg. 4556, effective March 4, 2011; amended at 35 Ill. Reg. 6386, effective March 31, 2011; amended at 35 Ill. Reg. 13875, effective August 1, 2011; amended at 36 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

Section 250.160 Incorporated and Referenced Materials

a) The following regulations and standards are incorporated in this Part:

1) Private and professional association standards:

A) American Society for Testing and Materials (ASTM), Standard No. E90-99 (2002): Standard Test Method for Laboratory Measurement of Airborne Sound Transmission Loss of Building Partitions and Elements, which may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, Pennsylvania 19428-2959. (See

Section 250.2420.)

B) The following standards of the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE), which may be obtained from the American Society of Heating, Refrigerating, and Air-Conditioning Engineers, Inc., 1791 Tullie Circle, N.E., Atlanta, Georgia 30329: (See Section 250.2480.)

i) ASHRAE Handbook of Fundamentals (2005);

ii) ASHRAE Handbook for HVAC Systems and Equipment (2004);

iii) ASHRAE Handbook-HVAC Applications (2003).

C) The following standards of the National Fire Protection Association (NFPA), which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169:

i) NFPA 101 (2000): Life Safety Code; (See Sections 250.2420, 250.2450, 250.2460, 250.2470, and 250.2490.)

ii) NFPA 10 (1998): Standards for Portable Fire Extinguishers; (See Section 250.1980.)

iii) NFPA 13 (1999): Standards for the Installation of Sprinkler Systems; (See Sections 250.2490 and 250.2670.)

iv) NFPA 14 (2000): Standard for the Installation of Standpipe, Private Hydrants and Hose Systems; (See Sections 250.2490 and 250.2670.)

v) NFPA 25 (1998): Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems;

vi) NFPA 30 (1996): Flammable and Combustible Liquids Code; (See Section 250.1980.)

vii) NFPA 45 (1996): Standard on Fire Protection for Laboratories Using Chemicals;

viii) NFPA 54 (1999): National Fuel Gas Code;

ix) NFPA 70 (1999): National Electrical Code; (See Sections 250.2440 and 250.2500.)

x) NFPA 72 (1999): National Fire Alarm Code;

xi) NFPA 80 (1999): Standard for Fire Doors and Fire Windows; (See Section 250.2450.)

xii) NFPA 82 (1999): Standard on Incinerators and Waste and Linen Handling Systems and Equipment; (See Section 250.2440.)

xiii) NFPA 90A (1999): Standard for Installation of Air Conditioning and Ventilating Systems; (See Sections 250.2480 and 250.2660.)

xiv) NFPA 96 (1998): Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations; (See Section 250.2660.)

xv) NFPA 99 (1999): Standard for Health Care Facilities; (See Sections 250.1410, 250.1910, 250.1980, 250.2460, 250.2480, 250.2490 and 250.2660.)

xvi) NFPA 101-A (2001): Guide on Alternative Approaches to Life Safety; (See Section 250.2620.)

xvii) NFPA 110 (1999): Standard for Emergency and Standby Power Systems;

xviii) NFPA 220 (1999): Standard on Types of Building Construction; (See Sections 250.2470 and 250.2620.)

xix) NFPA 221 (1997): Standard for Fire Walls and Fire

Barrier Walls;

xx) NFPA 241 (1996): Standard for Safeguarding Construction, Alteration and Demolition Operations;

xxi) NFPA 255 and 258 (2000): Standard Method of Test of Surface Burning Characteristics of Building Materials, and Recommended Practice for Determining Smoke Generation of Solid Materials; (See Section 250.2480.)

xxii) NFPA 701 (1999): Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (See Sections 250.2460 and 250.2650.)

D) American Academy of Pediatrics and American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, Sixth Edition (2007), which may be obtained from the American College of Obstetricians and Gynecologists Distribution Center, P.O. Box 933104, Atlanta, Georgia 31193-3104 (800-762-2264). (See Section 250.1820.)

E) American College of Obstetricians and Gynecologists, Guidelines for Women's Healthcare, Third Edition (2007), which may be obtained from the American College of Obstetricians and Gynecologists Distribution Center, P.O. Box 933104, Atlanta, Georgia 31193-3104 (800-762-2264). (See Section 250.1820.)

F) American Academy of Pediatrics (AAP), Red Book: Report of the Committee on Infectious Diseases, 28th Edition (2009), which may be obtained from the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, Illinois 60007. (See Section 250.1820.)

G) American Academy of Pediatrics and the American Heart Association, 2005 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines, which may be obtained from the American Academy of Pediatrics, 141 Northwest Point Blvd.,

Elk Grove Village, Illinois 60008, or at pediatrics.aappublications.org/cgi/reprint/117/5/e1029.pdf. (See Section 250.1830.)

H) National Association of Neonatal Nurses, Position Statement #3009 Minimum RN Staffing in NICUs, which may be obtained from the National Association of Neonatal Nurses, 4700 W. Lake Ave., Glenview, Illinois 60025, or at nann.org/pdf/08_3009_rev.pdf. (See Section 250.1830.)

I)~~F)~~ National Council on Radiation Protection and Measurements (NCRP), Report 49: Structural Shielding Design and Evaluation for Medical Use of X-rays and Gamma Rays of Energies up to 10 MeV (1976) and NCRP Report 102: Medical X-Ray, Electron Beam and Gamma-Ray Protection for Energies Up to 50 MeV (Equipment Design, Performance and Use) (1989), which may be obtained from the National Council on Radiation Protection and Measurements, 7910 Woodmont Ave., Suite 800, Bethesda, Maryland 20814-3095. (See Sections 250.2440 and 250.2450.)

J)~~G)~~ DOD Penetration Test Method MIL STD 282 (1995): Filter Units, Protective Clothing, Gas-mask Components and Related Products: Performance Test Methods, which may be obtained from Naval Publications and Form Center, 5801 Tabor Avenue, Philadelphia, Pennsylvania 19120. (See Section 250.2480.)

K)~~H)~~ National Association of Plumbing-Heating-Cooling Contractors (PHCC), National Standard Plumbing Code (2003), which may be obtained from the National Association of Plumbing-Heating-Cooling Contractors, 180 S. Washington Street, P.O. Box 6808, Falls Church, Virginia 22046 (703-237-8100).

L)~~I)~~ The International Code Council, International Building Code (2000), which may be obtained from the International Code Council, 4051 Flossmoor Road, Country Club Hills, Illinois 60477-5795. (See Section 250.2420.)

M)~~J)~~ American National Standards Institute, Specifications for Making Buildings and Facilities Accessible to, and Usable by, the

Physically Handicapped (1968), which may be obtained from the American National Standards Institute, 25 West 433rd Street, 4th Floor, New York, New York 10036. (See Section 250.2420.)

N)~~K)~~ Accreditation Council for Graduate Medical Education, Essentials of Accredited Residencies in Graduate Medical Education (1997), which may be obtained from the Accreditation Council for Graduate Medical Education, 515 North State Street, Suite 2000, Chicago, Illinois 60610. (See Section 250.315.)

O)~~L)~~ The Joint Commission ~~on Accreditation of Healthcare Organizations~~, 2006 Hospital Accreditation Standards (HAS), Standard PC.3.10, which may be obtained from the Joint Commission ~~on Accreditation of Healthcare Organizations~~, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181. (See Section 250.1035.)

P)~~M)~~ National Quality Forum, Safe Practices for Better Health Care (2009), which may be obtained from the National Quality Forum, 601 13th Street, NW, Suite 500 North, Washington DC 20005, or from www.qualityforum.org.

2) Federal Government Publications:

A) Department of Health and Human Services, United States Public Health Service, Centers for Disease Control and Prevention, "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" and "Guidelines for Infection Control in Health Care Personnel, 1998, which may be obtained from National Technical Information Service (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161. (See Section 250.1100.)

B) Department of Health and Human Services, United States Public Health Service, Centers for Disease Control and Prevention, "Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations − Animals in Health Care Facilities", "Morbidity and Mortality Weekly Report", June 6, 2003/Vol. 52/No. RR-10, which may be obtained from the Centers for

Disease Control and Prevention, 1600 Clifton Road, MS K-95, Atlanta, Georgia 30333.

C) Department of Health and Human Services, United States Public Health Services, Centers for Disease Control and Prevention, "Guidelines for Hand Hygiene in Health-Care Settings", October 25, 2002, which may be obtained from the National Technical Information Services (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161.

D) Department of Health and Human Services, United States Public Health Service, Centers for Disease Control and Prevention, "Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008", which may be obtained from the Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, Georgia 30333.

E) National Center for Health Statistics and World Health Organization, Geneva, Switzerland, "International Classification of Diseases", 10th Revision, Clinical Modification (ICD-10-CM) (1990), Version for 2007, which can be accessed at http://www.who.int/classifications/icd/en/.

3) Federal Regulations

A) 45 CFR 46.101, To What Does the Policy Apply? (October 2010).

B) 45 CFR 46.103(b), Assuring Compliance with this Policy – Research Conducted or Supported by any Federal Department or Agency (October 2010).

C) 42 CFR 482, Conditions of Participation for Hospitals (October 2010).

D) 21 CFR, Food and Drugs (April 2010).

b) All incorporations by reference of federal regulations and guidelines and the standards of nationally recognized organizations refer to the regulations, guidelines and standards on the date specified and do not include any editions or

amendments subsequent to the date specified.

c) The following statutes and State regulations are referenced in this Part:

1) State of Illinois statutes:

A) Hospital Licensing Act [210 ILCS 85].

B) Illinois Health Facilities Planning Act [20 ILCS 3960].

C) Medical Practice Act of 1987 [225 ILCS 60].

D) Podiatric Medical Practice Act of 1987 [225 ILCS 100].

E) Pharmacy Practice Act of 1987 [225 ILCS 85].

F) Physicians Assistant Practice Act of 1987 [225 ILCS 95].

G) Illinois Clinical Laboratory and Blood Bank Act [210 ILCS 25].

H) X-ray Retention Act [210 ILCS 90].

I) Safety Glazing Materials Act [430 ILCS 60].

J) Mental Health and Developmental Disabilities Code [405 ILCS 5].

K) Nurse Practice Act [225 ILCS 65].

L) Health Care Worker Background Check Act [225 ILCS 46].

M) MRSA Screening and Reporting Act [210 ILCS 83].

N) Hospital Report Card Act [210 ILCS 88].

O) Illinois Adverse Health Care Events Reporting Law of 2005 [410 ILCS 522].

P) Smoke Free Illinois Act [410 ILCS 82].

Q) Health Care Surrogate Act [775 ILCS 540].

R) Perinatal HIV Prevention Act [410 ILCS 335].

2) State of Illinois rules:

A) Department of Public Health, Illinois Plumbing Code (77 Ill. Adm. Code 890).

B) Department of Public Health, Sexual Assault Survivors Emergency Treatment Code (77 Ill. Adm. Code 545).

C) Department of Public Health, Control of Communicable Diseases Code (77 Ill. Adm. Code 690).

D) Department of Public Health, Food Service Sanitation Code (77 Ill. Adm. Code 750).

E) Department of Public Health, Public Area Sanitary Practice Code (77 Ill. Adm. Code 895).

F) Department of Public Health, Maternal Death Review (77 Ill. Adm. Code 657).

G) Department of Public Health, Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693).

H) Department of Public Health, Control of Tuberculosis Code (77 Ill. Adm. Code 696).

I) Department of Public Health, Health Care Worker Background Check Code (77 Ill. Adm. Code 955).

J) Department of Public Health, Language Assistance Services Code (77 Ill. Adm. Code 940).

K) Department of Public Health, Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640).

L) Health Facilities and Services Review Board, Narrative and Planning Policies (77 Ill. Adm. Code 1100).

M) Health Facilities and Services Review Board, Processing, Classification Policies and Review Criteria (77 Ill. Adm. Code 1110).

N)~~K)~~ Department of Public Health, Private Sewage Disposal Code (7 Ill. Adm. Code 905).

O)~~L)~~ Capital Development Board, Illinois Accessibility Code (71 Ill. Adm. Code 400).

P)~~M)~~ State Fire Marshal, Boiler and Pressure Vessel Safety (41 Ill. Adm. Code 120).

Q)~~N)~~ State Fire Marshal, Fire Prevention and Safety (41 Ill. Adm. Code 100).

R)~~O)~~ Illinois Emergency Management Agency, Standards for Protection Against Radiation (32 Ill. Adm. Code 340).

P) Illinois Emergency Management Agency, Use of X-rays in the Healing Arts Including Medical, Dental, Podiatry, and Veterinary Medicine (32 Ill. Adm. Code 360).

3) Federal Statute:

Health Insurance Portability and Accountability Act of 1996 [110 USC 1936].

(Source: Amended at 36 Ill. Reg. _____, effective _____)

SUBPART C: THE MEDICAL STAFF

Section 250.330 Orders for Medications and Treatments

a) No medication, treatment or diagnostic test shall be administered to a patient except on the written order of a member of the medical staff, a house staff

member under the supervision of a member of the medical staff, or allied health personnel ~~with clinical privileges recommended by the hospital medical staff and granted by the hospital governing board~~, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per medical staff-approved hospital policy that includes an assessment for contraindications.

1) The staff-approved *influenza and pneumococcal immunization policy shall include, but not be limited to, the following:*

A) *Procedures for identifying patients age 65 or older and, at the discretion of the* hospital, *other patients at risk;*

B) *Procedures for offering immunization against influenza virus when available between September 1 and April 1, and against pneumococcal disease upon admission or discharge, to patients age 65 or older, unless contraindicated*; and

C) *Procedures for ensuring that patients offered immunization, or their guardians, receive information regarding the risks and benefits of vaccination.*

2) *The hospital shall provide a copy of its influenza and pneumococcal immunization policy to the Department upon request.* (Section 6.26~~6.25~~ of the Act)

b) Verbal orders shall be signed before the member of the medical staff, the house staff member or allied health personnel ~~with clinical privileges recommended by the hospital medical staff and granted by the hospital governing board~~ leaves the area. Telephone orders shall be used sparingly and countersigned by the ordering practitioner or another practitioner who is responsible for the care of the patient as soon as practicable pursuant to a hospital policy approved by the medical staff, but no later than 72 hours after the order was given.

c) Members of the medical staff~~Medical Staff~~, house staff members or allied health personnel ~~with clinical privileges recommended by the hospital medical staff and granted by the hospital governing board~~ shall give orders for medication and treatment only to the licensed, registered or certified professional persons who are authorized by law to administer or dispense the medication or treatment in the course of practicing their identified specific discipline.

d) The medical directors of the laboratory, radiology or other diagnostic services may respectively authorize the performance of diagnostic tests and procedures at the request of other than members of the medical staff in accordance with policies approved by the medical staff and governing board.

e) The medical director of the physical therapy or rehabilitation department may authorize the provision of physical therapy or rehabilitation services or treatments at the request of other than members of the medical staff in accordance with policies approved by the medical staff and governing board.

(Source: Amended at 36 Ill. Reg. _____, effective _____)

SUBPART L: RECORDS AND REPORTS

Section 250.1510 Medical Records

a) Facilities

1) The hospital shall maintain~~Suitable~~ medical record facilities~~,~~ with adequate supplies and equipment~~, shall be maintained by the hospital~~.

2) Medical records shall be stored safely. Medical records are to be handled so as to assure safety from water seepage or fire damage and are to be safeguarded from unauthorized use.

b) Organization

1) Responsible Personnel

A) A~~It is recommended that a~~ qualified medical record practitioner (registered medical record administrator or accredited medical record technician) shall be employed as the director of the medical records department.

B) The director of the medical records department shall participate in educational programs relative to medical record activities, ~~in~~ on-the-job training and orientation of other medical record personnel, and in-service medical record educational programs. Professional

consultation services shallshould be provided for the medical record practitioner.

2) An adequate, accurate, timely, and complete medical record shall be maintained for each patient. Minimum requirements for medical record content are as follows:

A) Patientpatient identification and admission information;

B) Thehistory of the patient as to chief complaints, present illness and pertinent medicalpast history, family history, and social history;

C) A physical examination report;

D) Provisionalprovisional diagnosis;

E) Diagnosticdiagnostic and therapeutic reports on laboratory test results, x-ray findings, any surgical procedure performed, any pathological examination, any consultation, and any other diagnostic or therapeutic procedure performed;

F) Ordersorders and progress notes made by the attending physician and, when applicable, by other members of the medical staff and allied health personnel;

G) Observationsobservation notes and vital sign charting made by nursing personnel; and

H) Conclusionsconclusions as to the primary and any associated diagnoses;, brief clinical resume;, disposition at discharge, including to include instructions andand/or medications; and any autopsy findings on a hospital death.

3) For record requirements pertaining to obstetricmaternity patients and newborn infants, see Section 250.1830(hi).

4) A committee of the organized medical staff shall be responsible for reviewing medical records to ensure adequate documentation, completeness, promptness, and clinical pertinence.

5) The hospital shall establish requirements~~Requirements~~ for the completion of medical records and for the retention period for medical records ~~shall be established~~. Definite~~It is recommended that definite~~ policies and procedures pertaining to the use of medical records and the release of medical record information shall be issued, and discharge diagnoses shall be expressed in ~~acceptable~~ terminology of a recognized disease nomenclature.

c) Authentication of Medical Record Entries

1) All entries into the medical record shall be authenticated by the individual who made or authorized the entry. "Authentication," for purposes of this Section, means identification of the author of a medical record entry by that author, and confirmation that the contents are what the author intended, except that telephone orders may be authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and who is authorized to write orders pursuant to Section 250.330.

2) Medical record entries shall include all notes, orders or observations made by direct patient care providers and any other individuals required to make the~~such~~ entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments, including, but not limited to, radiologic or electrocardiographic reports, operative reports, reports of pathologic examination of tissue and other similar reports. The medical record may include entries that are transmitted by facsimile machine, provided that the faxed copies are~~will be maintained~~ on non-thermal paper and that the faxed copies are~~will be~~ dated and authenticated pursuant to~~in accordance with~~ hospital policy approved by the medical staff.

3) Written signatures or initials and electronic signatures or computer-generated signature codes are acceptable as authentication. All signatures or initials, whether written, electronic, or computer-generated, shall include the initials of the signer's credentials.

4) If~~In order for~~ a hospital uses~~to employ~~ electronic signatures or computer-generated signature codes for authentication purposes, the hospital's medical staff and governing board shall~~Board must~~ adopt a policy that

permits authentication by electronic or computer-generated signature. The policy shall identify those categories of the medical staff, allied health staff or other personnel within the hospital who are authorized to authenticate patient records using electronic or computer-generated signatures.

5) At a minimum, the policy shall include adequate safeguards to ensure confidentiality, including, but not limited to, the following:

A) Each user shall~~must~~ be assigned a unique identifier that is generated through a confidential access code.

B) The hospital shall~~must~~ certify in writing that each identifier is kept strictly confidential. This certification shall~~must~~ include a commitment to terminate a user's use of a particular identifier if it is found that the identifier has been misused. "Misused" shall mean that the user has allowed another person or persons to use his or her personally assigned identifier, or that the identifier has otherwise been inappropriately used.

C) The user shall~~must~~ certify in writing that he or she is the only person with user access to the identifier and the only person authorized to use the signature code.

D) The hospital shall~~must~~ monitor the use of identifiers periodically and take corrective action as needed. The process by which the hospital will conduct the monitoring shall be described in the policy.

6) A system employing the use of electronic signatures or computer-generated signature codes for authentication shall include a verification process to ensure that the content of authenticated entries is accurate. The verification process shall include, at a minimum, the following provisions:

A) The system shall require completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps or obvious contradictory statements appearing within those designated fields. The system shall also require that ~~correction or supplementation of~~ previously

authenticated entries are corrected or supplemented~~shall be made~~ by additional entries, separately authenticated and made after~~subsequent in time to~~ the original entry.

B) The system shall allow~~must make an opportunity available to~~ the user to verify that the document is accurate and that the signature has been properly recorded.

C) The hospital shall~~must~~, as part of its quality assurance activities, periodically sample records generated by the system to verify the accuracy and integrity of the system.

7) A user may terminate authorization for use of electronic or computer-generated signature upon written notice to the Director of Medical Records or other person designated by the hospital's policy.

8) Each report generated by a user shall~~must~~ be separately authenticated.

d) Indexing

1) A patient index that serves as a key to the location of the medical record of each person who is or has been an inpatient shall be maintained as a perpetual master index~~, using either a card index or a computer facility system~~. A daily register of patients admitted to the hospital and babies born in the hospital shall be maintained.

2) Medical records shall be classified and indexed according to diagnoses, surgical procedures, and physician, and other indices shall be developed as deemed necessary for the advancement of medical care.

3) The ~~It is recommended that the latest edition of the "~~International Classification of Diseases shall~~," or an adaptation thereof,~~ be used as the statistical classification for purposes of uniformity and compatability of data between and among hospitals.

e) Preservation

1) All original medical records or photographs of ~~such~~ records shall be preserved in accordance with Section 6.17 of the Act~~a hospital policy~~

~~based on American Hospital Association recommendations and legal opinion~~.

2) The hospital shall have a policy for the preservation of patient medical records if~~in the event of the closure of~~ the hospital closes.

(Source: Amended at 36 Ill. Reg. _____, effective _____)

SUBPART O: OBSTETRIC~~MATERNITY~~ AND NEONATAL SERVICE

Section 250.1810 Applicability of Other Provisions of this Part~~other Parts of these regulations~~

The requirements~~regulations~~ set forth elsewhere in this Part~~publication~~ (excluding Subpart P and Subpart Q), shall apply to the operation of obstetric~~maternity~~ hospitals and to obstetric~~maternity~~ and neonatal departments of general hospitals.

(Source: Amended at 36 Ill. Reg. _____, effective _____)

Section 250.1820 Obstetric~~Maternity~~ and Neonatal Service (Perinatal Service)

~~a) Chief of Obstetric and Pediatric Services~~

~~1) Each hospital should have an organized obstetric staff with a chief of obstetric service who is either certified or qualified in obstetrics or a physician who is interested in and regularly practicing obstetrics as chief of the maternity service, and document a source for obstetric consultation available on a 24-hour basis. The chief's level of qualification and expertise is to be appropriate to level of care rendered in the facility.~~

~~2) The chief's responsibilities shall include:~~

~~A) the general supervision of the care of the perinatal patients assigned to the unit;~~

~~B) the establishment of criteria for admissions;~~

~~C) the adherence to licensing requirements;~~

~~D)~~ ~~the adoption by the medical staff of standards of practice and privileges;~~

~~E)~~ ~~the identification of clinical conditions and procedures requiring consultation;~~

~~F)~~ ~~the arrangement of conferences held at regular intervals (quarterly is suggested as a minimum interval) to review operations, complications, and mortality;~~

~~G)~~ ~~assurance that the clinical records, consultations and reports are properly completed and analyzed;~~

~~H)~~ ~~the provision for exchange of information between medical, administrative and nursing staffs.~~

~~3)~~ ~~Each hospital should have an organized pediatric staff with a chief of service who is either certified or qualified in pediatrics or a physician who is interested in and regularly practicing neonatology as chief of the neonatology service and a source for neonatology consultation available on a 24-hour basis. This physician's responsibilities shall include subsections (a)(2)(A) through (H) of this Section, as relates to the care of newborn infants.~~

a)~~b)~~ Provision of Care

1) All hospitals license~~described or considered~~ as general hospitals by the ~~Illinois~~ Department ~~of Public Health~~ shall provide for the admission, medical care, transfer or discharge of obstetric and neonatal patients.

2) No hospital shall fail to provide such care without the ~~expressed~~ written consent of the Director or the Director's designee~~of the Illinois Department of Public Health~~.

3) Each ~~licensed~~ hospital providing ~~maternity and~~ perinatal services shall comply with the perinatal care standards in~~promulgated by~~ the ~~Department (~~Regionalized Perinatal Health Care Code~~, 77 Ill. Adm. Code 640)~~.

b)~~c)~~ Location

1) ObstetricMaternity and neonatal services shall be located and arranged to provide maximum protection for obstetricmothers and neonatal patients from infection and cross-infection from one another, patients in other services of the hospital and staff and visitors.

2) ObstetricHospital maternity and neonatal facilities shall be located in the hospital so as to prevent through traffic to any other part of the hospital.

c)d) Adequacy of Services

1) The hospital shall have well-organized obstetricmaternity and neonatal services that are adequately supervised by qualified personnel and with the necessary space, facilities, equipment and personnel to provide obstetricperform or make available maternity and neonatal services in compliance withcommensurate with the hospital's designated level of care pursuant to the Regionalized Perinatal Health Care Codeneeds of the population in the hospital service area.

2) Total live births generated by the hospital service area will determine the size of the postpartum nursing unit (number of rooms and beds), which in turn will be related to space allotments for delivery rooms, nurseries and other facilities. The size of the unit will affect medical and nursing care plans for the maternity and neonatal service.

d)e) ObstetricMaternity and Neonatal Service Plan

1) Hospitals providing obstetricmaternity and neonatal services shallmust develop a plan for the management of the obstetric and neonatal patients that meets the requirements of this Subpart and the requirements of the Regionalized Perinatal Health Care Code applicable to the hospital's level of care, as designated by the Department. The plan shallmust be developed by the nursing department and medical staff and shallmust be approved by the governing authority of the hospital.

2) The hospital's written ObstetricMaternity and Neonatal Service Plan and level of care shall be known to medical staff and nursing personnel and more specifically to obstetricmaternity and nursery personnel. A copy of the Plan shall be available in each obstetricmaternity and nursery unit and

in every relevant hospital service area; the Plan shall~~must~~ be reviewed at least every two years and revised as indicated by the review.

e)~~f)~~ Levels of Care

1) Care shall be provided to obstetric~~Maternity~~ and neonatal patients ~~should be identified~~ according to the following level of specialized care as defined in the Regionalized Perinatal Health Care Code: ~~required~~.

A) Level I hospitals provide care to low-risk pregnant women and newborns, operate general care nurseries and do not operate a Neonatal Intensive Care Unit (NICU) or a Special Care Nursery (SCN).~~or Primary Perinatal Care means the minimal level of care provided to the healthy or low risk patient.~~

B) Level II hospitals provide care to women and newborns at moderate risk, operate intermediate care nurseries and do not operate an NICU or an SCN.~~or intermediate perinatal care means the level of care provided to a mother, fetus or newborn infant that is less than tertiary or the greatest degree of intensive care but that is a greater degree of intensity than normal or general care.~~

C) Level II hospitals with Extended Neonatal Capabilities (IIE) provide care to women and newborns at moderate risk and do not operate an SCN but do operate an NICU.

D)~~C)~~ Level III hospitals care for patients requiring increasingly complex care, operate an NICU, and provide~~or intensive perinatal care means the level of care providing close medical and surgical coordination,~~ multidisciplinary consultation and supervision for~~provided to~~ those patients with medical and surgical problems that require highly specialized treatment and highly trained personnel.

2) Service Management Plan

A) A service management plan shall~~must~~ be provided for all ~~the primary, intermediate and intensive~~ levels of care for all patients. The plan shall~~must~~ provide for consultation services and shall

establish the ~~availability of such~~ services for~~to stimulate~~ early diagnosis of obstetric,~~maternal,~~ fetal and neonatal problems. The plan shall include an infection control risk assessment and policy and procedures if the hospital allows water births. Hospitals that are not designated~~Services unable~~ to provide all ~~three~~ levels of care shall~~of patients must~~ maintain plans for the safe transfer ~~of certain categories~~ of patients who require a higher level of care to hospitals with more specialized facilities, services and personnel, pursuant to the Regionalized Perinatal Health Care Code.

B) When the condition permits, a patient may be transferred from the Level III~~tertiary care~~ facility to a Level II~~an intermediate care~~ facility that is nearest the family residence or another facility that can provide the appropriate level of care, in accordance with the Regionalized Perinatal Health Care Code. ~~A neonatal patient should be transferred to a nursery nearest the family's home that is able to provide an appropriate level of care.~~

~~f)~~g) Infection Control

1) The hospital shall follow procedures approved by the hospital's infection control committee, including procedures for the isolation of known or suspected cases of infectious disease in the obstetric and neonatal departments.

2) The hospital shall establish policies and procedures for infection control in the obstetric and neonatal departments that are consistent with the Guidelines for Perinatal Care; Section 250.1100 of this Part; the Control of Tuberculosis Code; and the recommendations in the American Academy of Pediatrics Red Book, Report of the Committee on Infectious Diseases.

~~1)~~ ~~The facility shall establish policies and procedures that include the use of universal precautions and address isolation techniques and facilities. The policies and procedures must be well known to all personnel performing services in the maternity and newborn service areas. A copy of the procedures must be placed in each maternity and nursery unit and in relevant hospital service areas.~~

~~A)~~ ~~There must be a continuing program of instruction for all personnel on the mode of spread of infection.~~

~~B)~~ ~~The policies and procedures relative to the criteria for isolation and aseptic techniques must be enforced.~~

3)~~2)~~ The policy for infection control in the obstetric and neonatal departments shall include, but not be limited to, the following~~Infection Control Requirements~~:

~~A)~~ ~~Professional and ancillary maternity and nursery personnel who have contact with patients shall be free of transmissible disease.~~

A)~~B)~~ Health ~~assessment of~~ personnel shall:

~~i)~~ ~~Health assessment of nursery personnel shall be performed at a frequency determined by the Infection Control Committee and shall include screening for tuberculosis in accordance with Section 690.720 of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690).~~

i)~~ii)~~ Show evidence~~Evidence~~ of prior rubella infection or rubella vaccination and comply with the health assessment and immunization requirements of Section 250.450 (Personnel Health Requirements). Health care personnel in obstetric and neonatal services shall comply with any additional requirements for health and immunizations, pursuant to the hospital's policies and procedures for infection control in the obstetric department;~~shall be required of nursery personnel.~~

~~C)~~ ~~Except that hair must be properly covered or controlled, caps, beard bags, and masks are not needed for routine nursery activities. Caps, beard bags and masks are required in the delivery room, and for surgical procedures including umbilical vessel catheterization.~~

~~D)~~ii) Wash hands~~Handwashing~~ to above the elbows with an antiseptic agent using~~by~~ a procedure developed and posted by the infection control committee~~Infection Control Committee is required~~ before

entering the nursery, and between patients. Fingernails shall be kept short. Artificial fingernails or polish is acceptable;

~~E)~~iii) Remove all~~All~~ rings, watches and bracelets ~~shall be removed~~ before hand washing~~handwashing~~ and entering the nursery;~~,~~

B)~~F)~~ The hospital's infection control committee~~facility's Infection Control Committee~~ shall establish a dress code for ~~full and part-time~~ employees and visitors in compliance with the "~~"~~Guidelines for Perinatal Care."

~~G) In the normal care nursery, infants with suspected infections are moved to a transition nursery for observation.~~

~~H) Individual isolation technique is applied to the infected or potentially infected maternity or newborn infant. A closed isolette does not constitute isolation, nor is it a part of isolation technique.~~

C)~~I)~~ An infected newborn shall be placed in an isolation room with separate scrub facilities if the following conditions are not met in the newborn nursery (see Section 250.2440(h) for additional requirements):~~Movement of an infected newborn to a separate isolation room is not necessary if there is~~

i) Adequate~~adequate~~ nursing and medical staff for unhurried movement between patients; ~~and~~

ii) Adequate~~adequate~~ time for thorough hand washing~~handwashing~~ between patients and gowning;~~,~~

iii) Sufficient~~sufficient~~ space (4 to 6~~four to six~~ feet) for easy movement between patients so that staff will not~~and to remove temptation to~~ move from one patient to another without hand washing;~~handwashing,~~

iv) A~~a~~ continuing program of instruction for all nursery personnel on the mode of spread of infections;~~,~~ and

v) At least~~if there are~~ two sinks for each nursery room. ~~If~~

~~these conditions are not met, an isolation room with separate scrub facilities is necessary for the infected patient. See Section 250.2440(h) for additional requirements.~~

D)~~J)~~ The hospital shall develop infection control guidelines consistent with the Guidelines for Perinatal Care for infants~~Infants~~ born outside the hospital, other than transfers, or under conditions not aseptic, or born of mothers with membranes ruptured 24 hours or more, or born of mothers suspected of harboring infectious disease, ~~shall be cared for in the mother's private room, an observation or transition room, or in the primary care area~~ with careful attention to proper aseptic technique of attending personnel and to conditions described in subsection (f)(3)(C)~~(g)(2)(I)~~ of this Section.

E)~~K)~~ Infection control for the obstetric department shall include procedures for~~The physician in charge and the nursing supervisor with the Infection Control Committee should establish a program of~~ disinfection of~~for~~ patient areas~~. Clear descriptions of cleaning and disinfection methods should be incorporated into the patient care procedures manual. Incubators and bassinets are to be disinfected upon an infant's discharge, and other nursery and delivery equipment cleaned and sterilized by specific procedures~~ consistent with Guidelines for Perinatal Care~~recommendations of the American Academy of Pediatrics, American College of Obstetrics and Gynecology~~ and ~~outlined in~~ the unit's procedures manual.

F) Policies and procedures for water births shall include an infection control risk assessment by the hospital's infection control committee to identify potential sources of infection for the mother and infant and recommendations for mitigating infections during water deliveries. The policies and procedures shall be provided to the Department, upon request.

g)~~h)~~ Combined Facilities

1) Obstetric and clean gynecologic service facilities may be combined in

accordance with a plan that complies with the requirements of this Subpart. The combined service program, its functional operations and detailed requirements shall~~rules and regulations must~~ be approved by the hospital obstetric and newborn service, medical staff and governing authority~~Hospital Maternity and Newborn Service, Medical Staff and Governing Authority~~.

2) In combined programs, caesarean~~Cesarean~~ section and obstetrically related surgery, other than vaginal delivery, shall ~~may~~ be carried out in a designated and approved operating or delivery room. In combined programs, vaginal deliveries shall~~may~~ be carried out only in designated and approved delivery rooms or designated and approved operating rooms used solely for obstetric and~~/or~~ clean gynecologic procedures.

3) Gynecologic service and obstetric~~maternity~~ service may be provided ~~for~~ in a combined Obstetric~~Maternity~~ and Gynecologic Service, or clean gynecologic cases may be admitted to the postpartum nursing unit of an obstetric~~a maternity~~ service in accordance with the hospital's Obstetric and Neonatal~~Maternity~~ Service Plan.

4) Only members of the medical staff with appropriate privileges may admit and care for patients in ~~such~~ combined service areas. Admission shall~~Such admissions must~~ be strictly controlled and be subject to the final authority delineated in the medical staff bylaws and approved by the hospital governing authority. The~~There shall be close surveillance of the services by the~~ hospital's infection control committee shall provide close surveillance of the services.

5) Patients admitted to combined service facilities of hospitals with approved programs shall be limited to:

A) Obstetric patients admitted for delivery;~~.~~

B) Clean obstetric complications (regardless of month of gestation); and~~. Refer to Section 250.1830(g)(2).~~

~~C)~~ ~~Other noninfectious complications of pregnancy.~~

C)~~D)~~ Selected clean gynecologic patients.

6) Patient eligibility for admission shall comply with the hospital's infection control policy.~~Patients not eligible for admission include those:~~

~~A)~~ ~~with an active, acute or chronic infectious condition;~~

~~B)~~ ~~patients housed on other services of the hospital;~~

~~C)~~ ~~requiring radium or radiation isotope therapy, excluding external radiation therapy.~~

7) On~~There shall, on~~ a daily basis, ~~be~~ unoccupied reserve beds in the combined facilities shall be ready~~in readiness~~ for use by obstetric patients, pursuant to hospital policy. ~~This unoccupied reserve shall be not less than 10% of the average daily census for obstetric patients.~~

8) Patients admitted to the combined services may be taken to x-ray or other hospital facilities for diagnostic procedures, if the~~before or after surgery, so long as there is no evidence that such~~ procedures do not pose an infection risk or other hazard~~may be hazardous~~ to the patient or to other patients on the combined service.

9) Patients may receive postpartum or immediate postoperative care in the general recovery room prior to being returned to the combined service floor if the following conditions exist~~prevail~~ (refer to Section 250.1320(a)):

A) The recovery room or intensive care unit is a separate unit adjacent to or part of the general surgical operating suite and~~/or~~ delivery suite;~~.~~

B) The recovery room or intensive care unit contains no patients with known or suspected infectious or communicable disease or other adverse conditions;~~.~~

C) The recovery room is under the direct supervision of the anesthesia service (see Section 250.1410); and~~chairman of anesthesiology of the hospital. In separate maternity recovery rooms such supervision is provided by the obstetrician in charge or a qualified~~

~~designated physician.~~

D) Health care professionals providing care to post-surgical obstetric or gynecologic patients in a separate recovery room have training consistent with that required for health care professionals providing care in the general recovery room.

10) Nursing care of all patients shall be supervised by a registered ~~professional~~ nurse qualified to provide ~~such~~ supervision.

11) Nursing care of all patients may be provided~~given~~ by the same personnel.

12) Visiting regulations for obstetric patients shall apply to all patients admitted to the combined facilities~~.~~ (refer~~Refer~~ to Section 250.1830(k)).

h)~~i)~~ Activity Records

1) The hospital shall establish and keep ~~the necessary~~ daily records, including a Patient Log and the Obstetric~~Maternity~~ Services Daily Census Report, from which required reports can be prepared.

2) The Patient Log shall contain, at~~as~~ a minimum, the following data on each patient admitted to the department other than obstetric~~maternity~~ patients:

A) Name of patient or hospital patient number;

B) Age;

C) Attending physician's name;

D) Date of admission;

E) Admitting diagnosis;

F) Operative procedure;

G) Discharge diagnosis;

H) Date of discharge;

I) Days stay;

J) Transferred off floor;

Yes ___ Date ___; No ___ ; and

K) Reason for transfer.

3) An Obstetric~~A Maternity~~ Service Daily Census Report shall be kept~~,~~ that, ~~which~~ for each day of the month, gives the patient census (at the census-taking hour) of:

A) obstetric patients, including patients with clean obstetric complications;~~,~~

B) gynecologic patients;~~,~~

C) empty beds in the department;~~,~~ and

D) total patients.

4) The hospital shall submit required reports pursuant to the Regionalized Perinatal Health Care Code.~~including a supplement to its monthly Perinatal Activities Report to the Department. The report form shall be provided by the Department. Refer to Section 250.1830(i)(1).~~

(Source: Amended at 36 Ill. Reg. _____, effective _____)

Section 250.1830 General Requirements for All Obstetric~~Maternity~~ Departments

a) The temperature and humidity in the nurseries and in the delivery suite shall be maintained at a level best suited for the protection of mothers and infants~~mother and baby as determined by the responsible people in the maternity department and~~ as recommended by the Guidelines for Perinatal Care~~American Academy of Pediatrics and ACOG~~. Chilling of the neonate shall be avoided; the neonate shall, immediately after birth, be ~~immediately~~ placed in a~~an approved~~ radiant heat source that is ready to receive the infant and that allows access for resuscitation efforts. The radiant heat source shall comply with the recommendations of the

Guidelines for Perinatal Care. After the neonate has been stabilized, if the mother wishes to hold her newborn, a radiant heater or pre-warmed blankets shall be available to keep the neonate warm. Personnel shall be available who are trained to use the equipment to maintain a neutral thermal environment for the neonate ~~shall be available~~. For general temperature and humidity requirements, see Section 250.2480(d)(1). In general, a temperature between 72 degrees and 76 degrees and relative humidity between 35% and 60% are acceptable.

b) Linens and Laundry: Linens shall be cleaned and disinfected in compliance with the Guidelines for Perinatal Care.

1) Nursery linens shall be washed separately from other hospital linens.

~~2) Soiled linens shall be discarded into impervious plastic bags placed in hampers that are easy to clean and disinfect. Chutes from nursery to laundry shall be used only if a system of negative air pressure exists.~~

~~3) Plastic bags of soiled diapers (reusable or disposable) and other linens shall be sealed and removed from the nursery at least every eight hours.~~

~~4) Linens shall be transported to the nursery in an enclosed unit or otherwise protected from contamination.~~

2)~~5)~~ No new unlaundered garments shall be used in the nursery. ~~Linen used in observation and special care nurseries shall be autoclaved.~~

c) Sterilizing equipment, as required in Section 250.1090, shall be available. Sterilizing equipment~~This~~ may be provided in the obstetric~~maternity~~ department or in a central sterilizing unit, provided that flash sterilizing equipment or adequate sterile supplies and instruments are provided in the obstetric~~maternity~~ department.

d) Accommodations and facilities for obstetric patients~~mothers~~

1) The hospital shall identify specific rooms and beds, adjacent when possible to other obstetric~~maternity~~ facilities, as obstetric~~maternity~~ rooms and beds. These rooms and beds shall be used exclusively for obstetric~~maternity~~ patients or for combined obstetric~~maternity~~ and clean gynecological service beds in accordance with Section 250.1820(g~~h~~).

2) Patient~~Whenever feasible, adjacent patient~~ rooms and beds that are adjacent to another nursing unit may be used for clean cases as part of the adjacent nursing unit.~~may be used as "swing beds" to be made a part of another nursing unit. Adjacent rooms and beds may be used for clean cases.~~ A corridor partition with doors is recommended to provide a separation between the obstetric~~maternity~~ beds and ~~maternity~~ facilities and the non-obstetric~~nonmaternity~~ rooms. The doors shall be kept closed except when in active use as a passageway.

3) Facilities shall be available for the immediate isolation of all patients in whom an infectious condition ~~or other conditions~~ inimical to the safety of other obstetric~~maternity~~ and neonatal patients exist~~are thought to exist~~.

4) ~~It is preferred that labor rooms be private or two-bed rooms.~~ Labor rooms shall be convenient~~conveniently located with reference~~ to the delivery rooms and shall have facilities for examination and preparation of patients. Each room used for labor, delivery and postpartum (see Section 250.1870) shall include a bathroom equipped with a toilet and a shower. The bathroom also shall include a sink, unless a sink is located in the patient room. The bathroom shall be directly accessible from the patient room without going through the corridor.

5) Delivery rooms shall be equipped and staffed to provide emergency resuscitation for infants pursuant to the recommendation of the American Academy of Pediatrics and ACOG and shall comply with the American Academy of Pediatrics/American Health Association's American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines. ~~Equipment shall include an infant size positive pressure bag with capability of 100% O_2 delivery; bag and mask with attachment for oxygen; laryngoscope with 0- and 1-size blades; endotracheal tubes sizes 2.5, 3.0, and 3.5 millimeters or equivalent; oral airways; and an appropriate device to provide a source of continuous suction for aspiration of the pharynx and stomach. An umbilical vessel catheterization tray shall be available. Only personnel qualified and trained to do so shall use this equipment.~~

6) If only one delivery room is available and in use~~required~~, one labor room

shall be arranged as an emergency delivery room and shall have a minimum clear floor area of 180 square feet.

7) ~~A recovery room is recommended.~~ The patient shall be kept under close observation until her condition is stabilized following delivery. Observations at established time intervals shall be recorded in~~as a part of~~ the patient's medical record~~chart~~. A recovery area shall be provided. Emergency equipment and supplies shall be available for use in the recovery area. ~~Continuing education for personnel providing recovery room care shall be provided. Refer to Section 250.1410(g).~~

e) Accommodations and facilities for infants

1) Level I nurseries~~Primary Care Nurseries~~:

A) A clean nursery or nurseries shall be provided, near the mothers' rooms, with adequate lighting and ventilation. A~~There shall be a~~ minimum of 30 square feet of floor area for each bassinet and 3 feet between bassinets shall be provided. Equipment shall be provided to prevent direct draft on the infants. Individual~~Because one nursing staff person is required for every six to eight normal infants, individual~~ nursery rooms shall have a capacity of six to eight neonates or 12 to 16 neonates. The normal newborn infant care area in a smaller hospital shall limit room size to eight neonates, with a minimum of ~~so that~~ two ~~or more~~ rooms ~~are~~ available to permit cohorting in the presence of infection.

B) Bassinets equipped to provide for the medical examination of the newborn infant and for the storage of necessary supplies and equipment shall be provided in a number to exceed obstetric beds by at least 20% to accommodate multiple births, extended stay, and fluctuating patient loads. Bassinets shall be separated by a minimum of 3 feet, measuring from the edge of one bassinet to the edge of the adjacent one.

C) A glass observation window shall be provided through which infants~~babies~~ may be viewed.

D) Resuscitation equipment as described in subsection (e)(1)(E)(iii)~~for~~

~~the delivery suite and below~~, and personnel trained to use it, shall be available in the nursery at all times.

E) Each ~~primary care~~ nursery shall have necessary equipment immediately available~~on hand equipment necessary~~ to stabilize the sick infant prior to transfer. Equipment~~Such equipment~~ shall consist of:

i) A heat source capable of maintaining the core temperature of even the smallest infant at 98 degrees (an incubator, or preferably a radiant heat source);

ii) Equipment with the ability to monitor bedside blood sugar ~~frequently (Dextrostix)~~;

iii) A resuscitation tray containing equipment pursuant to the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines~~at least a laryngoscope, 0- and 1-size blades, endotracheal tubes of various neonatal sizes, infant size positive pressure bag and appropriate sized masks, gavage tubes, and an umbilical vessel catheterization tray~~; and

iv) Equipment for delivery of 100% oxygen concentration, and the ability to measure delivered oxygen in fractional inspired concentrations (FI O_2). The oxygen analyzer shall be calibrated and serviced according to the manufacturer's instructions at least monthly by the hospital's respiratory therapy department or other responsible personnel trained to perform the task.

F) Consultation and Referral Protocols shall comply with the Regionalized Perinatal Health Care Code.~~:~~

~~i) Each primary care nursery shall have a clearly designated Level II or Level III nursery to which it refers patients and from which it seeks consultation and advice. The telephone~~

~~number of the Level II or Level III nursery and the name of the nursery director shall be posted in the nursery. A log of communication between the general nursery and the referral nursery shall be maintained by the head nurse of the general nursery.~~

~~ii)~~ ~~Protocols for management of certain disease states, and for consultation and referral shall be developed by the nursery director in conjunction with the director of the Level II or Level III unit to which referrals are sent.~~

~~iii)~~ ~~These protocols shall spell out details for local management of disease states and specific transfer criteria. These protocols shall be maintained in the nursery.~~

2) Level II and Level III nurseries~~Intermediate and Intensive Care Nurseries~~ shall comply with the Regionalized Perinatal Health Care Code. Cribs~~meet all of the conditions described above except that infant cribs~~ shall be separated by 4 to 6 feet ~~of space~~ to allow for ease of movement of additional personnel, and to allow space for additional equipment used in care of infants in these areas. New buildings or additions or material alterations to existing buildings that affect the Level II with Extended Neonatal Capabilities nursery shall provide at least 70 square feet of space for each infant.~~There shall be 80 to 100 square feet of space for each infant cared for in the Level III or Intensive Care area.~~

3) A Level III nursery shall be 80 to 100 square feet of space for each infant.

4)~~3)~~ Facilities shall be available for the immediate isolation of all newborn infants who have or are suspected of having an infectious disease.

5)~~4)~~ When an infectious condition exists or is suspected of existing~~is thought to exist~~, the infant shall be isolated in accordance with policies and procedures established and approved by the hospital and consistent with recommended procedures of the Guidelines for Perinatal Care~~ACOG, AAP,~~ and the Control of Communicable Diseases Code.

f) The personnel requirements and recommendations set forth in Subpart D apply to the operation of the obstetric~~maternity~~ department, in addition to the following:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Each hospital shall have a staffing plan for nursing personnel providing care for obstetric and neonatal patients. The registered nursing components of the plan shall comply with Section 250.1130 of this Part, with requirements for the level of perinatal care, as designated in accordance with the Regionalized Perinatal Health Care Code, the Guidelines for Perinatal Care, the National Association of Neonatal Nurses' (NANN) Position Statement #3009 Minimum RN Staffing in NICUs, and the following parameters~~Nursing Staff – General Requirements~~:

A) Nursing supervision by a registered ~~professional~~ nurse shall be provided for the entire 24-hour period for each occupied unit of the obstetric~~maternity~~ and neonatal services. This nurse shall have education and experience in obstetric~~maternity~~ and~~/or~~ neonatal nursing.

B) At least one registered nurse~~maternity or neonatal nurse~~ trained in obstetric~~maternity~~ and nursery care shall be assigned to the care of mothers and infants at all times. To prepare for an unexpected delivery~~When infants are present in the nursery~~, at least one registered nurse~~person~~ trained to give care to ~~the~~ newborn infants shall be assigned at all times to the nursery with duties restricted to the care of the infants. Infants shall never be left unattended.

C) A registered ~~professional~~ nurse shall be in attendance at all deliveries~~,~~ and shall~~must~~ be available to monitor the mother's general condition and that of the fetus during labor, ~~and~~ for at least two hours after delivery, and longer if complications occur.

D) Nursing personnel providing care for obstetric and other patients shall be instructed on a continuing basis in the proper technique to prevent cross-infection. When it is necessary for the same nurse to care for both obstetric~~maternity~~ and non-obstetric~~nonmaternity~~ patients in the gynecologic unit, proper technique shall be followed.

E) Obstetric and neonatal department nurses providing input to the hospital's nursing care committee pursuant to Section 250.1130 of

this Part shall, prior to proposing their recommendations for the hospital's written staffing plan, consider the staffing standards listed in subsection (f)(1) of this Section. ~~Nursing personnel are permitted to be assigned to the maternity neonatal division only for an entire shift.~~

F) Temporary relief from outside the obstetric and ~~maternity~~ neonatal division by qualified personnel shall be permitted as necessary according to appropriate infection control policy.

2) Nursing staff ~~Staff~~ – Level I requirements ~~or Primary Care~~ for occupied units. These units shall meet the following requirements in addition to General Care Requirements in Section 250.1830(f)(1).

A) At least two nursing personnel shall be assigned per shift. Both shall be registered nurses. ~~Labor and Delivery Unit Staffing shall be planned to ensure that the total nursing personnel on each shift is equal to one-half the average number of deliveries per 24 hours. At least half of the personnel on each shift shall be R.N.s, and at no time shall the nursing staff on any shift be fewer than two. The nursing staff of the labor and post delivery recovery area shall not have other responsibilities in the labor/delivery suite except for emergencies.~~

~~B) Postpartum and General Care Newborn Unit:~~

~~i) If these units are organized as separate nursing units, staffing shall be based on a formula of one nursing personnel per six to eight patients and shall ensure one R.N. per unit per shift.~~

~~ii) If the units are combined as a rooming-in or modified rooming-in unit, the nursing staff shall be planned to provide one nursing personnel per four mother baby units and shall never be staffed at fewer than two nursing personnel per shift. One shall be an R.N.~~

B) ~~C)~~ The capability to provide neonatal resuscitation in the delivery room shall be demonstrated by the current completion of a

nationally recognized neonatal resuscitation program by medical, nursing and respiratory care staff or a hospital rapid response team, in accordance with the requirements of the Regionalized Perinatal Health Care Code.~~At least one member of the nursing staff on each shift, who is skilled in cardiopulmonary resuscitation of the newborn, shall be immediately available to the delivery suite and newborn nursery area.~~

C) Hospitals shall have the capability for continuous electronic maternal-fetal monitoring for patients, with staff available 24 hours a day, including physician and nursing, who are knowledgeable of electronic maternal-fetal monitoring use and interpretation. Physicians and nurses shall complete a competence assessment in electronic maternal-fetal monitoring every two years, in accordance with the Regionalized Perinatal Health Care Code.

~~D) Changes in medical staff regulations, where applicable, shall be provided to permit the perinatal medicine service to fully utilize the services of specially trained paramedical and nursing personnel where these personnel are needed and/or desired.~~

3) Nursing staff~~Staff~~ – Level II ~~Intermediate Perinatal Care~~ requirements for occupied units~~Requirements~~. These units shall meet the ~~following~~ requirements for Level I in subsection (f)(2)~~in addition to General Care Requirements in Section 250.1830(f)(1)~~. Nursery personnel may be shared with the Level I nursery as needed.

4) Nursing staff – Level II With Extended Neonatal Capabilities requirements for occupied units. In addition to the requirements in subsection (f)(3), the obstetric-newborn nursing services shall be directed by a full-time registered nurse experienced in perinatal nursing. Preference shall be given to registered nurses with a master's degree.

~~A) Labor and delivery shall include at least one registered professional nurse on each shift who must be competent in the use of continuous electronic fetal monitoring techniques.~~

~~B) Intermediate Care Nursery:~~

~~i)~~ ~~A staffing ratio of one licensed nursing personnel per three or four infants shall be available.~~

~~ii)~~ ~~Nursing personnel may be shared with the general care nursery as needed.~~

~~iii)~~ ~~There shall never be fewer than two licensed nursing personnel available in the general and intermediate care nurseries, at least one of whom is an R.N.~~

5)~~4)~~ Nursing staff~~Staff~~ – Level III requirements for occupied units~~Tertiary Perinatal Care~~. These units shall meet the following requirements in addition to requirements~~Intermediate Care Requirements~~ in subsection (f)(3). Half of all neonatal intensive care direct nursing care hours shall be provided by registered nurses who have two years or more of nursing experience in a Level III NICU. All neonatal intensive care direct nursing care hours shall be provided or supervised by registered nurses who have advanced neonatal intensive care training and documented competence in neonatal pathophysiology and care technologies used in the NICU.

~~A)~~ ~~Staffing patterns on each shift shall be such that a 1:1 ratio between patients who require intensive care during labor and delivery and a registered professional nurse who is competent, by virtue of training and/or experience, in the care of high risk obstetric patients can be maintained as necessary. A ratio of at least one registered professional nurse to 1½ patients shall be maintained at all times.~~

~~B)~~ ~~Neonatal intensive care nursing on a 1:1 basis shall be available as indicated. A ratio of at least one registered professional nurse to 1½ patients shall be maintained at all times.~~

6)~~5)~~ Medical personnel~~Personnel~~

A) Each hospital providing obstetric services shall have an organized obstetric staff with a chief of obstetric service. The chief's level of qualification and expertise shall be appropriate to the hospital's designated level of care. The responsibilities of the chief of

obstetric services shall include the following requirements, as they relate to the care of obstetric patients:

i) General supervision of the care of the perinatal patients assigned to the unit;

ii) Establishment of criteria for admissions;

iii) Adherence to licensing requirements;

iv) Adoption, by the medical staff, of standards of practice and privileges;

v) Identification of clinical conditions and procedures requiring consultation;

vi) Arrangement of conferences, held at least quarterly, to review operations, complications and mortality;

vii) Assurance that the clinical records, consultations and reports are properly completed and analyzed; and

viii) Provision for exchange of information between medical, administrative and nursing staffs.

B) Each hospital providing pediatric services shall have an organized pediatric staff with a chief of pediatric service. The chief's level of qualification and expertise shall be appropriate to the hospital's designated level of care. The responsibilities of the chief of pediatric services shall include those listed in subsection (f)(6)(A) of this Section, as they relate to the care of newborn infants.

C)~~A)~~ Level I shall comply with the Regionalized Perinatal Health Care Code~~or Primary Care~~:

i) One physician shall be Chief of Obstetrical~~Neonatal~~ Care. He or she shall be a board certified or board qualified obstetric~~pediatrician~~. If~~Where~~ this is not possible, a physician with experience and regular practice may be the

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Chief and be responsible for obstetrical~~neonatal~~ care and available on a 24-hour basis, and a source of obstetrical and maternal-fetal medicine ~~pediatric and/or neonatology~~ consultation shall be documented when indicated.

ii) One physician shall be Chief of Pediatric Service. He or she shall~~The director of obstetrical service shall~~ be a board certified or board qualified pediatrician~~obstetrician~~. If~~Where~~ this is not possible, a physician with experience and regular practice may be the Chief and be responsible for pediatric~~obstetric~~ care and available on a 24-hour basis, and a source of neonatology~~obstetric consultation~~ shall be documented when indicated.

D)~~B)~~ Level II shall comply with the Regionalized Perinatal Health Care Code~~or Intermediate Care~~:

~~i)~~ A board certified obstetrician~~pediatrician with special interest and training in neonatal/perinatal medicine or a certified neonatologist~~ shall be Chief of Obstetrical~~Neonatal~~ Care. A board certified pediatrician~~obstetrician~~ shall be Chief of Neonatal~~Obstetrical~~ Care. Obstetrical anesthesia shall be directed by a board certified anesthesiologist with experience and competence in obstetrical anesthesia. Hospital staff shall also include a pathologist and an "on call" radiologist 24 hours a day. Specialized medical and surgical consultation shall be readily available.

~~ii)~~ ~~Other staff: Laboratory and X-ray technicians in the hospital shall be readily available at all times. In addition, a respiratory therapist may be part of the staff.~~

E) Level II With Extended Neonatal Capabilities: Staffing shall comply with the Regionalized Perinatal Health Care Code.

F)~~C)~~ Level III ~~or Intensive Care~~: Staffing shall comply with the Regionalized Perinatal Health Care Code.

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~~i)~~ ~~The Chief of Neonatal Pediatrics shall be eligible for certification by the American Board of Pediatrics' subspecialty board of neonatal/perinatal medicine, and is responsible for care in intensive care areas. Only physicians eligible for certification in neonatal/perinatal medicine shall be responsible for care of infants in the Intensive Care area, but other physicians shall be encouraged to participate. The Chief shall be full-time with the hospital service. There shall be sufficient number of qualified or certified neonatologists to assure availability of such care at all times. The chief of obstetric/perinatal service at the Level III facility shall be a board certified obstetrician and preferably certified in fetal/maternal medicine.~~

~~ii)~~ ~~Pediatric medical and surgical subspecialists shall be available for consultation. An anesthesiologist with special training in maternal fetal and neonatal anesthesia shall be in charge of anesthesia services. A pathologist and radiologist with experience in interpretation of radiographs of neonatal patients shall be members of the hospital staff.~~

~~6)~~ ~~Nutritionist Staff:~~

~~A)~~ ~~For Level II units, a registered dietitian with professional experience and/or course work that relates to perinatal maternal and newborn dietary management shall be available.~~

~~B)~~ ~~For Level III units, a registered dietitian with professional experience and/or course work that relates to perinatal maternal and newborn dietary management shall be available.~~

g) Practices and procedures for care of mothers and infants:

1) The hospital shall follow procedures approved by the infection control committee for the isolation of known or suspected cases of infectious disease in the obstetric department.~~effect all necessary precautionary measures against the admission to the maternity department of actual or suspected infectious patients.~~

2) Patients with clean obstetric complications (regardless of month of gestation), such as pregnancy-induced hypertension~~toxemia of pregnancy~~ for observation and treatment, placenta previa~~praevia~~ for observation or delivery, ectopic pregnancy, and hypertensive heart disease in a pregnant patient, may be admitted to the obstetric~~maternity~~ department and be subject to~~under~~ the same requirements~~rules~~ as any other obstetric~~maternity~~ case. (See Section 250.1820(g) ~~(h)~~(6)~~(B)~~.)

3) The physician shall determine whether a prenatal serological test for syphilis and a test for HIV have~~has~~ been done on each mother and the results recorded. If no tests have~~such test has~~ been done before the admission of the patients, the tests~~test~~ shall be performed as soon as possible pursuant to the Perinatal HIV Prevention Act. Specimens for a syphilis test may be submitted in appropriate containers to an Illinois Department of Public Health laboratory for testing without charge. Mothers shall be tested for Group B streptococcus prior to delivery and for Hepatitis B prior to discharge of either mother or infant.

4) No obstetric~~maternity~~ patient under the effect of an analgesic or an anesthetic, in the second stage of~~active~~ labor or delivery, shall be left unattended at any time.

5) Fetal lung maturity shall be established and documented prior to elective inductions and caesarean~~Cesarean~~ sections. The hospital shall establish a written policy and procedure concerning the administration of oxytocic drugs.

A) Oxytocin shall be used for the contraction stress test only when qualified personnel, determined by the hospital staff and administration, can attend the patient closely. Written policies and procedures shall be available to the team members assuming this responsibility. ~~It is recommended that Oxytocin be administered by controlled infusion.~~

B) The oxytocin solution shall be administered intravenously via a controlled infusion device, using both a primary intravenous solution and a secondary oxytocin solution.

C)~~B)~~ Oxytocin shall be used for medical induction or stimulation of labor only when qualified personnel, determined by the hospital staff and administration, can attend the patient closely. Written policies and procedures shall be available to the team members assuming this responsibility. The~~It is recommended that the~~ following shall be included in these policies:

i) The attending physician shall evaluate the patient for induction or stimulation, especially with regard to indications.

ii) The physician or other individuals starting the Oxytocin shall be familiar with its effect and complications and be qualified to identify both maternal and fetal complications.

iii) A qualified physician shall be immediately available as is necessary to manage any complication effectively.

~~iv) The intravenous route is the only acceptable mode of administration. It is recommended that an infusion pump, or other device for accurate control of the rate of flow, and a two-bottle system, one of which contains no Oxytocin substance, be used.~~

iv)~~v)~~ During Oxytocin administration, the fetal heart rate; the resting uterine tone; and the frequency, duration and intensity of contractions shall be monitored electronically and recorded. Maternal blood pressure and pulse shall be monitored and recorded at intervals comparable to the dosage regimen; that is, at 30 to 60 minute intervals, when the dosage is evaluated for maintenance, increase or decrease. Evidence of maternal and fetal surveillance shall be documented.

6) Identification of infants:

A) While the neonate is still in the delivery room, the nurse in the delivery room shall prepare identical identification bands for both the mother and the neonate, as outlined in the hospital's policy.

Wrist bands alone may be used; however, it is recommended that both wrist and ankle bands be used on the neonate. The hospital shall not use footprinting and fingerprinting alone as methods of patient identification. The bands shall indicate the mother's admission number, the neonate's gender, the date and time of birth, and any other information required by hospital policy. Delivery room personnel shall review the bands prior to securing them on the mother and the neonate to ensure that the information on the bands is identical. The nurse in the delivery room shall securely fasten the bands on the neonate and the mother without delay as soon as he/she has verified the information on the identification bands. The birth records and identification bands shall be checked again before the neonate leaves the delivery room.

B) If the condition of the neonate does not allow the placement of identification bands, the identification bands shall accompany the neonate and shall be attached as soon as possible, as outlined in the hospital's policy. Identification bands ~~shall be affixed to the bassinet or incubator until they are placed on the infant and~~ shall not be left unattached and unattended in the nursery.

C) When the neonate is taken to the nursery, both the delivery room nurse and the admitting nursery nurse shall check the neonate's identification bands and birth records, verify the gender of the neonate, and sign the neonate's medical record. The admitting nurse shall complete the bassinet card and attach it to the bassinet.

D) When the neonate is taken to the mother, the nurse shall check~~examine~~ the mother's and the neonate's identification bands, verify the gender of the neonate and verify that the information on the bands is identical.

E) The umbilical cord (cords, with multiple births) shall be identified according to hospital policy (e.g., by the use of a different number of clamps) so that umbilical cord blood specimens are correctly labeled. All umbilical cord blood samples shall be labeled correctly with an indication that these are a sample of the neonate's umbilical cord blood and not the blood of the mother.

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F) The hospital shall develop a newborn infant security system. This system shall include instructions to the mother regarding safety precautions designed to avoid abduction ~~when her newborn infant is rooming in~~. Electronic sensor devices may be included as well.

7) Within one hour after delivery, ~~a one percent silver nitrate solution or~~ ophthalmic ointment or drops containing tetracycline or erythromycin shall be instilled into the eyes of the newborn infant as a preventive against ophthalmia neonatorum. The eyes shall~~Do~~ not be irrigated~~irrigate~~ immediately. ~~This solution may be obtained free of charge from the Department.~~

8) A single parenteral dose of vitamin K-1, water soluble 0.5 miligrams, shall be given to the infant, once he or she is weight appropriate, as a prophylaxis against hemorrhagic disorder in the first days of life.

9)~~8)~~ Each infant shall be given complete individual cribside care. The use of a common bath table is prohibited. Scales shall be adequately protected to prevent cross-infection.

10)~~9)~~ Artificial feedings and formula changes shall not be instituted except by written order of the attending physician.

11)~~10)~~ Facilities for drug services. See Section 250.2130(a).

12)~~11)~~ Newborn~~Transport of newborn~~ infants shall be transported from the delivery room to the nursery ~~shall be done~~ in a safe manner. Adequate support systems (heating, oxygen, suction) shall be incorporated into the transport units for ~~these~~ infants (e.g., to x-ray). Chilling of the newborn and cross-infection shall be avoided. If~~Where~~ travel is excessive and through other areas, special transport incubators may be required. The method of transporting infants from the nursery to the mothers shall be individual, safe and free from cross-infection hazards.

13)~~12)~~ The stay of the mother and the infant~~baby~~ in the hospital after delivery shall be planned to allow the identification of problems and to reinforce instructions in preparation for the infant's care at home. The mother and infant shall be carefully observed for a sufficient period of time and assessed prior to discharge to ensure that their conditions are stable.

Healthy infants shall be discharged from the hospital simultaneously with the mother, or to other persons authorized by the mother.~~(by the mother) personnel~~ if the mother remains in the hospital for an extended stay. Follow-up shall be provided~~It is recommended that there be a provision for follow-up~~ for ~~the~~ mothers and infants~~babies~~ discharged within 48~~24~~ hours after delivery, including~~. This follow-up shall include~~ a face-to-face encounter with a health care provider who will assess the condition of mother and infant~~baby~~ and arrange for intervention if problems are identified.

14)~~13)~~ When a patient's condition permits, an infant may be transferred from an intensive care nursery to the referring nursery or to another nursery that is nearest the home and at which an appropriate level of care may be provided. Transfers shall be conducted pursuant to the Regionalized Perinatal Health Care Code.

15)~~14)~~ The hospital shall have a policy regarding circumcisions performed by a Mohel.~~Circumcisions by a Mohel shall be performed under aseptic conditions. Such circumcisions shall not be performed in the delivery room. A registered nurse or physician shall be in attendance, and attendance by visitors shall be limited.~~

16)~~15)~~ Circumcisions shall not be performed in the delivery room or within the first six hours after birth. A physician may order and perform a circumcision when the infant is over the age of six hours and, in the physician's professional judgment, is healthy and stable.

~~16)~~ ~~A single parenteral dose of vitamin K-1, water soluble 0.5 mgm, shall be given to the infant soon after birth as a prophylaxis against hemorrhagic disorder in the first days of life.~~

17) The hospital shall comply with the~~adhere to the practices prescribed in~~ Guidelines for Perinatal Care and Guidelines for Women's Health Care ~~(American College of Obstetricians and Gynecologists)~~ (see Section 250.160).

h) Medical records~~Records~~

1) Obstetric records:

A) Adequate, accurate, and complete medical records shall be maintained for each patient. The medical records shall include findings during the prenatal period, which shall be available in the obstetric~~maternity~~ department prior to the patient's admission and shall include medical and obstetric history, observations and proceedings during labor, delivery and the postpartum period, and laboratory and x-ray findings.

B) Records shall be maintained in accordance with hospital medical records policies and procedures, including the applicable requirements of the Health Insurance Portability and Accountability Act and the minimum observations and laboratory tests outlined in Guidelines for Perinatal Care and Guidelines for Women's Health Care. The physician director of the obstetric~~maternity~~ department shall require all physicians delivering obstetric~~obstetrics~~ care to send copies of the prenatal records, including laboratory reports, to the obstetric~~obstetrical~~ unit at or before 37 weeks of gestation, including updates from that time until admission.

2) Infant records. Accurate and complete medical records shall be maintained for each infant. The medical records shall include:

A) History of maternal health and prenatal course, including mother's HIV status, if known.

B) Description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid.

C) Time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room.

D) Report of a complete and detailed physical examination within 24 hours following birth; report of a medical examination within 24

hours after~~of~~ discharge and daily during any remaining hospital stay~~one at least every three days during the hospital stay~~.

E) Physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily.

F) Documentation of infant feeding: intake, content, and amount if by formula.

G) Clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3) The hospital shall keep a record of births that contains data sufficient to duplicate the birth certificate. The requirement may be met by:

A) ~~by~~ retaining the yellow "hospital copy" of the birth certificate properly bound in chronological order, or

B) ~~by~~ retaining this copy with the individual medical record.

i) Reports

1) Each hospital that provides obstetric and neonatal services~~maternity service~~ shall submit a monthly perinatal activities report to its affiliated Administrative Perinatal Center.~~on forms provided for this purpose by the Department. This report shall be signed by a representative of the department preparing the document and shall be mailed not later than the 15th of the following month.~~

2) Maternal death report~~Death Report~~

A) The hospital shall submit an immediate report of the occurrence of a maternal death to the Department, in accordance with the Department's rules titled Maternal Death Review ~~(77 Ill. Adm. Code 657)~~. Maternal death is the death of any woman dying of any cause whatsoever while pregnant or within one year after termination of the pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it

was terminated. A death shall be reported regardless of whether the death occurred in the obstetric department~~maternity division~~ or any other section of the hospital, or whether the patient was delivered in the hospital where death occurred, or elsewhere.

B) The filing of this report shall in no way preclude the necessity of filing a death certificate or of including the death on the Perinatal~~Maternity~~ Activities Report.

3) The hospital shall comply with the laws of the State and the rules~~regulations~~ of the Department in~~as regards~~ the preparation and filing of birth, death~~stillbirth,~~ and fetal death certificates.

4) Epidemic and communicable disease reporting~~Communicable Disease Reporting~~

A) The hospital shall develop a protocol for the management and reporting of infections consistent with the Control of Communicable Diseases Code, the Perinatal HIV Prevention Act, ~~and with~~ Guidelines for Perinatal Care and Guidelines for Women's Health Care, and as approved by the infection control committee~~Infection Control Committee~~. These policies shall be known to obstetric~~maternity~~ and nursery personnel.

B) The facility shall particularly address those infections specifically related to mothers and infants, including but not limited to, methicillin-resistant Staphylococcus Aureus occurring in infants under 61 days of age, ophthalmia neonatorum, and perinatal hepatitis B infection.

j) Formula

The hospital shall have a policy for the preparation of formula by hospital staff when hospital-prepared formula is needed in place of commercially-prepared formula. Adequate space, equipment and procedures for processing, handling and storing commercially-prepared formula shall be provided.

~~1)~~ ~~If pasteurized, commercially prepared formula is used exclusively and no formula is prepared by the hospital, a formula room and formula room~~

~~equipment are not required. However, adequate space, equipment and procedures acceptable to the Department for processing, handling and storing of commercially prepared formula shall be provided. Procedures and aseptic techniques shall be established and enforced. Provisions shall be made for the preparation of special formula.~~

1)~~2)~~ All hospitals providing obstetric~~maternity~~ or pediatric services that prepare their own formula shall provide a well-ventilated and well-lighted formula room, which shall be adequately supervised and used exclusively for the preparation of formulas.

2)~~3)~~ Equipment shall include hand-washing facilities with hot and cold running water with knee, foot or elbow controlled valves; a double-section sink for washing and rinsing bottles; facilities for storing cleaning equipment, refrigeration facilities; utensils in good condition for preparation of formulas; cupboard and work space and a work table; an autoclave and a supply of individual formula bottles, nipples and protecting caps, adequate to prepare a 24-hour supply of formula and water for each infant. Procedures shall be established by the hospital and enforced.

k) Breast milk

The hospital shall provide the mother with information regarding lactation, the nutritional benefits of breast milk and lactation support organizations within the area. The hospital shall include, at a minimum, a lactation support staff with certification or experience in lactation training. The lactation support staff shall attend annual continuing education in relation to lactation counseling and training.

l)~~k)~~ Visiting policy~~regulations~~

1) The visiting requirements~~regulations~~ set forth in Subpart B shall apply to obstetric~~maternity~~ departments, except as modified in this subsection.

2) Each obstetric department shall have a visting policy that complies with the Guidelines for Perinatal Care and is approved by the hospital's infection control committee. ~~It is recommended that visitors be limited to two per patient at any one time.~~

3) The visiting policy shall cover all programs in the obstetric department.

~~Contact with the infant shall be restricted to the father, or one other adult selected by the mother, except as provided in subsection (k)(4) of this Section or as part of a rooming-in program as provided in Section 250.1850.~~

4) The visiting policy shall comply with the hospital's infection control policy and shall include signage instructing visitors to wash their hands. ~~Siblings and grandparents may have contact with the infant only if the hospital has established specific policies and procedures for such a program. The program shall include:~~

~~A) Approval of the program by the hospital's Infection Control Committee and Governing Board;~~

~~B) A requirement for written consent of the mother for visitation by specific siblings or grandparents;~~

~~C) A procedure for hand washing by visitors prior to having contact with the infant; and~~

~~D) A policy on the location where visitation will occur.~~

~~5) The presence of the father or individual selected by the mother in the delivery room shall be discretionary with the individual hospital. If the father or the individual selected by the mother of the baby is to be admitted to the delivery room of any hospital, the hospital shall first have adopted a policy statement on the matter that includes the following conditions:~~

~~A) Written consent of both the mother and the attending physician;~~

~~B) Prior orientation preparation of the father of the baby or the selected individual and mother to this experience; and~~

~~C) Application of safeguards against the introduction of infection or other hazard by the father of the baby or selected individual.~~

~~6) Visiting hours shall not correspond with periods during which infants are with the mothers or with periods during which mothers are receiving~~

~~nursing care, nor interfere with the care of patients.~~

~~7)~~ ~~Visitors shall neither sit nor place their clothing upon the beds.~~

m)~~l)~~ *Every hospital shall demonstrate to the Department that the following* have been adopted:

1) *Procedures designed to reduce the likelihood that an infant patient will be abducted from the hospital. The procedures may include, but need not be limited to, architectural plans to control access to infant care areas, video camera observation of infant care areas, and procedures for identifying hospital staff and visitors.*

2) *Procedures designed to aid in identifying allegedly abducted infants who are recovered. The procedures may include, but need not be limited to, footprinting infants by staff who have been trained in that procedure, photographing infants, and obtaining and retaining blood samples for genetic testing.* (Section 6.15 of the Act)

(Source: Amended at 36 Ill. Reg. _____, effective _____)

Section 250.1845 Caesarean Birth

a) A hospital may permit the father or a support person to be present at a delivery by caesarean birth if the program is part of the hospital's Obstetric and Neonatal Service Plan. Nothing in this Part shall be construed to require a hospital to permit the father or a support person to attend caesarean births. This Part does not vest any right upon any lay person to attend a caesarean birth. The operating physician shall always have the right to exclude a father or support person from a caesarean birth for any reason. For the purposes of this Section, a support person is the husband of the mother, the father of the infant, or any other person selected by the mother, who is acceptable to the physician and meets the requirements of the hospital's policies.

b) The hospital's Obstetric and Neonatal Service Plan shall include:

1) Criteria for admitting the father or other support person to the delivery by caesarean birth;

2) Education, counseling or other preparation furnished to the mother and father or to the support person attending a caesarean birth; and

3) Operating room procedures and assignments for caesarean birth.

(Source: Added at 36 Ill. Reg. _____, effective _____)

Section 250.1850 Single Room Postpartum Care of Mother and Infant~~Rooming-In Care of Mother and Infant~~

The following requirements apply when postpartum care is provided to a mother and her infant in the same room:

a) The patient's room shall be of sufficient size and arrangement for the bedside care of the mother and infant.

b) The patient's room shall be equipped with a toilet, a hand-washing lavatory and a supply of clean towels.

c) Equipment and supplies shall include:

1) Separate equipment and supplies for the mother and the infant;

2) Separate enclosed storage space for the infant's clean linen, equipment and supplies; and

3) Adequate covered containers for the infant's soiled linen.

d) Single room postpartum care for the mother and infant shall meet the following requirements:

1) The hospital's obstetric and neonatal service plan shall establish the conditions of the mother and infant that are appropriate for mother and infant postpartum care in the same room.

2) All nursing care of the mother and infant shall be given by the same nurse on each shift.

3) Adequate observation and nursing care shall be assured.

4) The care of mothers and infants shall include procedures to prevent cross-infection, emphasizing conscientious hand washing by parents, visitors and personnel, and the careful handling of soiled linen.

5) Adequate nursery facilities shall be provided for periods when infants are not with their mothers.

~~a) Rooming-in care of newborn infants is permissible under these regulations. The rooming-in plan may be either:~~

~~1) continuous -- with the infant at the bedside constantly; or~~

~~2) intermittent -- in which the infant is removed from the mother's bedside to the nursery during visiting and night hours.~~

~~Programs which permit the presence of the baby's father in the room with the infant, during feeding or otherwise, shall be considered as an intermittent rooming-in program.~~

~~b) Whichever plan is used, the following requirements and recommendations apply.~~

~~1) Personnel~~

~~A) There shall be sufficient personnel who understand and can carry out the procedures necessary for a successful rooming-in experience.~~

~~B) It is recommended that all nursing care of the mother and infant unit be given by one nurse.~~

~~2) Physical facilities~~

~~A) The patient's room must be of sufficient size and arrangement for bedside care of mother and infant.~~

~~B) The room must be equipped with handwashing lavatory, with a supply of soap and clean towels.~~

~~3) Equipment and supplies~~

~~A) Mother and infant shall have individual equipment and supplies.~~

~~B) Individual enclosed storage space shall be provided for the infant's clean linen, equipment, and supplies.~~

~~C) Adequate covered containers shall be provided for the infant's soiled linen.~~

~~4) Policies and procedures for rooming-in~~

~~A) A policy should be established by the medical staff and approved by the governing authority as to the condition of the mother and infant when rooming-in may be initiated.~~

~~B) The procedures of individual care of mothers and of infants shall be established to prevent cross-infection, stressing conscientious handwashing by parents and personnel and careful handling of soiled linen.~~

~~C) Adequate observation and nursing care must be assured.~~

~~D) A planned parent education routine is desirable.~~

~~E) Visiting shall be restricted to the father of the infant or one other adult selected by the mother. Grandparents and siblings may visit if the hospital has a program for such visitation which has been approved as provided in Section 250.1830(k)(4).~~

~~F) Visitors must wash their hands.~~

(Source: Amended at 36 Ill. Reg. _____, effective _____)

Section 250.1860 Special Programs (Repealed)

~~a) Attendance at Caesarean Births (Limited waiver of Section 250.1305(a))~~

~~1) A hospital may permit the father or a support person to be present at a~~

~~delivery by Caesarean Birth if such a program is approved by the Department as part of the hospital's Maternity and Neonatal Service Plan. However, nothing in these rules shall be construed to require a hospital to permit the father or a support person to attend Caesarean Births. These rules do not vest any right upon any lay person to attend a Caesarean Birth. Presence at Caesarean Birth is a privilege which may be extended only when the best of conditions exist, in accordance with the medical judgment of the responsible physician, and proper education and counseling (a structured formal written orientation as to what is expected to transpire in the surgery) have taken place. At most the acceptance into the program shall be an intent to extend this privilege. The operating physician shall always have the right to exclude a father or support person from a Caesarean Birth for any reason.~~

~~2)~~ ~~Each hospital desiring to implement a program to permit fathers and support persons to attend Caesarean Births shall submit an application to the Department. The application shall include:~~

~~A)~~ ~~a description of the plan to implement the program;~~

~~B)~~ ~~documentation of administration and affected staff approval;~~

~~C)~~ ~~policies and procedures applicable to this program, including:~~

~~i)~~ ~~criteria for admission to the program;~~

~~ii)~~ ~~consent forms;~~

~~iii)~~ ~~education, counseling, and other preparation furnished the mother and father or support person;~~

~~iv)~~ ~~operating room procedures and assignments;~~

~~v)~~ ~~post-delivery evaluations.~~

~~3)~~ ~~Upon submission of the application, the application shall be reviewed by Department program personnel. Based upon the submitted plan, required to be compatible with the approved Maternity and Neonatal Service Plan, the Department shall issue an approval within 30 days of the submission~~

of the application, or notify the hospital in writing of the specific reasons and concerns why the program is disapproved.

4) A record system (Refer to Section 250.1820(i)) shall be maintained that identifies all patients with the father or a support person present at Caesarean Births and includes provisions for reporting to the Department:

A) the number of patients participating in the program;

B) the number of patients denied admission to the program and the reasons for denial;

C) all complications experienced.

5) For the purposes of this Section, a support person is the husband of the mother, the father of the infant, or any other person selected by the mother, who is acceptable to the physician and meets the requirements of the hospital's policies.

b) Birthing Room Programs

1) Establishment of Birthing Room Program

A) A hospital may provide a Birthing Room program if such a program is approved by the Department as part of the hospital's Maternity and Neonatal Service Plan.

B) Nothing in these rules shall be construed to require a hospital to provide Birthing Rooms. These rules do not vest any right upon any person to admittance to a Birthing Room. Admission to a Birthing Room is a privilege which may be extended only when the best of conditions exist, in accordance with the medical judgment of the responsible physician, and proper education and counseling (a structured formal written orientation as to what is expected to transpire in the birthing room) have taken place. The attending physician shall always have the right to exclude anyone from a Birthing Room for any reason.

2) Each hospital desiring to implement a Birthing Room program shall

~~submit an application to the Department. The application shall include:~~

~~A)~~ ~~a description of the plan to implement the program;~~

~~B)~~ ~~documentation of administration and affected staff approval;~~

~~C)~~ ~~policies and procedures applicable to this program, including:~~

~~i)~~ ~~criteria for admission to the program;~~

~~ii)~~ ~~consent forms;~~

~~iii)~~ ~~education, counseling, and other preparation furnished the mother, and any other persons (if any) who will be present in the Birthing Room;~~

~~iv)~~ ~~post-delivery evaluations.~~

~~3)~~ ~~Upon submission of the application, the application shall be reviewed by Department program personnel. Based upon the submitted plan, required to be compatible with the approved Maternity Neonatal Service Plan and appropriate physical location of the Birthing Room, the Department shall issue an approval within 30 days of the submission of the application, or notify the hospital in writing of the specific reasons and concerns why the program is disapproved.~~

~~4)~~ ~~A record system (Refer to Section 250.1820(i)) shall be maintained that identifies all patients using the Birthing Room and those in attendance. It shall include provisions for reporting to the Department:~~

~~A)~~ ~~the number of patients participating in the program;~~

~~B)~~ ~~the number of patients denied admission to the program and the reasons for denial;~~

~~C)~~ ~~all complications experienced.~~

(Source: Repealed at 36 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 250.1870 Labor, Delivery, Recovery and Postpartum~~Single Room Maternity~~ Care

a) Hospitals may establish a labor, delivery, recovery and postpartum~~single room maternity~~ care program in compliance with this Section. The labor, delivery, recovery and postpartum~~single room maternity~~ care program may include the hospital's entire obstetric~~maternity~~ service or a specific portion of the hospital's obstetric~~maternity~~ service.

b) General Description

1) A labor, delivery, recovery and postpartum~~single room maternity~~ care program provides labor, delivery, recovery~~,~~ and postpartum care for a mother in one~~a single~~ room. The combination of functions in one~~a single~~ room is designed to reduce the movement of the mother within the hospital.

2) The labor, delivery, recovery and postpartum~~single room maternity~~ care program shall~~must~~ be coordinated with other obstetric~~maternity~~ services of the hospital. Facilities for emergency caesarean~~Cesarean~~ deliveries shall~~must~~ be available. Labor, delivery, recovery and postpartum~~Single~~ rooms may be used in hospitals at all Level designations~~for all levels of maternity care~~, except for caesarean~~other than Cesarean~~ deliveries, based on the hospital's program.

3) Rooms used for labor, delivery, recovery and postpartum~~single room maternity~~ care shall~~must~~ include facilities for care of the infant during delivery and ~~immediately~~ after birth. ~~Such rooms may also include facilities for rooming-in of the infant.~~

c) Program Operation~~Establishment~~

1) The labor, delivery, recovery and postpartum obstetric~~single room maternity~~ service program shall be part of ~~submitted to the Department as an amendment to~~ the hospital's maternity and neonatal services plan and shall~~. The amendment shall~~ include all of the policies and procedures that~~for operation of the program which~~ are required by this Section.

2) The hospital shall have policies and procedures for assessing the level of risk for each patient, for determining which patients may not qualify for

labor, delivery, recovery and postpartum care, and for referring patients to another hospital.

~~2)~~ ~~The program shall be approved by the Board of the hospital prior to submission to the Department.~~

~~3)~~ ~~Architectural plans for any remodeling or changes in room functions which are required for operation of the program shall be submitted to the Department for review as provided in Section 250.2420.~~

3)~~4)~~ Any increases or decreases in the number of beds in the hospital's obstetric~~maternity~~ service that~~which~~ occur as a result of the establishment of a labor, delivery, recovery and postpartum~~single room maternity~~ care program may also require the approval of the Illinois Health Facilities and Services Review~~Planning~~ Board. (See~~Refer to the rules of the Illinois Health Facilities Planning Board at~~ 77 Ill. Adm. Code 1100 and 1110.)~~.~~

~~5)~~ ~~The hospital shall not implement the program prior to approval of the program and any architectural plans by the Department.~~

d) Designation of Rooms. The labor, delivery, recovery and postpartum~~single room maternity~~ care program shall designate~~specify~~ the specific rooms that~~which~~ will be used for labor, delivery, recovery and postpartum~~single room maternity~~ care. These rooms may be used as patient rooms for other obstetric~~maternity~~ patients in the obstetric department~~maternity unit~~ at times when they are not being used for labor, delivery, recovery and postpartum~~single room maternity~~ care.

e) Staffing Requirements

1) The program shall include a staffing plan that~~which~~ meets the nursing needs of the patients.

2) The program shall include provisions for specialized orientation and training for nurses and other health care personnel in the operation of the labor, delivery, recovery and postpartum~~single room maternity~~ care program, including the care of both mothers and infants.

~~f)~~ ~~Visiting Requirements. The program shall include specific policies and procedures concerning visiting. These policies and procedures shall include the~~

~~following:~~

~~1)~~ ~~A requirement that the consent of the mother and the physician be obtained for each visitor who will be permitted in the room during delivery.~~

~~2)~~ ~~Provisions for prior orientation and education for visitors who will be permitted in the room during delivery.~~

~~3)~~ ~~A requirement for gowning and handwashing by all visitors who are present in the room during delivery.~~

~~4)~~ ~~Provisions for visiting during labor, recovery, and postpartum care of the mother which comply with Section 250.1830(k).~~

~~5)~~ ~~Provisions for visiting during rooming-in of the infant which comply with Section 250.1850.~~

~~f)~~g) Physical Plant Requirements

1) Each room used for labor, delivery, recovery and postpartum~~single room maternity~~ care shall be considered a private room. Occupancy by two patients, the mother and the infant, shall be permitted~~a single patient room~~. Rooms for multiple patients are not otherwise permitted for labor, delivery, recovery and postpartum care.

2) Architectural plans for new construction or remodeling that are required for the establishment or continued operation of a labor, delivery, recovery and postpartum care program shall be submitted to the Department for review and approval pursuant to the requirements of this Section and Section 250.2420. The hospital shall not implement the program prior to the Department's approval of the program and of the architectural plans. ~~Minimum Room Sizes~~

3)~~A)~~ Each room used for labor, delivery, recovery and postpartum~~single room maternity~~ care shall include a minimum dimension of 12 feet and a minimum clear area of 250 square feet except as provided in subsection~~subsections~~ (f)(4)~~(g)~~(2)~~(B)~~ or (f)(6)~~(g)~~(2)~~(C)~~ of this Section.

4)~~B)~~ Rooms that~~which~~ were approved for use as "birthing rooms" by the Department prior to September 1, 1990, may continue to be used for labor, delivery, recovery and postpartum~~single room maternity care~~. The hospital shall continue to comply with~~must follow~~ the requirement of this Part~~policies and procedures under which the rooms were approved~~.

5) At least one delivery room with a minimum clear area of not less than 300 square feet shall be available for more complex deliveries and unanticipated risks. The delivery room shall be in the obstetric unit, on the same level as the rooms in which labor, delivery, recovery and postpartum care is provided, and accessible without passing through any areas used for functions other than labor, delivery, recovery and postpartum care, and without traversing any obstacles. In determining the accessibility of the delivery room, the Department will consider factors including, but not limited to, traffic patterns, corridor width, corridor width changes and the number of turns.

6)~~C)~~ The Department will approve rooms that~~Rooms which~~ contain a minimum dimension of 10 feet and a minimum clear area of 180 square feet ~~will be approved by the Department~~ for labor, delivery, recovery and postpartum~~single room maternity~~ care, when the hospital demonstrates that all of the following conditions are met:

A)~~i)~~ Policies and procedures for assessing the level of risk for each patient, for determining which patients may not qualify for labor, delivery, recovery and postpartum ~~utilize single room maternity~~ care, and for referring patients to other hospitals~~facilities~~ have been established and are being followed.

B)~~ii)~~ The hospital participates in a Regional Perinatal Network and has been approved for Level I, ~~or~~ Level II, or Level II extended neonatal care. The hospital does not provide Level III care as described in the ~~Department's rules entitled "~~Regionalized Perinatal Health Care Code~~" (77 Ill. Adm. Code 640)~~.

~~iii) At least one delivery room with a minimum clear area of not less than 300 square feet is available for more complex deliveries and unanticipated risks. The delivery room must be in the maternity unit, on the same level as the rooms in~~

~~which single room maternity care is provided, and accessible without passing through any areas used for functions other than single room maternity care, labor, or delivery, and without traversing any obstacles. In determining the accessibility of the delivery room the Department will consider factors such as traffic patterns, corridor width, corridor width changes, and number of turns.~~

C)~~iv)~~ The medical staff of the hospital has approved the use of the rooms for labor, delivery, recovery and postpartum~~single room maternity~~ care based on the~~their~~ medical staff's judgment that this~~such~~ care can be provided safely within the rooms.

7)~~D)~~ For the purposes of this subsection (f)~~(g)~~, clear area shall include only useable space within the patient room and shall not include entry or vestibule areas~~, space required for door swings,~~ or space for fixed, immovable furniture. The bathroom shall not be included in calculating the clear area of the patient room.

8)~~3)~~ Staff hand-washing sink~~Handwashing Sink~~

A) Each room used for labor, delivery, recovery and postpartum~~single room maternity~~ care shall have direct access to a hand-washing~~handwashing~~ sink for the exclusive purpose of staff hand washing~~handwashing~~ prior to and during the delivery process. The sink may be used for other purposes at other times.

B) The staff hand-washing~~handwashing~~ sink shall~~must~~ be adequate in size and appropriately equipped to allow thorough hand washing~~handwashing~~.

C) The staff hand-washing~~handwashing~~ sink may be located in the room, in the adjacent bathroom (if the bathroom is not shared with another patient room), or directly outside the room.

9)~~4)~~ Bathroom

A) Each room used for labor, delivery, recovery and postpartum~~single~~

~~room maternity~~ care shall include a bathroom equipped with a toilet and ~~with~~ a shower or bathtub. The bathroom shall also include a sink, unless a sink is located in the patient room.

B) The bathroom shall be directly accessible from the patient room without going through the corridor.

~~C) Bathrooms may be shared by no more than two patient rooms.~~

10)~~5)~~ An area for gowning by staff and visitors prior to delivery shall be provided within or immediately adjacent to each room used for labor, delivery, recovery and postpartum~~single room maternity~~ care.

11)~~6)~~ Rooms used for postpartum care of the mother shall also comply with the patient room requirements of Section 250.2630(d)(1) or~~of~~ Section 250.2440(d)(1), as applicable.

12)~~7)~~ Adequate nursery facilities shall be provided for periods when infants are not with their mothers. ~~rooming-in of infants is not utilized, when individual mothers choose not to participate in rooming-in of the infant, and when intermittent rooming-in of infants is utilized. (See Sections 250.1830(e), 250.1850, 250.2440(h), and 250.2630(h).)~~

13)~~8)~~ Each room used for labor, delivery, recovery and postpartum~~single room maternity~~ care shall also comply with the following requirements:

A) The mechanical~~Mechanical~~ requirements for patient rooms in Section 250.2480(e)(8) or Section 250.2660.

B) The electrical~~Electrical~~ requirements for patient rooms in Section 250.2500 or Section 250.2680.

14)~~9)~~ Wall, floor, and ceiling finishes shall be cleanable. All finishes shall be able to withstand cleaning and treatment with chemicals and disinfectants.

g)~~h)~~ Equipment Requirements

1) All equipment necessary for delivery, for emergency care of the mother, for infant care, and for infant resuscitation shall be available to each room

used for labor, delivery, recovery and postpartum~~single room maternity~~ care.

2) A complete set of delivery and infant care equipment shall be provided for every four or fewer rooms used for labor, delivery, recovery and postpartum~~single room maternity~~ care. For example: if four rooms are used, one complete set of equipment shall be provided; if five to eight rooms are used, two sets of equipment shall be provided; if nine to twelve rooms are used, three sets of equipment shall be provided.

3) Equipment may be stored in an equipment alcove or closet in the room, or in a separate equipment storage room. The~~However, the~~ equipment shall~~must~~ be accessible for use without passing through another patient room. Each equipment storage area shall be located on the same floor and not more than 75 feet from each of the rooms served by the equipment storage area.

~~i) The policies and procedures approved by the Department in the amendment to the hospital's maternity and neonatal services plan shall be followed in the operation of the program. The program shall also be operated in accordance with all other requirements of this Part, unless specifically modified by this Section.~~

(Source: Amended at 36 Ill. Reg. _____, effective _____)