GEORGIA DEPARTMENT OF COMMUNITY HEALTH

David A. Cook, Commissioner

Nathan Deal, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia,gov

RE: Hospital (State Licensure)

This letter is intended to provide information regarding the State Licensure Requirements for Hospitals in Georgia. This Section is responsible for licensing of hospitals under State Law and assisting the Centers for Medicare and Medicaid Services in performing the certification function for those providers wishing to participate in the Medicare program.

INITIAL STATE LICENSURE APPLICATION REQUIREMENTS:

Before this Section can survey your facility for a license to operate a hospital, you must submit the following documents:

1. A completed application to operate a hospital.
2. A copy of the Certificate of Need (CON) issued by the Division of Health Planning (DHP). You can contact DHP at (404)656-0655, 2 Peachtree Street, Room 34.262, Atlanta, Georgia 30303-3142.
3. A copy of the construction plan approval and final inspection letters issued by the state architect.
4. A copy of the local (city or county) fire safety authority inspection report which states an inspection has been made of the premises and that state and local fire safety requirements have been met.
5. Copy of the certificate of occupancy for the hospital.
6. Evidence that X-Ray facilities in the hospital meet the Rules and Regulations promulgated by DHR. You can contact the Diagnostic Services Unit at 404-657-5450.
7. Evidence that any Laboratory Services offered at your facility meet Federal and State requirements. You can contact the Diagnostic Services Unit at 404-657-5450.

STATE LICENSURE SURVEY:

Once you have submitted your completed licensure application, you may contact this Section to answer any questions you may have regarding the licensure process and to make arrangements for your initial licensure survey. The survey process consists of review of policies and procedures, staff interviews and a tour of your facility. A survey preparation checklist is available for your convenience. However the checklist is not all inclusive. You are advised to read all the Rules and Regulations for Hospitals, Chapter 290-9-7, or the Rules and Regulations for Residential Mental Health Facilities for Children and Youth, Chapter 290-4-4, if applicable, and prepare to show surveyors how your facility will comply with all the rules.

ISSUANCE OF A PERMIT NUMBER:

If at the completion of the survey, your facility is found to be in full compliance with the Rules and Regulations for Hospitals (Chapter 290-9-7) or the Rules and Regulations for Residential Mental Health Facilities for Children and Youth (Chapter 290-4-4.), your permit will be issued effective the last day of the survey. If deficiencies are cited, your permit will be issued effective the date that an acceptable plan of correction is received in this Section.

Under State law and regulations, you must notify this Section at least 30 days in advance of any change in ownership. The State Permit is not transferable.

If we can be of further assistance to you, please contact the Acute Care Unit at (404) 657-5430.

ENCLOSURES:
State Regulations
License Application
Checklist for Initial Application
Checklist for Initial Licensure Survey

DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION DIVISION
2 PEACHTREE STREET N.W.
SUITE 31.447
ATLANTA, GA 30303-3142
404-657-5550

APPLICATION FOR A PERMIT TO OPERATE A HOSPITAL

(PLEASE TYPE or PRINT)

Pursuant to provisions of O.C.G.A. 31-7-1 et seq. Application is hereby made to operate the Hospital which is identified as follows:

SECTION A: IDENTIFICATION

Date of Application _____ **Effective Date for Any Change** _____

Type of Application	☐ Initial	☐ Change of Ownership (CHOW)* *Entities intending to purchase a nonprofit hospital must submit evidence of approval from the state Attorney General's Office re: compliance with Georgia House of Representatives, House Bill 600 (HB600).		
	☐ Name Change	☐ Address Change	☐ Governing Body Name Change	☐ Bed Capacity Change
	☐ Services Change	☐ Provider Information Update	☐ Other _____	

Hospital Classification (Check only one): ☐ General ☐ Specialized (Type) _____

Trade Name of Hospital

Administrator Title

Street Address City County Zip+4

Phone: ( ) _____-_____ FAX: ( ) _____-_____ E-Mail Address: _____

Mailing Address (different from Street Address)

Official Name and Address of Governing Body Principal Officer of Governing Body

Legal (Corporate) Name of Owner of Hospital

For Name Change or CHOW: Indicate **previous name** of Hospital or **previous owner**

Agent For Service (name) Address Phone Number

SECTION B: TYPE OF OWNERSHIP (Check only one)

PROPRIETARY (PROFIT):		**NON-PROFIT:**	
☐ Individual	☐ Partnership	☐ State	☐ Hospital Authority
☐ Corporation	☐ LLC	☐ County	☐ Church
☐ Other (Specify) _____		☐ City	☐ Other (Specify) _____

SECTION C: BED CAPACITY

1. Total number of **State Division of Health Planning (DHP) Authorized (CON)** beds: _____
2. Bed utilization:
   a. Number of **Acute** beds: _____ b. Number of **Psychiatric** beds: _____
   c. Number of **Rehabilitation** beds: _____ d. Number of **Swing** beds: _____
3. Total number of beds currently staffed & set up to receive patients:_____

SECTION D: SERVICES TO BE PROVIDED (organized services only)

☐ Emergency: Trauma Level_____		☐ Surgical	☐ Open Heart Surgery
☐ Maternal & Newborn Services Level_____	☐ Neonatal	☐ Pediatrics	☐ Organ/Tissue Transplants Type_____
☐ Psychiatric Type: ☐ Child ☐ Adolescent ☐ Adult		☐ Burn Unit	☐ Nuclear Medicine

☐ Other_____

☐ Outpatient: List details below for all **off-site** services

OFF-SITE OUTPATIENT SERVICES:

TYPE OF SERVICE	ADDRESS	DISTANCE FROM HOSPITAL (MILES)

SECTION E: CERTIFICATION

I certify that this hospital will comply with all Rules and Regulations for Hospitals, Chapter 290-9-7, Chapter 290-4-4 for Residential Mental Health Facilities for Children and Youth. I further certify that the above information is true and accurate to the best of my knowledge.

Signature _____ Title _____ Date _____

For Department of Community Health Use Only

Date Received _____ **Reviewed By** _____

Classification of Hospital:

☐ General

☐ Specialized (Specify type): _____

Bed Capacity: Total Number of **DHP Authorized** beds: _____

Permit Number: _____

Effective Date: _____

Recommend Approval: _____
Regional Director

RULES OF
DEPARTMENT OF HUMAN SERVICES
OFFICE OF REGULATORY SERVICES

CHAPTER 290-9-7
RULES AND REGULATIONS FOR HOSPITALS

History: Original Rules effective, December 12, 2002. "Hospital Inspections and Required Reports to the Department" revised and effective November 22, 2005. "Facilities Exempt from These Rules", "Discharge Planning and Transfer for Inpatients", and "Imaging and Therapeutic Radiology Services" revised and effective April 09, 2009.

Y Tag #	[Disclaimer: This document is not intended to substitute for that version of the rules duly adopted and promulgated by the Board of Human Resources and published by the Secretary of State in the official compilation of the Rules and Regulations of the State of Georgia.] **Rule**	**Clarification for Providers (This information is intended to clarify rules and to provide technical assistance and examples for providers. Such clarification and examples are subject to change from time to time as necessary to better reflect rule requirements. References to "Best Practices" are suggestions for raising the quality of care but are not requirements at this time. References to other related rules may be provided here to assist the reader in finding information.)**
0100	**290-9-7-.01 Title and Purpose.** These rules shall be known as the Rules and Regulations for Hospitals. The purpose of these rules is to provide for the inspection and issuance of permits for hospitals and to establish minimum requirements for facilities operating under a hospital permit. Authority O.C.G.A. Secs. 31-7-2.1 and 31-7-3.	
0200	**290-9-7-.02 Definitions.** Unless the context otherwise requires, these identified terms mean the following when used in these rules: (a) ***Board certified*** means current certification of a licensed physician by a specialty board recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) or other nationally recognized specialty's certifying board.	
0201	(b) ***Board eligible*** means a licensed physician who meets the criteria for examination for the designated specialty as published by that nationally recognized specialty's certifying board.	A hospital's medical staff may apply more stringent criteria to be used in its internal definition of board eligible, at its discretion.
0202	(c) ***Bylaws*** means a set of laws or rules formally adopted internally by a facility, organization, or specified group of persons to govern internal functions or practices within that group, facility, or organization.	Bylaws generally are interpreted here to be internally set standards of care or practice, which may include ethical standards and standards for qualifications or credentialing. Internal policies and procedures may also be adopted to organize operations of the group or facility, as an adjunct to the bylaws.
0203	(d) ***Department*** means the Department of Human Resources of the State of Georgia.	
0204	(e) ***Governing body*** means the hospital authority, board of trustees or directors,	

0204 cont	partnership, corporation, entity, person, or group of persons who maintain and control the hospital.	
0205	(f) ***Hospital*** means any building, facility, or place in which are provided two (2) or more beds and other facilities and services that are used for persons received for examination, diagnosis, treatment, surgery, or maternity care for periods continuing for twenty-four (24) hours or longer and which is classified by the department as a hospital.	
0206	(g) ***Inpatient*** means a person admitted to a hospital for an intended length of stay of twenty-four (24) hours or longer.	Hospitals are permitted to assign patients to an "observation status", which allows them to be classified as other than an inpatient for up to 48 hours while determining whether or not there is a need for admission.
0207	(h) ***Medical record*** means the written or electronic collection of diagnostic and/or treatment information and data pertaining to the patient, including but not limited to identifying information and, as applicable, medical orders, assessment findings, diagnostic test results, progress notes, x-ray films, monitoring data, and details of treatment.	Rules for storage, organization, and content of patients' medical records are detailed in 290-9-7-.18. X-ray films, for example, would be considered information related to treatment or diagnosis that would be part of the medical record, yet usually would be stored in a separate location from other records.
0208	(i) ***Medical staff*** means the body of licensed physicians, dentists, and/or podiatrists, appointed or approved by the governing body, to which the governing body has assigned responsibility and accountability for the patient care provided at the hospital.	This defines the body of individuals to whom the term "medical staff" refers when the term is used in these rules. A hospital may expand its own internal definition of "medical staff", and may establish categories of medical staff which include other licensed individuals who are granted clinical privileges, as long as the organization of the staff clearly limits those who are not physician**s**, dentists, or podiatrists from having a voice in decisions regarding the provision of medical care.
0209	(j) ***Organized service(s)*** means any inpatient or outpatient service offered by the hospital which functions as an administrative or operational unit under the governing body of the hospital.	A hospital department or unit would be an organized service, such as "outpatient services," "maternal and newborn services," or "surgical services." The term is not used to mean a single test or procedure, but an administrative unit of operations, which usually will contain several actual patient services. An off-site outpatient clinic would be an organized service, for example, but the tests or procedures performed there

0209 cont		would simply be "services." Organized services function administratively under the hospital's permit and must abide by all applicable rules and regulations for the hospital.
0210	(k) ***Outpatient*** means a person who presents to a hospital for diagnostic or treatment services and who is not admitted to the hospital as an inpatient by a member of the medical staff.	Examples of outpatient services include surgery procedures, diagnostic radiology, and observation patients.
0211	(l) ***Patient*** means any person presenting at a hospital for the purpose of evaluation, diagnosis, monitoring, or treatment of a medical condition, mental condition, disease, or injury.	Psychiatric conditions are considered to be medical conditions. Patient would include persons receiving overnight respite care.
0212	(m) ***Peer review*** means the procedure by which professional health care providers evaluate the quality and efficiency of services ordered or performed by other professional health care providers in the hospital for the purposes of fostering safe and adequate treatment of the patients and compliance with standards set by an association of health care providers and with the laws, rules, and regulations applicable to hospitals.	
0213	(n) ***Permit*** means the authorization granted by the Department to a hospital governing body to operate the hospital's authorized services.	Services are currently authorized through the Department of Community Health, Office of Regulatory Review.
0214	(o) ***Physical restraint*** means any manual method or physical or mechanical device used with a patient such that the patient's freedom of movement or access to his/her own body is restricted.	
0215	(p) ***Physician*** means any person who is licensed to practice medicine in this state by the Georgia Composite State Board of Medical Examiners.	
0216	(q) ***Practitioner*** means an individual engaged in the practice of the profession for which they are licensed, certified, or otherwise qualified or authorized to practice.	
0217	(r) ***Professional staff*** means a person or persons licensed by the state of Georgia to practice a specified health profession and employed by or contracting with the hospital for the practice of that profession.	
0218	(s) ***Rules and regulations*** means the set of rules formally adopted internally by a specified hospital body to provide guidance for internal functions or practices.	

0219	(t) ***Seclusion*** means the confinement of a person to a room or an area where the person is prevented from leaving.	This would include placing a patient in a room or area, even with the door remaining open, while utilizing a method to prevent the patient from leaving. The method used to prevent the patient from leaving may be as simple as a person standing outside the door.
0220	(u) ***Surveillance*** means the systematic method of collecting, consolidating, and analyzing data concerning the distribution and determinants of a given disease or medical event, followed by the dissemination of that information to those who can improve the outcomes.	
0221	(v) The singular indicates the plural, the plural the singular, and the masculine the feminine, when consistent with the intent of these rules. Authority O.C.G.A. Secs. 31-7-1, 31-7-2.1, 31-7-15, and 31-7-131 et seq.	
0300	**290-9-7-.03 Hospital Permit Requirement.** No person, corporation, association, or other entity shall establish, operate, or maintain a hospital in Georgia without a permit or provisional permit.	
0301	(a) A permit is required for each hospital. Multi-building hospitals may request a single permit to include all buildings provided that the hospital buildings are in close proximity to each other, the facilities serve patients in the same geographical area, and the facilities are operated under the same ownership, control, and bylaws.	
0302	1. Services offered in separate buildings or on separate premises, which do not by themselves meet the definition of a hospital, including, but not limited to, satellite urgent care centers, outpatient or mammography clinics, or hospital-owned physicians' offices, shall be considered organized services of the hospital for the purposes of these rules.	Billing for services through a hospital's Medicaid or Medicare provider number would be considered billing under the hospital permit. These services would be expected to comply with applicable hospital rules and regulations, such as involvement in the QM system, maintaining a safe and clean environment of care, etc. Marketing materials distributed by the hospital must reflect those services operating under the hospital permit. The key words to subparagraph 1. are "meet the definition of a hospital." If, for instance, the facility is not equipped or staffed to provide 24-hour care of patients, it would not fit the definition for requiring a separate permit.
0303	2. Only those services operated by the hospital under the permit as approved by the Department shall be presented to the public as a service of the hospital.	
0304	(b) A permit, either continuing or provisional, is required prior to the admission of any patients or initiation of any patient care services in the hospital. A provisional permit may be issued for a limited time to a newly established hospital to allow the hospital to demonstrate that its operational procedures equal standards specified by the rules.	

0305	(c) The permit shall designate the classification of the hospital as determined by the Department following evaluation of the hospital's services and in accordance with the Certificate of Need.	
0306	1. The classification shall be one of the following: (i) Classification as a general hospital means a facility meets the definition of a hospital and provides continuous care for a variety of patients who have a variety of medical conditions. A critical access hospital shall fall under the general hospital classification; or (ii) Classification as a specialized hospital means a facility that meets the definition of a hospital and provides care to a specialized or specified group of patients and/or patients who have specified conditions. The type of specialization shall be designated on the hospital permit.	Types of specialized hospitals may include: psychiatric hospitals, institutional infirmaries (which provide 24 hour care), pediatric hospitals, long term acute care hospitals, rehabilitation hospital, etc. Specialized hospitals, because their scope of services is limited, will find applicability of only certain sections of these rules. For instance, if the hospital does not provide surgical services, those rules would not apply. Unless indicated as applying only to a specific service, rules apply to all classifications.
0307	2. If changes occur in the organized services offered by the hospital, including the addition of any services requiring CON review or off-campus service locations, the hospital's administrator or governing body shall submit to the Department a new description of services at least thirty (30) days prior to the change. Change in the classification of the hospital shall require application for a new permit.	The addition of new organized services (such as the addition of surgical services, psychiatric services, cardiac rehab, or the opening of a new outpatient service site) may require an inspection by the Department. If changes are significant enough to warrant a change in classification, a new permit application would be required. If the facility questions whether or not a specific change requires notification, clarification may be obtained from the Department.
0308	(d) To be eligible for a permit the hospital shall be in substantial compliance with these rules and regulations and any provisions of law as applicable to the construction and operation of the hospital. In its discretion, the Department may issue a provisional permit for a limited time to a new or existing hospital to allow the hospital a reasonable length of time to come into compliance with these rules provided the Department has received an acceptable plan of correction.	"Substantial compliance" here means that the hospital must have in place all the necessary equipment, supplies, medications, and staff, so that they can immediately admit patients and provide patient care safely.
0309	(e) The permit issued to the hospital shall be prominently displayed in a public area of the hospital at all times.	The posted permit should be easily located at the inspection visit.
0310	(f) A permit is not transferable from one governing body to another nor from one hospital location to another.	

0311	(g) If the hospital anticipates that it will close or cease to operate, the governing body shall notify the Department at least thirty (30) days prior to the anticipated closure.	
0312	1. Prior to the hospital closure, the hospital shall inform the Department of the planned storage location for patients' medical records, medical staff information, and other critical information after closure. The hospital shall publish in a widely circulated newspaper(s) in the hospital's service area a notice indicating where medical records and other critical information can be retrieved and shall notify the Department of Transportation of the anticipated date of closure for removal of the hospital locator signs. Following closure, the Department shall be notified of any change in location of the patients' medical records, medical staff information, and other critical information from the published location.	The hospital would be responsible for providing for maintenance of medical records for the required time period: five years after discharge, or five years past the age of majority for minors, as specified in 290-9-7-.18(1)(h). The Division of Health Planning also requires notification of the anticipated closure.
0313	2. When the hospital ceases to operate, the permit shall be returned to the Department within ten (10) days of closure. The permit shall be considered revoked, unless placed on inactive status as described in these rules.	
0314	3. If the hospital is closing for a period of less than twelve (12) months, and plans to reopen under the same ownership, name, classification, and bed capacity, the hospital may request to have the permit placed on temporary inactive status.	
0315	(i) When placed on temporary inactive status, the permit shall be returned to the Department within ten (10) days of closure and the hospital shall not operate until the permit has been reactivated. The hospital shall notify the Department of Transportation of the intended closure.	DOT will cover or remove blue hospital signs as it sees fit.
0316	(ii) The hospital shall request in writing that the permit be reactivated at least thirty (30) days prior to the desired date of re-opening. Prior to reactivation of the permit, the hospital may be subject to inspection by the Department. If the permit is not reactivated within twelve (12) months, the permit shall be considered revoked.	When approved for reactivation, the Department will issue a permit with an effective date to coincide with the re-opening date of the hospital.
0317	(h) A new permit may be obtained by application to the Department and is required if the hospital is moved to another location, has a change in operational or trade name, has a change in ownership or classification, or has a change in the authorized bed capacity. The former permit shall be considered revoked upon the issue of a new permit and the former permit shall be returned to the Department.	A change in bed capacity that does not exceed the bed capacity authorized by the Department of Community Health does not require a new permit. See Section .05 for instructions on applying for a new permit under these conditions. Application may require additional documentation.
0318	(i) A permit shall remain in effect unless suspended or revoked or otherwise rescinded or	

318 cont	removed as provided in these rules. Authority O.C.G.A. Secs. 31-7-1, 31-7-2, 31-7-2.1, and 31-7-3.	
0400	**290-9-7-.04 Facilities Exempt from These Rules.** The following classes of hospitals are exempt from these rules: (a) **Federally owned and/or operated hospitals.** Hospitals owned or operated by the federal government are exempt from these rules and the requirement for a Georgia hospital permit; and (b) **Residential Mental Health Facilities for Children and Youth.** A sub-classification of specialized hospitals which are licensed to provide twenty-four (24) hour care and have as their primary function the diagnosing and treating patients to age twenty-one (21) with psychiatric disorders are exempt from these rules in lieu of meeting the specific regulations under Chapter 290-4-4. Authority O.C.G.A. Secs. 31-2-4, 31-7-2, and 31-7-5.	
0500	**290-9-7-.05 Application For a Permit.** An application for a permit to operate a hospital shall be submitted on forms provided by the Department. The application submitted to the Department shall be an original document. No application shall be considered by the Department unless it is complete and accompanied by all required attachments.	Hospitals should keep a copy of the application submitted and any supporting documents.
0501	(a) **Application for Initial Permit.** The application for an initial permit shall be submitted to the Department not later than thirty (30) days prior to the anticipated date of the opening and initiation of operations by the hospital**.** The application shall be signed by the hospital administrator or the executive officer of the hospital's governing body and shall include:	
	1. A listing of the services provided;	
	2. Proof of hospital ownership. In the case of corporations, partnerships, and other entities authorized by law, the applicant shall provide a copy of its certificate of incorporation or other acceptable proof of its legal existence together with the names and address of all persons owning five (5) percent or more;	The application must disclose ownership or participation in the facility, whether a partnership, limited liability company, etc.
	3. A list of the locations of any services offered by the hospital on separate premises; and	
	4. A copy of the Certificate of Need (CON) from the Department of Community Health.	

0502	(b) **Application Due to a Change in Name, Location, or Bed Capacity of a Hospital.** The application for a new permit due to a change in name, location, or authorized bed capacity of a hospital shall be submitted at least thirty (30) days prior to the proposed effective date of the change.	An increase in authorized bed capacity would require approval from the DCH, unless excepted by the provisions of O.C.G.A. Section 31-6-47(15). Failure to report a change may result in a fine or other sanction (O.C.G.A. Section 31-6-40.1).
0503	(c) **Application Due to a Change in the Classification of the Hospital.** The application for a new permit due to a change in the classification for the hospital shall be submitted at least thirty (30) days prior to the proposed effective date of the change. The application shall be signed by the hospital administrator or the executive officer of the governing body and shall include:	A change significant enough to change the hospital classification may indicate review for a new certificate of need, or may require an inspection by the Department before approval of the new permit.
	1. A listing of the service(s) to be provided; and	
	2. A copy of the required Certificate Of Need (CON) from the Department of Community Health, if applicable.	The changing or addition of services which would require a change in hospital classification (for example, from a general hospital to a specialty hospital) would require a new CON from the DCH per O.C.G.A. 31-6-2(14)(D).
0504	(d) Application Due to a Change in Ownership. The application for a new permit due to a change in ownership shall be submitted at least thirty (30) days prior to the change whenever possible. Proof of ownership documents, as required with the application for the initial permit and any other approvals required by state law, shall be submitted upon the completion of the transaction changing ownership. Authority O.C.G.A. Sec. 31-7-3.	
0600	**290-9-7-.06 Permit Denial and Sanctions.** The Department may refuse to grant an initial permit, revoke a current permit, or impose other sanctions as described herein and in the rules for the "Enforcement of Licensing Requirements," Chapter 290-1-6.	
0601	(a) **Denial of an Application for a Permit.** The Department may refuse to grant an initial permit or provisional permit without the requirement of holding a hearing prior to the action. Denial of an application for a change to a permit from an existing facility shall be subject to notice and opportunity for a hearing following the denial. An application may be refused or denied if:	
	1. The hospital has failed to demonstrate compliance with these rules and regulations;	

0601 cont	2. The applicant or alter ego of the applicant has had a permit denied, revoked, or suspended within one (1) year of the date of a new application;	
	3. The applicant has transferred ownership or governing authority of a hospital within one (1) year of the date of the new application when such transfer was made in order to avert denial, suspension, or revocation of a permit; or	
	4. The applicant has knowingly made any verbal or written false statement(s) of material fact in connection with the application for the permit or on documents submitted to the Department as part of any inspection or investigation or in the falsification or alteration of facility records made or maintained by the hospital.	
0602	(b) Sanction of a Permit. 1. The Department may take an action to sanction the hospital permit holder, subject to notice and opportunity for a hearing, where the Department finds that the hospital has:	The parameters for sanctions, including fines, reprimands, suspension and revocation of permits, are outlined in the Rules for Enforcement of Licensing Requirements, Chapter 290-1-6. The severity of the sanction would depend on the severity of the violation, the risk the violation posed to patients, and/or the frequency or recurring nature of the violation.
	(i) Knowingly made any verbal or written false statement of material fact either in connection with the application for the permit or on documents submitted to the Department as part of any inspection or investigation or in the falsification or alteration of hospital records made or maintained by the hospital;	
	(ii) Failed or refused, without legal cause, to provide the Department with access to the premises subject to regulation or information pertinent to the initial and continued licensing of the hospital;	
	(iii) Failed to comply with the licensing requirements of this state; or	
	(iv) Failed to comply with the provisions of O.C.G.A. Section 31-2-6 or Rules for the Enforcement of Licensing Requirements, Chapter 290-1-6.	
0603	2. Such sanctions of a Permit may include any one or more of the following: (i) Administration of a public reprimand;	

0603 cont	(ii) Suspension of the permit;	
	(iii) Prohibition of persons in management or control;	
	(iv) Imposition of civil penalties as provided by law; and	
	(v) Revocation of the permit.	
0604	(c) If the sanction hearing process results in revocation of the permit, the permit shall be returned to the Department. Authority O.C.G.A. Secs. 31-2-6 and 31-7-1, et seq., and the Rules for Enforcement of Licensing Requirements, Chapter 290-1-6.	
0700	**290-9-7-.07 Hospital Inspections and Required Reports to the Department.** (1) **Inspections by the Department.** The hospital shall be available during all hours of operation for observation and examination by properly identified representatives of the Department.	
0701	(a) **Initial Inspection.** There shall be an initial inspection of a hospital prior to the opening date in order to determine that the hospital is in substantial compliance with these rules. Prior to this initial inspection, the hospital shall submit to the Department:	For the purposes of these rules, an "initial inspection" refers to the first inspection of a new hospital, not an inspection for a new permit for a previously permitted hospital. An inspection triggered by the latter would be a "periodic inspection" as in (b) of this section.
	1. A copy of the certificate of occupancy;	
	2. Verification of building safety and fire safety from local and state authorities; and	
	3. Evidence of appropriate approvals by the state architect.	
0702	(b) **Periodic Inspections.** The hospital shall be subject to periodic inspections to determine that there is continued compliance with these rules, as deemed necessary by the Department.	For example, an application for a new permit due to a change in classification may prompt an inspection.
0703	(c) **Random Inspections.** The hospital may be subject to additional or more frequent inspections by the Department where the Department receives a complaint alleging a rule violation by the hospital or the Department has reason to believe that the hospital is in violation of these rules.	

0704	(d) **Plans of Correction.** If violations of these licensing rules are identified, the hospital will be given a written report of the violation that identifies the rules violated. The hospital shall submit to the Department a written plan of correction in response to the report of violation, which states what the hospital will do, and when, to correct each of the violations identified. The hospital may offer an explanation or dispute the findings or violations in the written plan of correction, so long as an acceptable plan of correction is submitted within ten (10) days of the hospital's receipt of the written report of inspection. If the initial plan of correction is unacceptable to the department, the hospital will be provided with at least one (1) opportunity to revise the unacceptable plan of correction. The hospital shall comply with its plan of correction.	
0705	(e) **Accreditation in Place of Periodic Inspection.** The Department may accept the accreditation of a hospital by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Osteopathy Association (AOA), or other approved accrediting body, in accordance with specific standards determined by the Department to be substantially equivalent to state standards, as representation that the hospital is or remains in compliance with these rules.	
0706	1. Hospitals accredited by an approved accrediting body shall present to the Department a copy of the full certification or accreditation report each time there is an inspection by the accreditation body and a copy of any reports related to the hospital's accreditation status within thirty (30) days of receipt of the final report of the inspection.	For JCAHO accredited hospitals, the copy of the accreditation report must be provided to the Department as soon as it is available to the hospital, and must include the Accreditation Decision Award letter, the Accreditation Decision Grid, and the Official Accreditation Decision Report including any supplemental recommendations.
0707	2. Hospitals accredited by an approved accrediting body are excused from periodic inspections. However, these hospitals may be subjected to random inspections by the Department for continuation of the permit when:	
	(i) A validation study of the accreditation process is necessary;	
	(ii) There has been a complaint alleging a rule violation which the Department determines requires investigation;	
	(iii) The Department has reason to believe that there is a patient incident or situation in the hospital that presents a possible threat to the health or safety of patients; or	The Department accepts that the accrediting body is addressing minor rule violations listed in their reports, without requiring additional inspection. However, if there appears to be a possible threat to the safety of patients due

0707 cont		to the rule violation, the Department may elect to do its own inspection. Any report, including reports required by the Department or newspaper reports, which give the Department reason to suspect that patients may be at-risk, may prompt an inspection.
	(iv) There are additions to the services previously offered by the hospital which the Department determines requires an on-site visit.	These additions are required by the Rules to be reported to the Department within 30 days.
0708	(2) **Required Reports to the Department.** (a) **Patient Incidents Requiring Report.** 1. No later than 90 days after the effective date of these rules, the hospital's duly constituted peer review committee(s) shall report to the Department, as required below, whenever any of the following incidents involving hospital patients occurs or the hospital has reasonable cause to believe that a reportable incident involving a hospital patient has occurred:	Hospitals must promptly report any of the types of incidents listed, but may also report any other incidents serious enough to put hospital patients or personnel at risk.
	(i) Any unanticipated patient death not related to the natural course of the patient's illness or underlying condition;	This would include, for example, patient suicide, deaths related to procedural or drug errors, or deaths resulting from a fall or other accident while in the hospital.
	(ii) Any rape which occurs in a hospital;	"Rape" is defined in O.C.G.A. 16-6-1. "Statutory rape" would also be included as a reportable event, and is defined under O.C.G.A. 16-6-3. O.C.G.A. 16-6-5.1 specifically includes a definition of sexual assault as any sexual contact from a person in a supervisory or authority position with a patient in a hospital.
	(iii) Any surgery on the wrong patient or the wrong body part of the patient; and	
0709	…(iv) Effective three (3) months after the Department provides written notification to all hospitals the hospital's duly constituted peer review committee(s) shall also report to the Department, whenever any of the following incidents involving hospital patients occurs or the hospital has reasonable cause to believe that a reportable incident involving a hospital patient has occurred:	

0709 cont	(I) Any patient injury which is unrelated to the patient's illness or underlying condition and results in a permanent loss of limb or function;	
	(II) Second or third degree burns involving twenty (20) percent or more of the body surface of an adult patient or fifteen (15) percent or more of the body surface of a child which burns were acquired by the patient in the hospital;	
	(III) Serious injury to a patient resulting from the malfunction or intentional or accidental misuse of patient care equipment;	The criteria for "serious injury" here would be an injury meeting the "serious injury" definition of the reporting requirements for the federal Safe Medical Devices Act of 1990, which is "an injury or illness that is life-threatening, results in permanent impairment or permanent damage to a body structure, or necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure." Federal law requires that such injuries/deaths also be reported to the FDA and to the manufacturer, if resulting from an equipment failure or malfunction.
	(IV) Discharge of an infant to the wrong family;	
	(V) Any time an inpatient, or a patient under observation status, cannot be located, where there are circumstances that place the health, safety, or welfare of the patient or others at risk and the patient has been missing for more than eight (8) hours; and	A patient leaving the hospital voluntarily, even if against medical advice, does not normally require a report.
	(VI) Any assault on a patient, which results in an injury that requires treatment.	
0710	2. The hospital's peer review committee(s) shall make the self-report of the incident within twenty-four (24) hours or by the next regular business day from when the hospital has reasonable cause to believe an incident has occurred. The self-report shall be received by the Department in confidence and shall include at least:	Initial report may be made by telephone, transmitted by facsimile, or by email, on a form provided by the Department, or with the information required by the form, and should be made to the Health Care Section of the Office of Regulatory Services. It is recognized that a hospital may only believe that an incident falls into this category, and will not know for sure until an investigation is completed.
	(i) The name of the hospital;	

0710 cont	(ii) The date of the incident and the date the hospital became aware that a reportable incident may have occurred;	
	(iii) The medical record number of any affected patient(s);	
	(iv) The type of reportable incident suspected, with a brief description of the incident; and	The "type" would be one of the categories defined in (a)1.
	(v) Any immediate corrective or preventative action taken by the hospital to ensure against the replication of the incident prior to the completion of the hospital's investigation.	
0711	3. The hospital's peer review committee(s) shall conduct an investigation of any of the incidents listed above and complete and retain on site a written report of the results of the investigation within forty-five (45) days of the discovery of the incident. The complete report of the investigation shall be available to the Department for inspection at the facility and shall contain at least:	
	(i) An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or other systematic analysis;	
	(ii) Any findings or conclusions associated with the review; and	
	(iii) A summary of any actions taken to correct identified problems associated with the incident and to prevent recurrence of the incident and also any changes in procedures or practices resulting from the internal evaluation using the hospital's peer review and quality management processes.	
	4. The Department shall hold the self-report made through the hospital's peer review committee(s) concerning a reportable patient incident in confidence as a peer review document or report and not release the self-report to the public. However, where the Department determines that a rule violation related to the reported patient incident has occurred, the Department will initiate a separate complaint investigation of the incident. The Department's complaint investigation and the Department's report of any rule violation(s) arising either from the initial self-report received from the hospital or an independent source shall be public records.	

0712	(b) **Other Events/Incidents Requiring Report.** 1. The hospital shall report to the Department whenever any of the following events involving hospital operations occurs or when the hospital becomes aware it is likely to occur, to the extent that the event is expected to cause or causes a significant disruption of patient care:	
	(i) A labor strike, walk-out, or sick-out;	
	(ii) An external disaster or other community emergency situation; and	
	(iii) An interruption of services vital to the continued safe operation of the facility, such as telephone, electricity, gas, or water services.	Brief power or service interruptions that could be covered by emergency generators, emergency water supplies, etc., would not have to be reported, as long as patient care could safely continue during the interruption.
0713	2. The hospital shall make a report of the event within twenty-four (24) hours or by the next regular business day from when the reportable event occurred or from when the hospital has reasonable cause to anticipate that the event is likely to occur. The report shall include:	
	(i) The name of the hospital;	
	(ii) The date of the event, or the anticipated date of the event, and the anticipated duration, if known;	
	(iii) The anticipated effect on patient care services, including any need for relocation of patients; and	
	(iv) Any immediate plans the hospital had made regarding patient management during the event.	
0714	3. Within forty-five (45) days following the discovery of the event, the hospital shall complete an internal evaluation of the hospital's response to the event where opportunities for improvement relating to the emergency disaster preparedness plan were identified. The hospital shall make changes in the emergency disaster preparedness plan as appropriate. The complete report of the evaluation shall be available to the Department for inspection at the facility. Authority O.C.G.A. Secs. 31-2-4, 31-2-6, 31-5-5, 31-7-2.1, 31-7-15, 31-7-133, 31-7-140, and 50-18-70.	

0800	**290-9-7-.08 Hospital Ownership.** There shall be full disclosure of hospital ownership to the Department at the time of the initial application and when requested. In the case of corporations and partnerships, the names of all corporate officers, partners, and all others owning five (5) percent or more of corporate stock or ownership shall be made known to the Department. Authority O.C.G.A. Sec. 31-7-3.	
0900	**290-9-7-.09 Governing Body and Hospital Administration.** The hospital shall have an established and functioning governing body that is responsible for the conduct of the hospital as an institution and that provides for effective hospital governance, management, and budget planning.	
0901	(a) The governing body shall be organized under bylaws and shall be responsible for ensuring the hospital functions within the classification for which it is permitted by the Department.	A hospital permitted as a general hospital classification that also offers psychiatric or drug treatment services should not expand those "specialized services" to the extent that they are greater than the "general" services. This is also true for "swing beds". Whatever service(s) the hospital provides that generated the original classification should remain the major service(s) of the hospital.
0902	(b) The governing body shall appoint members of the medical staff within a reasonable period of time after considering the recommendations of the medical staff, if any, and shall ensure the following:	For example, start-up hospitals would obviously not have a medical staff to give recommendations to the governing body. The governing body would appoint the initial medical staff without this input.
	1. That every inpatient is under the care of a qualified member of the medical staff;	
	2. That the medical staff is organized and operates under medical staff bylaws and medical staff rules and regulations, which shall become effective when approved by the governing body; and	
	3. That the medical staff is responsible to the governing body for the quality of all medical care provided to patients in the hospital and for the ethical and professional practices of its members while exercising their hospital privileges.	

0903	(c) If the hospital does not provide emergency services as an organized service, the governing body shall ensure that the hospital has written policies and procedures approved by the medical staff for the appraisal of emergencies, the initial treatment of emergencies, and the referral for emergency patients as appropriate.	For example, a specialized hospital such as a psychiatric, rehab, or sub-acute hospital, that does not operate an emergency room, needs to have protocols and procedures which staff would follow if a patient experienced an unexpected emergency condition. Protocols for handling emergencies at the hospital should designate which staff are responsible for appraisal of the patient's condition, what initial treatment the hospital is equipped and staffed to provide, and a procedure and system for contacting a physician for consultation.
0904	(d) The governing body shall identify an administrator or chief executive officer who is responsible for the overall management of the hospital. The administrator or chief executive officer shall:	The selection of the individual <u>also</u> could be addressed through a contract with a management company or through delegation to a committee.
	1. Ensure that there are effective mechanisms in the hospital's organization to facilitate communication between the governing body, the medical staff, the nursing staff, and other departments of the hospital;	Communication mechanisms may take the form of committees, internal councils, or other internal organizational groups, which have established policies and procedures for cross-departmental membership and/or reporting of issues, minutes, etc.
	2. Ensure that patients receive the same quality of care throughout the hospital; and	"The same quality of care" means that the patient's condition determines the level of care provided and the allocation of hospital resources, regardless of what area of the hospital the patient is in at the time of treatment. The level of care for patients who have been administered anesthesia should be required to be the same whether the anesthesia is administered in the operating room or elsewhere. The level of nursing care provided should be the same for patients throughout the hospital who have comparable nursing care needs. Protocols for infection control for specific procedures and environments should be the same for those procedures and environments in any area of the hospital.

0904 cont	3. Be responsible for reporting to the appropriate licensing board any member of the medical staff whose privileges at the hospital have been denied, restricted, or revoked, or who has resigned from practice at the hospital, to the extent required by state law.	This reporting is to the professional licensing board, not to the Department. O.C.G.A. 31-7-8 has specifics regarding the timelines allowable for this reporting, the required content of the report, and the confidentiality of this information. Results of any legal appeal of the hospital's sanction must also be reported. The law specifies that failure of the CEO to report this information to the professional licensing board may be grounds for denial or revocation of the hospital permit.
0905	(e) The hospital shall advise the Department immediately and in writing of a change in the designation of the administrator or chief executive officer.	
0906	(f) The governing body shall ensure that the hospital is staffed and equipped adequately to provide the services it offers to patients, whether the services are provided within the facility or under contract. All organized services providing patient care shall be under the supervision of qualified practitioners.	Services offered should not exceed the space, equipment, and staff training the service will require for adequate patient care. For example, a service for laser surgery could not be offered until and unless support systems are in place for that service (staff trained in follow-up, etc.), or telemetry services shall not be offered until and unless staff are trained and in place to interpret the readings and to intervene as necessary. "Qualified" would include the requirement for state licensure where applicable, as well as special competencies, training or experience as required by the rules or, in addition to the rule requirements, are deemed necessary by the hospital or the hospital's medical staff.
0907	(g) The governing body shall be responsible for compliance with all applicable laws and regulations pertaining to the hospital. Authority O.C.G.A. Sec. 31-7-2.1.	
1000	**290-9-7-.10 Hospital-Patient Communications.** The hospital shall develop, implement, and enforce policies and procedures to ensure that each patient is:	

1000 cont	(a) Informed about the hospital's grievance process, including whom to contact to file a grievance or complaint with the hospital and that individual's telephone number, and the name, address, and telephone number of the state regulatory agency;	Currently, the state regulatory agency **is** the Office of Regulatory Services, Healthcare Section, 2 Peachtree St., NE, 33rd Floor, Atlanta, GA 30303, (404) 657-5726 or 5728.
1001	(b) Provided an opportunity to give informed consent, or have the patient's legally authorized representative give informed consent, as required by state law, with documentation of provision of such opportunity in the patient's medical record;	Informed consent is an area of the law that is in transition. Hospitals need to comply with state law. See Ketchup v. Howard decided November 29, 2000 by the Georgia Court of Appeals. Also see O.C.G.A. Sec. 31-9-6.1 which generally requires, subject to certain exceptions consent for any surgical procedure under general anesthesia, spinal anesthesia, or major regional anesthesia, an amniocentesis diagnostic procedure, or a diagnostic procedure which involves the intravenous or intraductal injection of a contrast material.
1002	(c) Afforded the right to refuse medical and surgical treatment to the extent permitted by law;	O.C.G.A. 31-9-7 gives this right to all persons over the age of 18. O.C.G.A Title 37 Chapters 3 and 4 detail these rights for mentally ill and mentally retarded individuals, respectively. Patients under a court order for involuntary treatment may have restrictions to their rights to refusal of treatment. If so, this should be well documented in the patient's record.
1003	(d) Have advance directives honored in accordance with the law and afforded the opportunity to issue advance directives if admitted on inpatient status;	O.C.G.A. Chapter 31-32-4 requires that if the advance directive is prepared after the hospital admission it must be witnessed by the chief of the medical staff, another physician on the medical staff who is not involved in the patient's care, or another person on the staff hospital staff who is not involved the patient's care who has been designated by the chief of staff and hospital administrator to do so, in addition to the other witnesses required. If a durable power of attorney is prepared for a patient in the hospital at the time of preparation, O.C.G.A. Chapter 31-36-5 requires that this document be witnessed by the patient's attending physician as well as other required witnesses.

1004	(e) Provided, upon request, a written summary of hospital charge rates, per service, sufficient and timely enough to allow the patient to compare charges and make cost-effective decisions in the purchase of hospital services;	O.C.G.A. 31-7-11 is the referenced statute here.
1005	(f) Provided an itemized statement of all charges for which the patient or third-party payer is being billed; and	Per O.C.G.A. § 10-1-393, failure of a hospital to deliver such an itemized statement to a patient, with or without a specific request by the patient, is declared unlawful.
1006	(g) Provided communication of information in a method that is effective for the recipient, whether the recipient is the patient or the patient's designated representative. If the hospital cannot provide communications in a method that is effective for the recipient, attempts to provide such shall be documented in the patient's medical record. Authority O.C.G.A. Secs. 10-1-393(14), 31-7-2.1, 31-7-11, 31-9-2, 31-9-7, 31-11-82, 31-32-1, et seq., 31-33-2, and 31-33-3.	Hospital procedures should reflect the need to ascertain the effective communication method for the patient or representative, and that attempts should be made to accommodate the need for interpreters or alternative communication format (written if deaf but literate, verbal if blind, for example).
1100	**290-9-7-.11 Medical Staff.** Each hospital shall have an organized medical staff that operates under bylaws adopted by the medical staff and approved by the governing body. The bylaws may provide for the exercise of the medical staff's authority through committees.	Individuals granted clinical privileges at the hospital, as well as individuals who perform physician-delegated tasks, are usually governed by the medical staff bylaws of the hospital. Other practitioners, who do not report directly to the medical staff, may function as hospital employees and be governed by the policies and procedures of the hospital. The signature of the authorized representative of the governing body on the bylaws document is evidence of the approval by that body.
1101	(a) **Organization of the Medical Staff.** The medical staff shall be organized and may operate through defined committees as appropriate.	
1102	1. Any physician, podiatrist, or dentist providing patient care, whether directly or by contract with the hospital, shall obtain clinical privileges through the hospital's medical staff credentialing process.	
1103	2. The medical staff shall be responsible for the examination of credentials of any candidates for medical staff membership and for any other individuals seeking clinical privileges and for the recommendations to the governing body concerning appointment of such candidates. Minimum requirements for medical staff appointments and clinical privileges shall include:	Surveyors will check to see that credential files have privileges delineated and that hospital policies and procedures define responsibilities and lines of supervision for individuals who are granted clinical privileges.

1103 cont	(i) Valid and current Georgia license to practice the respective profession; (ii) Confirmed educational qualifications for the position of appointment; (iii) References for practice and performance background; (iv) Current health and mental status sufficient to perform medical and professional duties; (v) Current Drug Enforcement Agency registration, if applicable; (vi) Evidence of inquiry through relevant practitioner databases, such as databases maintained by licensing boards and the National Practitioner Data Bank; and (vii) Congruity of the qualifications and/or training requirements with the privilege requested.	There should be evidence the state professional licensing board has been contacted to verify the license, and that the license is current and in good standing. The hospital may require a physician's verification of an individual's capability to work, and any limitations or needed accommodations, or may require the individual's attestation as to status. DEA registration is not required for all individuals granted privileges. This requirement would depend on the anticipated function of the candidate. For those hospitals receiving CMS funds, violations of the NPDB query requirement are required to be reported to CMS for appropriate referral or action. The final requirement describes the matching of the credentials to the privileges considered. Specialized training or other requirements must be specified for special privileges (for example, training for added surgical procedures such as laparoscopic procedures for cholecystectomy or appendectomy).
1104	3. The medical staff shall evaluate at least biennially the credentials and professional performance of any individual granted clinical privileges for consideration for reappointment.	
1105	4. The medical staff shall establish a system for the approval of temporary or emergency staff privileges when needed.	
1106	(b) **Medical Staff Accountability.** The medical staff shall be accountable to the governing body for the quality of medical care provided to all patients.	
1107	1. The medical staff shall require that all individuals granted clinical privileges comply with generally accepted standards of practice.	

1108	2. The medical staff shall implement measures, including peer review, to monitor the on-going performance of the delivery of patient care by those granted clinical privileges, including monitoring of compliance with the medical staff bylaws, rules and regulations, and hospital policies and procedures.	As for other organized services at the hospital, the medical staff must participate in quality management efforts. Some efforts may be internal to the medical service and others may be interdisciplinary or cross over into other areas of service. A system of peer review should be clearly defined, including the scope, timelines, and procedures for these reviews. As with other quality management efforts, there would be a system for communicating the results of quality management efforts to the governing body, and for quality improvement programs to be initiated when indicated.
1109	3. The medical staff shall establish effective systems of accountability for any hospital services ordered by physicians and other practitioners.	These systems would apply also to physicians and other practitioners not on the medical staff of the hospital who may want their patients to utilize hospital services. For example, the hospital might specify in the system what information the ordering practitioner, whether or not a member of the medical staff, must include in the order for services (reason for the order, etc.), and what would be the mechanism for reporting the results of any ordered treatment, testing, or patient care.
1110	4. The medical staff shall review and, when appropriate, recommend to the governing body denial, limitation, suspension, or revocation of the privileges of any practitioner who does not practice in compliance with the scope of privileges, the medical staff bylaws, rules and regulations, generally accepted standards of practice, or hospital policies and procedures.	The administrator appointed by the governing body has the responsibility of reporting of these restrictions to the appropriate licensing body for the state, per 290-9-7-.09(6)(c).
1111	(c) **Medical Staff Bylaws and Rules and Regulations.** The medical staff of the hospital shall adopt and enforce bylaws and rules and regulations which provide for the self-governance of medical staff activities and accountability to the governing body for the quality of care provided to all patients. The bylaws and rules and regulations shall become effective when approved by the governing body and shall include at a minimum:	All of the listed areas must be addressed in either the facility's medical staff bylaws or rules and regulations.
1112	1. A mechanism for participation of medical staff in policy decisions related to patient care in all areas of the hospital;	The system of medical oversight usually is organized through committees established for that purpose.

1113	2. A plan for administrative organization of the medical staff and committees thereof, which clearly delineates lines of authority, delegation, and responsibility for various tasks and functions;	The medical staff may delegate medical care tasks to various other licensed practitioners, including physician's assistants, nurses, nurse practitioners, and others as allowed by law.
1114	3. Description of the qualifications and performance to be met by a candidate in order for the medical staff to recommend appointment or reappointment by the governing body;	
1115	4. Criteria and procedures for recommending the privileges to be granted to individual physicians, dentists, or podiatrists;	
1116	5. A requirement that members of the medical staff comply with ethical and professional standards;	
1117	6. Requirements for regular health screenings for all active members of the medical staff that are developed in consultation with hospital administration, occupational health, and infection control/safety staff. The health screenings shall be sufficient to identify conditions which may place patients or other personnel at risk for infection, injury, or improper care. There shall be a mechanism for the reporting of the screening results to the hospital, either through the medical staff or otherwise;	Best practice would be to require the same screenings for medical staff as is required for all other healthcare personnel who work in similar areas of the hospital. The screenings would not have to be performed at the hospital, but there should be documentation for every active member of the medical staff that the screenings are current.
1118	7. A mechanism for ensuring physician response to inpatient emergencies twenty-four (24) hours per day;	This does not require that every specialty must have an on-call list 24 hours every day.
1119	8. A mechanism for physician coverage of the emergency department and designation of who is qualified to conduct an emergency medical screening examinations where emergency services are provided;	This is applicable for all facilities which offer emergency services**.**
1120	9. A requirement that referral for consultations will be provided to patients when a patient's physical or mental condition exceeds the clinical expertise of the attending member of the medical staff;	This may include internal or external consultations for diagnostic services or treatment.
1121	10. The requirements for the patient's history and physical examination, which must be performed either within twenty-four (24) hours after admission or within the thirty (30) days prior to admission and updated upon admission. See Rule 290-9-7-.28(a)(2) for history and physical requirements when surgery is being performed;	

1122	11. Establishment of procedures for the choice and control of all drugs in the hospital;	There should be guidelines established for the prudent use of certain classes of drugs, such as antibiotics and anticoagulants.
1123	12. The requirements for the completion of medical records;	
1124	13. The requirements for verbal/telephone orders, to include which Georgia-licensed or Georgia-certified personnel or other qualified individuals may receive verbal/telephone orders, and the acceptable timeline for authentication of the orders, not to exceed the timeline requirements in these rules;	The Medical Records section 290-9-9-.18(2)(b) requires that verbal/telephone orders be authenticated within 48-hours**.** The hospital may elect to establish shorter timelines for specific medications or procedures.
1125	14. A mechanism for peer review of the quality of patient care, which includes, but is not limited to, the investigation of reportable patient incidents involving patient care as described in Rule 290-9-7-.07(2)(a); and	
1126	15. A procedure for review and/or update of the bylaws and rules and regulations as necessary, but at least once every three (3) years.	
1127	(d) **Other Medical Staff Policies.** If not addressed through the medical staff bylaws or rules and regulations, the medical staff shall develop and implement policies to address, at a minimum:	
	1. Criteria for when an autopsy shall be sought and a requirement that the attending physician be notified when an autopsy is performed; and	State law requires that deaths occurring under certain circumstances must be reported to law enforcement authorities, who may require that they be handled in a certain manner. Hospital policies concerning the handling of deaths would have to comply with such legal requirements. The policies described here would address cases outside those circumstances, over which the medical staff could internally exercise some management discretion.
1128	2. A requirement that every member of the medical staff provide appropriate medical care for each of their patients until the patient is stable for discharge or until care of the patient has been transferred to another member of the medical staff or to another facility. Authority O.C.G.A. Secs. 31-7-2.1 and 31-7-15.	

1200	**290-9-7-.12 Human Resources Management.** The hospital shall select and organize sufficient qualified and competent personnel to meet patients' needs and in a manner appropriate to the scope and complexity of the services offered.	As new or more complex services are added, there would need to be evidence that there has been planning and reorganization of personnel to support those services according to generally accepted standards of practice. Examples of service expansions needing specific support would be nuclear medicine, diagnostic or cardiac rehabilitation.
1201	(a) The hospital shall establish and implement human resources policies and procedures to include at least:	
	1. Procedures for selecting qualified personnel;	
	2. A system for documenting the current licensure and/or certification status for those personnel whose positions or functions require such licensure or certification;	There may be special certifications required by the hospital for special units such as Advanced Cardiac Life Support (ACLS) for cardiac care units, or Pediatric Advanced Life Support (PALS) for the pediatrics unit. If required by the hospital policies or by the medical staff bylaws, there must be documentation of the status of that certification for affected personnel.
	3. A system for assessing competency of all personnel providing health care services, on a time schedule defined by hospital policy; and	The hospital may elect to perform competency or performance evaluations on all staff as a management tool. For providers of health care services, best practice would be to provide reassessment of certain professional competencies at least annually.
	4. Policies and procedures regarding the hospital-approved method for identification of personnel to patients, other staff, and visitors.	
1202	(b) **Written Job Descriptions.** The hospital shall have a written description of responsibilities and job duties, with qualification requirements, for each position or job title at the hospital.	

1203	(c) **Health Screenings.** The hospital shall have in place a mechanism and requirement for initial, regular, and targeted health screenings of personnel who are employed or under contract with the hospital or providing patient care services within the hospital setting. The screening shall be sufficient in scope to identify conditions that may place patients or other personnel at risk for infection, injury, or improper care. The health-screening program shall be developed in consultation with hospital administration, medical staff, occupational health, and infection control/safety staff.	Infectious or communicable diseases that may pose a threat to patient well being, and conditions which may place patients at risk, should be targeted by the health screening program for all healthcare workers at the hospital. The requirements for medical staff are listed under the Medical Staff Bylaws and Rules and Regulations. See Rule 290-9-7-.11. Policies should address how job functions or responsibilities may change following the results of the health screenings, e.g. any restrictions or accommodations that may be made to reduce patient risk. Hospitals may require employed physicians, as employees of the hospital, to meet the human resources health screening requirement.
1204	(d) **Personnel Training Programs.** The hospital shall have and implement a planned program of training for personnel to include at least: 1. Hospital policies and procedures; 2. Fire safety, hazardous materials handling and disposal, and disaster preparedness; 3. Policies and procedures for maintaining patients' medical records; 4. The infection control program and procedures; and 5. The updating of job-specific skills or knowledge.	Initial training in (1.) through (3.) should be provided prior to new personnel assuming regular job duties. A regular program of renewing skills and knowledge, preferably annual, should be required for all staff. To ensure that personnel keep up with current standards of practice, there should be opportunities for the updating of skills within the hospital's training program. Hospitals are not, however, required to provide all training necessary for personnel to renew professional licenses or certificates.
1205	(e) Personnel records shall be maintained for each employee of the hospital and shall contain, at a minimum:	Hospitals must have all of the listed information for all personnel. The information is not required to be kept in one location. For example, a Human Resources department may keep application, hiring, and job description information, but a departmental supervisor may keep competency evaluations. The hospital must be able to assemble all required information for an individual employee if requested.
	1. The employment application or resume;	

1205 cont	2. Dates of hire and position changes since hiring;	
	3. The job or position description(s) for the employee;	
	4. All evaluations of performance or competencies for the employee since the date of hire or at least the last five (5) years;	
	5. Credible evidence of current registration, licensure, or certification as required for that position by state law;	Credible evidence includes an original document, or notarized copy or facsimile thereof, or a print out from the licensing board's website confirming status.
	6. Evidence of completion of in-service training as required by hospital policy; and	
	7. Evidence of completion of any requirements of the occupational health program at the hospital. Authority O.C.G.A. Sec. 31-7-2.1.	
1300	**290-9-7-.13 Quality Management.** The governing body shall establish and approve a plan for a hospital-wide quality management program, which includes the use of peer review committees. The purpose of the quality management program is to measure, evaluate, and improve the provision of patient care.	A written quality management plan must be available for review. Minutes from governing body or its subcommittees' meetings should reflect review of reports from quality management activities, and at least annual review of the program's effectiveness.
1301	(a) The scope and organization of the quality management program shall be defined and shall include all patient services and clinical support services, contracted services, and patient care services provided by the medical staff.	All organized services should show some QM activities. Examples of clinical support services are: housekeeping, dietary services, and medical records departments. Interdisciplinary approaches may be utilized in the QM process, and are encouraged. QM activities for contracted services must also be evident.
1302	(b) The hospital's quality management program shall be designed to systematically collect and assess performance data, prioritize data, and take appropriate action on important processes or outcomes related to patient care, including but not limited to:	Best practices would include performance measurements of high risk and high volume service areas and patient satisfaction surveys.
	1. Operative procedures and other invasive and non-invasive procedures that place patients at risk;	These types of procedures are often monitored through surgical case review.
1303	2. Nosocomial infection rates;	

1304	3. Patient mortality;	
1305	4. Medication use;	
1306	5. Patient injuries, such as, but not limited to, those related to falls and restraint use;	
1307	6. Errors in procedures or practices which could compromise patient safety ("near-miss" events);	
1308	7. Discrepancies or patterns of discrepancies between preoperative and postoperative diagnosis, including those identified during the pathologic review of specimens removed during surgical or invasive procedures;	
1309	8. Significant adverse drug reactions (as defined by the hospital);	
1310	9. Adverse events or patterns of adverse events during anesthesia;	
1311	10. Equipment malfunctions, for equipment used for patient care; and	
1312	11. Reportable patient incidents as required under Rule 290-9-7-.07.	
1313	(c) The quality management program shall utilize a defined methodology for implementation, including at least mechanisms and methodologies for:	The mechanisms for monitoring, evaluating, and assessing accountability, and the reporting and resolution of problems in the service, should be evident by reviewing any of the hospital's QM activities. There should be a priority for monitoring high-risk procedures and high volume admissions related to diagnoses. There should be evidence of root cause analysis and that the scope of a problem had been evaluated once the problem was identified.
	1. Performance measurement including consideration of scope of services;	
	2. Monitoring, evaluating, and assessing accountability;	
	3. Setting priorities;	

1313 cont	4. Root cause analyses, as appropriate, of problems identified;	
	5. Process improvement;	
	6. Identification of expected outcomes;	
	7. Reporting mechanisms; and	
	8. Authority for problem resolution.	
1314	(d) Results or findings from quality management activities shall be disseminated to the governing body, the medical staff, and any services impacted by the results.	There must be evidence that information from QM, or at least the results, are disseminated laterally within the hospital as well as upward to the governing body.
1315	(e) The hospital shall take and document action to address opportunities for improvement identified through the quality management program.	The hospital should be able to demonstrate that remedial action was taken as appropriate for any selected completed QM project, unexpected outcomes of care, or unusual incident.
1316	(f) There shall be an on-going evaluation of the quality management program to determine its effectiveness, which shall be presented at least annually for review and appropriate action to the medical staff and governing body. Authority O.C.G.A. Secs. 31-7-2.1 and 31-7-15.	Either a designated individual or a committee could prepare this evaluation. There should be a summary document generated that has been reviewed by the governing body.
1400	**290-9-7-.14 Physical Environment.** The hospital shall be equipped and maintained to provide a clean and safe environment for patients, employees, and visitors.	
1401	(a) **Safety.** The hospital shall develop and implement an effective hospital-wide safety program that includes the following components:	
	1. A fire safety program including compliance with the applicable provisions of the *Life Safety Code*® (NFPA 101®), as enforced by the state fire marshal;	*Life Safety Code*® and NFPA 101® are registered trademarks of the National Fire Protection Association, Inc. The safety program would include internal monitoring for continuous compliance with life safety codes, quarterly fire drills, and documentation of training of all staff in fire emergency procedures.

1402	2. An incident monitoring system that promptly identifies, investigates, and takes effective action regarding all incidents that involve injury to patients, employees, or visitors or that involve significant damage to property;	The monitoring system may investigate systems, processes, procedures, and/or other physical environment problems presenting a safety risk.
1403	3. A program to inspect, monitor, and maintain biomedical equipment, electrical equipment, and emergency power generators;	The program should establish monitoring and calibrations schedules appropriate to manufacturer's specifications, applicable state and federal rules and regulations, or specified standards of practice. "Biomedical equipment" includes any equipment used in the diagnosis or treatment of patients or their diseases or disorders. "Electrical equipment" would be other equipment not involved in patient diagnosis or treatment, such as TVs, radios, clocks, lamps, etc. the hospital may elect to have different monitoring and maintenance programs for the biomedical equipment and other electrical equipment.
1404	4. A program for the monitoring and maintenance of electrical safety;	This would include the maintenance of electrical wiring, electrical outlets, etc., in safe working condition.
1405	5. Security procedures for controlling access to sensitive areas, as defined by the hospital, for patients, employees, and visitors;	Procedures must include provisions for controlling access to and egress from areas identified by the hospital to need such access control. Sensitive areas may include, for example, newborn nurseries, the emergency department, psychiatric units, the pharmacy, and medical records areas, and/or pediatrics.
1406	6. Procedures for the safe management of medical gases;	Procedures must be in place to assure that gases are handled safely, and that tanks, nozzles, etc., are monitored for adequate supply, absence of leakage, and safe and accurate functioning.
1407	7. A system for patients or staff to summon assistance, when needed, from patient rooms, bathrooms, and treatment areas;	
1408	8. Policies regarding smoking which apply to employees, patients, and visitors; and	

1409	9. Procedures for storage and disposal of biohazardous medical waste in accordance with applicable laws.	
1410	(b) **Cleanliness and Sanitation.** The hospital shall maintain an environment that is clean and in good repair, through a program that establishes and maintains:	
	1. Standardized daily, interim, and terminal cleaning routines for all areas;	
1411	2. Facilities for convenient and effective hand washing throughout the hospital;	Handwashing facilities must be functioning, and stocked with soap and disposable towels. (If stocked solely with waterless handwashing soap, towels would not be required.)
1412	3. Systems for management of linens, including collection, sorting, transport, and washing of soiled linens, and storage and distribution of clean linens: (i) Collection and sorting procedures shall be designed to prevent contamination of the environment and personnel. Collection procedures shall include bagging of soiled linen at site of use. Sorting and rinsing of soiled linens shall not take place in patient care areas; (ii) Clean and soiled linens shall be transported in separate containers or carts; (iii) The laundering process for soiled linens shall be sufficient to remove organic soil and render the linen incapable of causing human illness; and (iv) Any soiled linen processing area shall be separate from the area used for clean linen storage, from patient care areas, and from area**s** where clean or sterilized supplies and equipment are stored;	The hospital may have facilities for cleaning linens internally, or may use an external contracted service. The facility must be able to show that staff has been trained in the procedures designed to prevent contamination. Bagging materials would not be considered adequate separation; for example, it would not be permitted to transport clean and soiled linens in the same cart, regardless of how they were bagged. Hot water washing is not required as long as the facility can show that its methods are designed to adequately clean the linens. For example, cold water washes with sufficient bleach and laundry chemicals may be used. Separation of areas may be accomplished by physical barriers, negative airflow systems for the soiled linen areas, positive airflow systems from the clean linen area to the soiled linen area, or a combination of systems.
1413	4. Standards regarding the use of hospital disinfectants;	

1414	5. Systems for the storage and disposal of garbage, trash, and waste in a manner that will not permit the transmission of disease, create a nuisance, or provide a breeding place for insects or rodents; and	
1415	6. Procedures for the prevention of infestation by insects, rodents, or other vermin or vectors.	
1416	(c) **Light, Temperature, and Ventilation.** The hospital shall provide adequate lighting, ventilation, and control of temperature and air humidity for optimal patient care and safety of the hospital's patients and staff and shall monitor and maintain such systems to function at least minimally to the design standards current at the time of approved facility construction or renovation.	Renovations of areas, especially if the renovation involved a change in the function of an area or space, may change the ventilation and temperature control needs for the area. At the time the renovation is planned, these needs should be considered. If a patient requests that the room be warmer or cooler, barring medical contraindications, the actual room temperature could be varied according to patient wishes. Historically, operating rooms have been known to have been kept very cool for the comfort of the medical and surgical staff, but this places the patient at risk for hypothermia when under anesthesia. There are published guidelines to keep hospitals abreast of temperature ranges felt to be optimal for patient health and safety. The necessary ventilation and air exchange rates will differ for different areas of the hospital – for example, the surgical suites, infectious disease isolation rooms, and soiled linen areas would have different requirements. In food preparation areas, the ventilation should be adequate to maintain temperatures sufficiently cool to prevent food spoilage during preparation and to prevent the contamination of food with staff perspiration. The hospital should be able to identify which standards it uses for its ventilation and air exchange systems. Currently, guidelines are available from the American Institute of Architects (AIA) in the Standards for the Design and Construction of Healthcare Facilities, from the Association of Professionals in Infection Control (APIC), the Centers for Disease Control (CDC), and through the *Life Safety Code*® (NFPA 101®).

1417	(d) **Space.** The hospital shall provide sufficient space and equipment for the scope and complexity of services offered. Authority O.C.G.A. Sec. 31-7-2.1.	
1500	**290-9-7-.15 Disaster Preparedness.** The hospital shall prepare for potential emergency situations that may affect patient care by the development of an effective disaster preparedness plan that identifies emergency situations and outlines an appropriate course of action. The plan must be reviewed and revised annually, as appropriate, including any related written agreements.	Best practice would be for the plan to include the four elements of disaster response recommended by the EMA – mitigation (actions taken to prevent or lessen the impact of an incident or disaster), preparation (actions taken prior to a disaster to prepare for responding should the event occur), response (actions taken immediately following an event to ensure patient safety or community support), and recovery (actions taken to restore the hospital or the community to normal operations).
1501	(a) The disaster preparedness plan shall include at a minimum plans for the following emergency situations: 1. Local and widespread weather emergencies or natural disasters, such as tornadoes, hurricanes, earthquakes, ice or snow storms, or floods; 2. Manmade disasters such as acts of terrorism and hazardous materials spills; 3. Unanticipated interruption of service of utilities, including water, gas, or electricity, either within the facility or within a local or widespread area; 4. Loss of heat or air conditioning; 5. Fire, explosion, or other physical damage to the hospital; and 6. Pandemics or other situations where the community's need for services exceeds the availability of beds and services regularly offered by the hospital.	'Acts of terrorism' might include use of explosives, chemical agents, biological agents, or radioactive materials. It is prudent for the hospital disaster plan to address, for example, triage management, management of the press, management of patient's families, and adjustments that may have to be made in other hospital services while the disaster is being managed.
1502	(b) There shall be plans to ensure sufficient staffing and supplies to maintain safe patient care during the emergency situation.	Hospitals should be able to show that they have sufficient supplies and food for a least three days with the average inpatient census.

1503	(c) There shall be plans for the emergency transport or relocation of all or a portion of the hospital patients, should it be necessary, in vehicles appropriate to the patient's condition(s) when possible, including written agreements with any facilities which have agreed to receive the hospital's patients in these situations.	An effective plan should include agreements with both local facilities (for local relocations) and facilities at longer distances in case there is a need for evacuation of the entire area.
1504	(d) The hospital shall document participation of all areas of the hospital in quarterly fire drills.	
1505	(e) In addition to fire drills, the hospital shall have its staff rehearse portions of the disaster preparedness plan, with a minimum of two (2) rehearsals each calendar year either in response to an emergency or through planned drills, with coordination of the drills with the local Emergency Management Agency (EMA) whenever possible.	The rehearsal should be realistic enough to assess the appropriateness of personnel response, and the integrity of support system arrangements. Rehearsal shall not require the actual movement of non-ambulatory patients or other patients for whom the rehearsal could aggravate their condition.
1506	(f) The plan shall include the notification to the Department of the emergency situation as required by these rules.	As required by 290-9-7-.08, certain situations must be reported to the Health Care Section of the Office of Regulatory.
1507	(g) The hospital shall provide a copy of the internal disaster preparedness plan to the local Emergency Management Agency (EMA) and shall include the local EMA in development of the hospital's plan for the management of external disasters.	Efforts to coordinate planning with the local EMA should be documented. It is recognized that the hospital cannot require the participation of other agencies.
1508	(h) The hospital's disaster preparedness plan shall be made available to the Department for inspection upon request.	
1509	(i) The Department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared a public health emergency. Authority O.C.G.A. Secs. 31-7-2.1, 31-7-3, and 31-12-2.1.	
1600	**290-9-7-.16 Infection Control.** The hospital shall have an effective infection control program to reduce the risks of nosocomial infections in patients, health care workers, volunteers, and visitors.	Review of infection control surveillance data, program minutes, policies and procedures, interview with infection control staff, and tour of the hospital, should show evidence that infection control problems are identified promptly, appropriate control strategies implemented, and continual efforts made at reducing the infection risks of patients, staff, and others in the healthcare environment.

1601	(a) The hospital shall designate qualified infection control staff to coordinate the infection control program.	Qualifications should show training and experience in the discipline of infection control. Best practice would be to have the Certification in Infection Control (CIC) by the National Certification Board of Infection Control. If the hospital should find itself without the services of a qualified infection control professional, arrangements should be made to have mentoring from such a professional until the facility can recruit or train someone to fill this role. The program should reflect the time designated staff will dedicate to the program, which should reflect the intensity and complexity of patient care delivered at the hospital, the severity of patient illnesses, the total numbers of patients, and patient care locations within the hospital.
1602	(b) The administrative and medical staff of the hospital, as well as staff from appropriate organized services, shall participate in the infection control program.	The program should show evidence of active involvement of the medical staff, administration, and participation by various organized services of the hospital. Those services more directly involved with patient care should be evident, e.g.: nursing, respiratory services, laboratory, pharmacy, dietary, housekeeping, sterile processing services, and others as related to problems identified in the infection control program.
1603	(c) The infection control program shall function from a well-designed surveillance plan that is based on accepted epidemiological principles, is tailored to meet the needs of the hospital, and includes both outcome and process surveillance methodologies.	A well-designed program should describe the population (denominator) and events (infections) to be studied as concisely as possible, include systematic data collection methods, tabulation and analysis of data, and reporting mechanisms. In smaller hospitals where very few invasive procedures are performed and the patient population is much smaller, the risk for acquiring infection may be lower and sometimes infrequent. With a small sample size, additional emphasis should be placed on monitoring critical procedures known to be associated with infection outcomes. Hospitals utilizing priority-directed or site-specific surveillance instead of total or house-wide surveillance should show methods of identifying clusters or outbreaks of infections.

1604	(d) The surveillance plan shall require collection of sufficient baseline data on the incidence of nosocomial infections in order that outbreaks can be identified.	The hospital should be able to show data related to endemic nosocomial infection rates in the hospital over time so that objective quantitative comparisons can be made about the ongoing infection risks and methods can be developed to improve the trends.
1605	(e) The infection control methodologies for effective investigation and control of outbreaks, once identified, shall include at least:	When a cluster, outbreak, or an unusual infection is identified by the program, there should be evidence of prompt control measures and attempts to identify the factors that contributed to the infections. Measures should be implemented in order to prevent similar infections in the future.
	1. The availability of microbiology laboratory capacity to detect and investigate outbreaks;	There should be evidence of laboratory support, either internal to the hospital or by arrangement, in order to identify cases and collect critical data and specimens.
	2. A system for obtaining appropriate clinical specimens for culture;	Sufficient authority should be evident for infection control professionals in order to obtain the clinical specimens necessary for cultures and the investigation of infections.
	3. Access to necessary information in order to investigate infectious outbreaks; and	There should be no evidence of restrictions imposed by the hospital solely to restrict access to hospital medical records or other information necessary for an outbreak investigation by infection control staff.
	4. Administrative, physician, and nursing support to direct hospital changes to achieve immediate control of outbreaks and for implementation of corrective actions.	When outbreaks or unusual pathogens are identified, the hospital must show evidence of the necessary support required to quickly control the problem.
1606	(f) The program shall specify policies and procedures for infection control that apply to all areas of the hospital, and these shall include at least the following:	There should be evidence that each area and service of the hospital was evaluated related to potential infection risks for staff, patients and visitors, and relevant policies and procedures developed. Infection risks in vending machine areas, equipment rooms, storage rooms, visitor and volunteer areas are all often overlooked. Examples of resources for assessing risks and controlling infections in these areas can be found through the Centers for Disease

1606 cont		Control (CDC), the American Institute of Architects (AIA), the Association for Professionals in Infection Control (APIC), the Association for Operating Room Nurses (AORN), and the Society for Healthcare Epidemiology of America (SHEA).
	1. The approved hospital isolation system;	The hospital must specify in policies and procedures which system(s) are "approved" to be used. Examples of systems would be "standard precautions" or a system specific to a disease. The approved system(s) may be combinations of other published systems.
	2. The approved procedures for handling and disposing of hazardous waste products;	The hospital must specify methods for the disposal of materials contaminated with blood or other potentially infectious materials. The methods should comply with the Bloodborne Pathogens Rule issued by OSHA, and applicable state environmental agency regulations.
	3. The standards for approved cleaning, disinfection, and sterilization for all areas of the hospital;	The hospital must specify standards for cleaning the environment, equipment and materials such as linens. Only approved procedures and disinfectants should be used in any area of the hospital. Hospital sterilization and disinfecting procedures should include approved monitoring systems and be consistent hospital-wide.
	4. The standards for hand washing and hand antisepsis; and	Since handwashing is generally considered the single most important procedure for preventing nosocomial infections, the hospital must develop and implement procedures for handwashing that meet generally accepted standards of practice. Accepted standards would reflect
		guidelines such as those issued by the Centers for Disease Control (CDC), Association for Professionals in Infection Control (APIC).
	5. A communicable disease health-screening plan for the hospital that includes required communicable disease activities, immunizations, exposure evaluations, tuberculosis surveillance, and work restrictions. There shall be evidence that the plan was developed in	If the health screening plan is not a function of infection control, there shall be evidence of sharing of information related to exposure, infections, outbreaks and

1606 cont	consultation with hospital administration, medical staff, and safety staff.	collaboration in the development of policies and procedures for the program and education initiatives. Activities include reporting communicable diseases, surveillance and investigation.
1607	(g) The infection control program shall have an organized and effective ongoing education plan for hospital health care workers and volunteers that includes at least:	An education program for infection control should include all healthcare workers and all other staff or volunteers at the hospital, including medical staff.
	1. An orientation plan;	There must be evidence of orientation for new employees related to basic infection control policies and procedures such as handwashing, isolation techniques, and employee health.
	2. A plan for on-going training on isolation precautions, aseptic practices, and prevention of blood and body fluid exposure; and	The on-going training plan should include review of basic infection control policies and procedures such as handwashing, isolation techniques, and employee health issues. Best practice would be to focus also on emerging infection control issues and advances in infection control techniques.
	3. Provision for specially designed training programs that result from outcome and process surveillance data.	Specific educational programs should be developed to address needs identified in the infection control program.
1608	(h) The hospital shall designate which departments are responsible for the reporting of communicable diseases as required by law.	O.C.G.A. 31-12-2 requires that healthcare providers notify the Georgia Division of Public Health of outbreaks or detection of certain communicable diseases, as specified by the Department. The list of diseases or conditions requiring notification are available from the Georgia Notifiable Disease Unit, Division of Public Health (404) 657-2588 (or from the county health department). Information about notifiable diseases and the notification process may also be accessed through their website at http://health.state.ga.us. The hospital may choose which department(s) (e.g. laboratory, infection control) are responsible for such reporting. Departments include services and/or designated positions.

1609	(i) The infection control program shall be evaluated at least annually to determine the effectiveness of the program at lowering the risks and improving the trends of nosocomial infections in patients, health care workers, and volunteers. Changes in the infection control program shall reflect consideration of the results of the evaluations. Authority O.C.G.A. Sec. 31-7-2.1.	The evaluation should conclude with recommendations for any changes in the program such as the surveillance plan or activities that are aimed at reducing the overall rate and risks of infections.
1700	**290-9-7-.17 Sterile Processing Services.** Each hospital shall designate a sterile processing service area designed for the decontamination, cleaning, and sterilizing of reusable equipment, instruments, and supplies.	The functional design and work flow patterns must provide for the separation of soiled and contaminated items from those that are clean and sterile.
1701	(a) With the collaboration of the infection control program, the staff providing sterile processing services shall develop and implement standardized policies and procedures that conform to generally accepted standards of practice for:	Policies and procedures should be based on specified standards of practice, such as those from the Association of Operating Room Nurses (AORN), the Association for Advancement of Medical Instrumentation (AAMI), the Association for Professionals in Infection Control (APIC), or the Centers for Disease Control (CDC), American Society for Gastrointestinal Endoscopy (ASGE), Society of Gastrointestinal Nurses and Associates (SANA), or American Society for Hospital Central Service Professionals (ASHCSP), and the American College of Surgeons.
	1. Decontamination and cleaning of instruments and other items and description of reprocessing protocols for contaminated patient equipment;	Procedures should address the special attention needed for the cleaning of items prior to disinfection, especially endoscopes.
	2. Disinfecting and/or sterilizing equipment and other items;	If disinfection and sterilization are performed at more than one site in the hospital, the procedures to be used must be standardized throughout the hospital.
	3. Monitoring of the systems used for sterilization;	The monitoring must include mechanical, chemical, and
		biological methods of monitoring the function of the sterilization equipment. A biological indicator should be run with each implantable item.
	4. Procedures for ensuring the sterility of packaged instruments and supplies;	The system for assuring sterility may include the use of expiration dates or packaging in a manner that the

1701 cont		contents remain sterile unless the packaging is damaged or broken. The labeling of the supplies or instruments must clearly indicate the system that applies to each item. There must be evidence that there is an effective system for the checking and rotation of sterile supplies and the removal of outdated or damaged supplies.
	5. Recall of items; and	There must be a system to track, locate, and retrieve sterilized items from within the hospital, when necessary. For example, if there is a result of a positive biological indicator for a group of items, there must be a way the facility can locate all of the affected supplies and instruments.
	6. Mechanisms for protection of workers from exposure to blood and other potentially infectious materials and environmental hazards.	
1702	(b) The sterile processing service shall be staffed by qualified personnel. Authority O.C.G.A. Sec. 31-7-2.1.	Qualifications should include training and experience in the processing of sterile equipment and supplies. Best practices would be having persons certified by the National Institute for the Certification of Healthcare Sterile Processing and Distribution Personnel (NICHSPDP) or the American Society for Hospital Central Service Professionals (ASHCSP). At a minimum, competency testing should show that sterile processing staff complies with recognized standards of practice.
1800	**290-9-7-.18 Medical Records.** (1) **Management of Patients' Medical Records.** The hospital shall have an effective and organized medical records service that establishes the policies and procedures for the maintenance of the medical records for all patients and that is administratively responsible for the management of those records.	The medical records service staff should be knowledgeable of the maintenance of patients' medical records in all areas of the hospital and able to identify and retrieve medical records in a timely fashion. Medical records in service locations away from the main hospital site must also be maintained according to the policies and procedures established by the hospital's medical records service.
1801	(a) The medical records service shall maintain a list of accepted abbreviations, symbols, and medical terminology to be utilized by persons making entries into patients' medical records.	A list of the accepted abbreviations, symbols, and medical terminology should be available from the medical record service and in the various clinical areas of the hospital.

1802	(b) The medical records service shall utilize systems to verify the author(s) of entries in the patients' medical records. Delegation of use of computer codes, signature stamps, or other authentication systems, to persons other than the author of the entry, is prohibited.	The medical records service must be aware of and monitor use of computer codes, electronic signatures, signature stamps, and other systems used to authenticate entries in the records. Use of systems other than original signatures must be closely controlled. Systems for keeping these lists may vary from facility to facility. Some hospitals may departmentalize the responsibility for keeping lists of signatures or other authentication systems.
1803	(c) The hospital shall utilize systems defined by hospital policies and procedures to ensure that patients' medical records are kept confidential**.** Medical records shall be accessible only to hospital and medical staff involved in treating the patient and to other individuals as permitted by federal and state laws. The Department, in exercising its licensing authority, shall have the right to review and copy any patient's medical records.	The steps taken to ensure confidentiality of records are usually outlined by policies and procedures. Patients' medical records must not be left available to unauthorized eyes in patient treatment or reception areas. Patient information must not be accessible to unauthorized persons via computer screens. O.C.G.A 31-2-6(h) provides for access to patient records by the licensing authority. There is additional reference to this authority in Chapter 290-1-6-.06 of the Administrative Rules.
1804	(d) At any time during or after their course of treatment, patients shall be provided with copies of their medical records upon their written requests or the written requests of their authorized representatives in accordance with state law. Copies shall be provided within a reasonable time period not to exceed thirty (30) days after the request, unless the patient agrees to a lengthier delivery time. Copies of records shall be provided to patients for a reasonable fee in accordance with applicable laws.	If a patient requests a copy of a record which will not be complete within the 30 day limit, the hospital may explain to the patient the fact that the record is not complete, provide a date for completion, and offer the patient the choice of waiting for the copy until the completion date or copying the record that currently exists.
1805	(e) Copies of the patient's medical records shall be released to persons other than the patient or the patient's legally authorized representative either at the written request of the patient or as otherwise allowed by law. If the individual designated to receive the copy of the record is a health care provider, the copy of the record shall be released by the hospital in a timely manner so as not to interfere with the continuation of the patient's treatment.	There must be a documentation system, including any required consent procedures, for release of any information from a medical record to an outside entity. If parts of a medical record that cannot be duplicated are released, such as mammography films, there should be some documentation system to verify to whom the release was made and when.
1806	(f) Patients' medical records shall be coded and indexed in a manner that allows for timely retrieval by diagnosis or procedure when necessary.	There must be a system in place to retrieve records by diagnosis or procedure as needed for quality management activities, research, or other reasons.

1807	(g) The hospital shall utilize an effective process to ensure that patients' medical records are completed within thirty (30) days after the patients are discharged from the hospital. Reports of other parts of patients' records that are not within the control of the hospital or its medical staff shall be added to the patients' records as soon as they become available to the hospital.	Policies, procedures, and medical staff bylaws must specify how the hospital enforces the completion deadlines for the records. "Completed" means all applicable reports and data must be in the record, and all entries signed / authenticated. The medical records service must have a procedure to identify records that are not completed 30 days after the patient's discharge. Scope and severity will be considered in determining compliance with this requirement
1808	(h) The hospital shall retain all patients' medical records at least until the fifth anniversary of the patients' discharges. If the patient is a minor, the records must be retained for at least five (5) years past the age of majority. Records may be preserved in the hospital's format of choice, including but not limited to paper or electronic format, so long as the records are readable and capable of being reproduced in paper format upon request.	Records can be preserved in the format of choice: paper, electronic, etc. All data pertaining to a patient's diagnosis or treatment must be retained, including x-rays, films, monitoring data, etc. The age of majority in Georgia is eighteen (18) years.
1809	(i) Medical records shall be secured in such a manner as to provide protection from damage or unauthorized access.	Security of records against illegal access or loss may be an issue particularly during transport of records from one location in the hospital to another. There must be procedures that ensure the safe transport and accountability for the record's whereabouts. Security from loss during storage to fire or other damage, including electronic loss, should also be addressed. This rule applies to all parts of the patient's medical record, regardless of storage location.
1810	(2) **Entries in the Medical Record.** All entries in the patient's medical record shall be accurate and legible and shall contain sufficient information to support the diagnosis and to describe the treatment provided and the patient's progress and response to medications and treatments. Inpatient records shall also contain sufficient information to justify admission and continued hospitalization.	The facility should have policies and procedures that outline: requirements for legibility, accuracy, and completion, the mandatory sequence of documents in the record, the approved forms for the record, and the designated responsibility for monitoring the records for clinical pertinence. Practice must reflect the approved procedures. The content of entries must be legible. Legibility includes having printed or copied material sufficiently contrasted to be readable. Providers must be able to demonstrate that they can read the entries in the record.

1811	(a) The date of the entry, and the signature of the person making the entry, shall accompany all entries in the patient's medical record. Late entries shall be labeled as late entries.	The medical record should represent a chronological history of the treatment the patient received, the patient's response to treatment and the persons providing the treatment. The chronology of events may be particularly important in terms of monitoring the effects of treatment. "Signature" may be represented by initials, as long as there is a translation on-site to assist in identifying the initials.
1812	(b) The hospital, through its medical staff policies, shall appropriately limit the use of verbal/telephone orders. Verbal/telephone orders shall be used only in situations where immediate written or electronic communication is not feasible and the patient's condition is determined to warrant immediate action for the benefit of the patient. Verbal/telephone orders shall be received by an appropriately licensed or otherwise qualified individual as determined by the medical staff in accordance with state law.	The medical staff bylaws and/or rules and regulations must specify (by position or credential) which licensed and certified health care professionals may take and enter verbal orders in a medical record, if the hospital wishes to allow verbal and telephone orders. Hospital policies and procedures must also reflect the required time limits for authentication of these orders. It should be recognized by the hospital that some medications may not be appropriate for such orders. Best practice would be for the hospital to investigate a method to reduce the frequency of verbal orders as a quality management initiative.
1813	(c) The individual receiving the verbal/telephone order shall immediately enter the order into the medical record, sign and date the order, with the time noted, and, where applicable, enter the dose to be administered.	
1814	(d) The individual receiving the order shall immediately repeat the order and the prescribing physician or other authorized practitioner shall verify that the repeated order is correct. The individual receiving the order shall document, in the patient's medical record, that the order was "repeated and verified."	
1815	(e) The verbal/telephone order shall be authenticated by the physician or other authorized practitioner giving the order, or by a physician or other authorized practitioner taking responsibility for the order, in accordance with hospital and medical staff policies.	
1816	1. Where the procedures outlined in subparagraph (2)(d) of this rule are followed, the hospital shall require authentication of all verbal/telephone orders no later than thirty (30) days after the patient's discharge.	
1817	2. As an alternative to meeting the requirements set forth in subparagraph (2)(d) of this rule, the hospital shall require that verbal/telephone orders be authenticated within forty-eight (48) hours, except where the patient is discharged within forty-eight (48) hours of the	

1817 contd	time the verbal/telephone order was given, in which case authentication shall occur within thirty (30) days after the patient's discharge.	
1818	(f) The hospital's quality improvement plan shall include monitoring of the appropriate use of verbal/telephone orders in accordance with these rules and hospital policy and taking appropriate corrective action as necessary.	
1819	(3) **Minimum Requirements for Patients' Medical Records.** Upon completion, medical records for inpatients and outpatients shall contain, at minimum, the documents as specified below. Records for patients at the hospital for other specialized services, such as emergency services or surgical procedures, shall contain such additional documentation as required for those services.	
1820	(a) **Inpatient Records.** Medical records for inpatients shall contain at least the following:	
	1. A unique identifying number and a patient identification form, which includes the following when available: name, address, date of birth, sex, and person to be notified in an emergency;	This information should be organized in one location of the record. The form can be an electronic form.
	2. The date and time of the patient's admission;	
	3. The admitting diagnosis and clinical symptoms;	
	4. The name of the attending physician;	
	5. Any patient allergies;	
	6. Documentation regarding advance directives;	
	7. The report from the history and physical examination;	This is the history and physical form described in 290-9-7-.19(a)1. If the hospital is accepting a history and physical examination report from an examination completed prior to admission, it must be accompanied by an update completed upon admission, even if there has been no change in the patient's condition.

1820 cont	8. The report of the nursing assessment performed after admission;	This refers to the nursing assessment described in 290-9-7-.19(a)2.
	9. Laboratory, radiological, electrocardiogram, and other diagnostic assessment data or reports as indicated;	
	10. Reports from any consultations;	
	11. The patient's plan of care;	
	12. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders;	
	13. Progress notes from staff members involved in the patient's care, which describe the patient's response to medications, treatment, procedures, anesthesia, and surgeries;	
	14. Data, or summary data where appropriate, from routine or special monitoring;	Routine monitoring data may include vital signs, positioning and re-positioning, dietary and fluid intake and output. Special monitoring data may include telemetry readouts, restraint records, or post-surgical procedures.
	15. Medication, anesthesia, surgical, and treatment records;	
	16. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law;	The state law governing some informed consents is O.C.G.A. 31-9-6.1. **See also Ketchup v. Howard, Georgia Court of Appeals November 29, 2000.** There are samples of minimally acceptable forms included as appendices to the Rules of the Composite Board of Medical Examiners (360-14).
	17. Date and time of discharge;	
	18. Description of condition, final diagnosis, and disposition on discharge or transfer;	Description of disposition would include any recommendations for follow-up care.

1820 cont	19. Discharge summary with a summary of the hospitalization and results of treatment; and	
	20. If applicable, the report of autopsy results.	
1821	(b) **Outpatient Records.** Medical records for outpatients shall contain at least the following:	
	1. A unique identifying number and a patient identification form, which includes the following if available: name, address, date of birth, sex, and person to be notified in an emergency;	
	2. Diagnosis of the patient's condition;	
	3. The name of the physician ordering treatment or procedures;	
	4. Patient allergies;	
	5. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders as applicable;	
	6. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law;	See description of requirements for consent forms detailed under "Inpatient records" above.
	7. Reports from any diagnostic testing; and	
	8. Sufficient information to justify any treatment or procedure provided, reports of outcomes of treatment or procedures, and, as appropriate, progress notes and the disposition of the patient after treatment. Authority O.C.G.A. Sec. 31-7-2.1.	"Appropriate" means appropriate to the patient's course of treatment or length of stay. For example, if a patient came into the hospital just for a x-ray, progress notes and disposition statements would not be required. However, outpatient surgery, continuing rehab services, cardiac catheterizations, or other more lengthy and involved outpatient procedures would require those elements in the record.

1900	**290-9-7-.19 Patient Assessment and Treatment.** All patient care services provided by the hospital shall be under the direction of a member of the medical staff or a licensed physician, dentist, osteopath, or podiatrist who has been granted hospital privileges.	
1901	(a) **Patient Assessment/Screening on Admission**. The hospital shall provide each inpatient with an appropriate assessment of the patient's condition and needs at the time of admission. Such assessments shall be provided by personnel authorized by hospital policy or the medical staff bylaws and/or rules and regulations and shall be designed to trigger referral for further assessment needs.	The hospital may designate through policies, procedures, and bylaws, and/or rules and regulations, which healthcare professionals would be authorized to conduct an initial assessment of patients. Best practice: hospital identifies triggers requiring further assessment.
1902	1. A history and physical examination shall be completed within the first twenty-four (24) hours after admission. A history and physical examination completed by either the patient's physician or the appropriate practitioner operating under the direction of the physician as authorized by law no more than thirty (30) days prior to the admission may be accepted but must be updated to reflect the patient's condition at the time of admission. Where the patient is admitted solely for oromaxillofacial surgery, such history and physical may be completed by the oromaxillofacial surgeon.	
1903	2. A basic nursing assessment to include at least evaluation of physical and psychological status sufficient to develop an initial plan of care shall be completed within the first twelve (12) hours after admission. Within twenty-four (24) hours after admission, a comprehensive nursing assessment will be completed to include at least: (i) Screening and referral for further assessment of patient needs related to social, nutritional, and functional status; and (ii) Screening of educational and potential post-hospitalization needs.	A basic nursing assessment shall be sufficient enough to develop an appropriate initial plan of care that can later be supplemented or changed, as necessary, as additional information is acquired. The specifics of the nursing assessment at the time of patient admission should be outlined in the policies and procedures of the hospital.
1904	3. Inquiry as to the status of any advance directives for the patient shall be made at the time of admission.	Often patients have signed advance directives at home or in a safety deposit box, and a relative must retrieve the document after the patient has been admitted. The hospital should establish time limits for follow-up on the retrieval and content of the authorized advance directive. If the patient does not wish to invoke the advance directive, then the hospital does not have to do a recheck.

1905	(i) If a patient has an advance directive in place that the patient wishes to invoke, but the written directive is not available at the time of admission, there shall be a mechanism in place to trigger a recheck by hospital personnel for the document within a reasonable period of time.	
1906	(ii) If the patient does not have an advance directive in place, admissions procedures shall require that designated hospital personnel will offer information regarding advance directives according to hospital policy and timelines.	The hospital may designate which personnel are to provide the education about advance directives. The hospital may offer this information by providing a pamphlet on advance directive rights to the patients.
1907	(b) **Patient's Plan of Care.** 1. On admission, the plan of care shall be initiated by the designated hospital staff for each patient to meet the needs identified by the initial assessments. The initial plan of care shall be placed in the patient's record within twelve (12) hours of admission.	If the hospital uses "standards of care", "care maps", or "clinical pathways" instead of an individualized plans of care, the standards of care, care maps or clinical pathways must be appropriate for the patient.
1908	2. As the patient's treatment progresses, the plan of care shall be updated to reflect any changes necessary to address new or changing needs.	
1909	(c) **Reassessments of the Patient's Condition.** Reassessment of the patient's condition shall be performed periodically at appropriate intervals and defined in hospital policy. In addition, reassessments shall occur at least as follows:	
	1. During and following any invasive procedure;	For example, during endoscopy or spinal puncture.
	2. Following a change in the patient's condition or level of care;	For example, on conversion from a regular inpatient bed to a critical care bed, movement from the delivery area or room to a post-partum unit, or movement from surgery to a post-anesthesia unit and then to a surgical floor.
	3. During and following the administration of blood and blood products;	
	4. Following any adverse drug reaction or allergic reaction; and	
	5. During and following any use of physical restraints or seclusion.	

1910	(d) **Other Treatment Requirements.** 1. All patients shall be given the opportunity to participate, or have a designated representative participate, in decisions regarding their care.	
1911	2. Patients shall be provided treatment free from physical restraints or involuntary seclusion, unless utilized solely for protection during brief transport to a specified destination or authorized by a physician's order, for a limited period of time, to protect the patient or others from injury. Policies and procedures shall be in place to require that a patient's physical comfort and safety needs are addressed during any period of required physical restraint or confinement. A positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize during medical, dental, diagnostic, or surgical procedures is not considered a restraint.	Any use of restraint or seclusion should have adequate documentation of medical necessity in the patient's record. Restraint or restriction of movement by law enforcement personnel, such as use of handcuffs or guarding a door to prevent flight, as long as those methods were applied and monitored by the law enforcement personnel to persons in their custody, would not be considered a component of health or hospital care according to these rules.
1912	3. Patients shall receive care in a manner free from all forms of abuse or neglect.	"Abuse" or "neglect" means here any unjustifiable intentional or grossly negligent act, exploitation or series of acts, or omission of acts, which causes injury to a patient, and would include, for example, verbal abuse, assault, battery, failure to provide care or sexual harassment. For example, a patient is admitted to the hospital with pneumonia and severe bed sores. The hospital would be expected to treat the patient for both pneumonia and severe bedsores.
1913	4. Patients shall receive treatment in an environment that respects their personal privacy, both of their physical person and their treatment information.	Curtains or privacy screens are acceptable for issues of visual privacy. Observations of practice should show that privacy is respected, including adjusting voice volume when discussing the patient, or asking others to leave the room.
1914	5. The hospital shall establish and enforce policies and procedures that require that all personnel providing direct care to the patient identify themselves to the patient by name and title or function. Authority O.C.G.A. Sec.31-7-2.1.	The method of staff identification is at the hospital's discretion - name tags, required introductions, etc. Currently, in Georgia, RNs, LPNs, and Physician's Assistants are required to wear nametags, which also identify their titles, when engaging in patient care. EMTs are also required to wear identification which indicates their level of certification.

2000	**290-9-7-.20 Discharge Planning and Transfers for Inpatients.** The hospital shall utilize an effective and on-going discharge planning process that identifies post-hospital needs of inpatients and arranges for appropriate resource referral and follow-up care.	An effective discharge planning process should explore whether the patient will be able to provide self-care, could return to the pre-hospital environment (with the same level of support as previous) or may need other services and should document the patient's refusal of discharge services, if applicable.
2001	(a) On admission, the nursing assessment shall identify patients who are likely to suffer adverse consequences upon discharge in the absence of adequate discharge planning.	The screening for the possible need for a discharge plan must begin on admission. There must be a mechanism to ensure that those patients identified from the screening are provided with a discharge planning evaluation.
2002	(b) For those patients identified as needing a discharge plan, designated qualified staff shall complete an evaluation of post-hospital needs and shall develop a plan for meeting those needs. The discharge plan shall be revised as needed with changes in the patient's condition.	
2003	(c) The hospital shall provide education to patients, and their family members or interested persons as necessary or as requested by the patient, to prepare them for the patient's post-hospital care.	Education regarding post-hospital care must take place even if there is no formal discharge plan. This would be considered a normal part of preparation for discharge.
2004	(d) The hospital shall arrange for the initial implementation of any discharge plan, including, as applicable, any transfer or referral of the patient to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care. The hospital shall be responsible for the transfer of any necessary medical information to other facilities for the purpose of post-hospital care.	Patients must be accompanied by necessary medical information at the time of transfer. Patients referred to other facilities must be provided with the necessary medical information to take with them, or there must be transfer of necessary information to the facility in time for the provision of patient care.
2005	(e) The hospital shall regularly reassess the discharge planning process to ensure that it is responsive to patients' discharge needs.	The evaluation of this process should be included as a part of the hospital quality management program.
2006	(f) The hospital shall adopt and enforce a policy requiring annually during influenza season (inclusive of at least October 1st through March 1st) and prior to discharge, any patient 65 years of age or older shall be offered vaccinations for the influenza virus and pneumococcal disease unless contraindicated and contingent on availability.	
2007	1. The hospital policy may authorize such vaccinations to be administered per hospital medical staff approved standing order and protocol following an assessment for	

2007 contd	contraindications.	
2008	2. The hospital policy must also require the inpatient's medical record, where such vaccination is administered, to contain an assessment for contraindications, the date of such administration and patient response. Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Discharge Planning and Transfers for Inpatients" adopted. F. Nov. 22, 2002; eff. Dec. 12, 2002.	
2100	**290-9-7-.21 Nursing Services.** The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing care to meet the needs of the patients. Critical access hospitals are exempt from providing on-site twenty-four (24) hour nursing care when there are no hospitalized patients.	Nurses in CAH may be available via an on-call system.
2101	(a) **Organization of Nursing Services.** The hospital's nursing services shall be directed by a licensed registered nurse who shall be responsible for implementing a system for supervision and evaluation of nursing clinical activities.	
2102	1. The chief nurse executive shall establish and implement policies and procedures for nursing services based on generally accepted standards of practice including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program.	Policies and procedures should be kept current with generally accepted standards of practice to the extent that they meet the needs for patient safety and positive treatment outcomes. Standards of practice would be those, for example, published by the American Nurses Association. There may be special standards of practice for certain specialty areas.
2103	2. The chief nurse executive shall be responsible for ensuring that nursing personnel are oriented to nursing policies and procedures.	There must be documentation of orientation for each nursing staff member.
2104	3. Nursing services shall have and follow a written plan for organization, administrative authority, delineation of responsibilities for patient care, and staff qualifications and competencies.	Nursing services must be an organized service on the hospital's organizational chart. Staffing patterns must reflect 24-hour coverage. The nursing plan for the hospital must show lines of accountability for patient care.
2105	(i) The nursing service plan shall include the types and numbers of nursing personnel necessary to provide appropriate nursing care for each patient in the hospital.	Staffing plans must reflect the scope and complexity of patients and services, including specialty services.
2106	(ii) Specialty areas shall specify nursing requirements for their areas that also define any special nursing competency requirements, staffing patterns based on patient acuity, and the	Specialty areas would include critical care units, surgery, post-anesthesia care units, obstetrics, newborn nurseries,

2106 contd	required ratio of nurses to technical staff.	or any other area providing a specific type of care. Specialty areas usually will require more intense staffing ratios than areas of general clinical care., and may require that nurses have special training or qualifications
2107	(iii) A system of patient assignment shall be defined which reflects a consideration of patient needs and nursing staff qualifications and competencies.	The hospital must be able to describe a system of assignment which takes these factors into consideration. Actual assignments should reflect the implementation of this system.
2108	(b) **Delivery of Nursing Services**. Nursing services must be delivered in accordance with patients' needs and generally accepted standards of practice.	
2109	1. A licensed registered nurse must be on duty at all times to provide or supervise the provision of care. Critical access hospitals are permitted some flexibility in meeting this requirement as set forth in Rule 290-9-7-.38.	All patients should have access to a RN, either directly or through supervision of caregivers.
2110	2. Within the first twelve (12) hours after admission, a basic nursing assessment shall be completed for each patient and a plan of care initiated.	
2111	3. The patient's condition shall be monitored by nursing staff on a schedule appropriate to the patient's needs.	Monitoring frequency may differ for different patients.
2112	4. Nursing staff shall be responsible for updating the patient's plan of care based on any changes in the patient's condition.	
2113	5. Nursing staff administering drugs and biologicals shall act in accordance with the orders from the medical staff responsible for the patient's care, generally accepted standards of practice, and any federal and state laws pertaining to medication administration.	Orders for the administration of drugs, biologicals and intravenous medications shall be followed as written. If there is a conflict between the ordered drug (or method/schedule of administration) and generally accepted standards of practice or federal or state laws, this should be addressed with the ordering practitioner prior to administration, and a new order written if necessary.
2114	6. Nursing staff shall report medication administration errors and adverse drug reactions in accordance with established hospital policies.	

2115	7. Blood transfusions and other blood products shall be administered by licensed nursing staff or other qualified practitioners as authorized by law in accordance with established hospital policies, which shall include, at a minimum, the following:	
	(i) Obtaining and documenting appropriate patient consent to treatment and procedures, as required;	
	(ii) Responding to and reporting of transfusion reactions;	
	(iii) Monitoring patients appropriately; and	
	(iv) Designating personnel qualified to perform these procedures. Authority O.C.G.A. Sec. 31-7-2.1.	
2200	**290-9-7-.22 Pharmaceutical Services.** The hospital shall provide or have access to effective pharmaceutical services to meet the needs of its patients in accordance with generally accepted standards of practice and applicable laws and regulations.	Management of pharmaceuticals must comply with provisions of the Rules and Regulations of the Georgia Board of Pharmacy, Chapter 480-13, Hospitals; the Georgia Controlled Substances Act (OCGA Title 16, Chapter 13), and the federal Controlled Substances Act (CSA) 21 USC Chapter 13.
2201	(a) **Pharmacy Director.** All pharmaceutical services in the hospital shall be under the direction of a pharmacist licensed in Georgia. The responsibilities of the director of pharmaceutical services shall include:	Depending on their ability to fulfill the responsibilities, the director of the pharmacy services may be employed by the hospital on a part-time or full-time basis.
2202	The responsibilities of the director of pharmaceutical services shall include: 1. Developing, supervising, and coordinating all activities of the pharmaceutical service to be in compliance with state rules and regulations for hospital pharmacies including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program; and	The Georgia Board of Pharmacy has rules and regulations for pharmacies in hospitals (Chapter 480-13). The rules here are not intended to be in conflict with, nor are they as comprehensive as, those rules.
2203	2. Developing and implementing an effective system that does the following: (i) Minimizes drug errors and identifies potential drug interactions and adverse drug reactions;	
2204	(ii) Controls the availability and storage of drugs throughout the hospital;	If the hospital offers services at multiple sites or in

2204 contd		multiple buildings, the distribution, management, and storage of pharmaceuticals must be consistent with the procedures used in the main hospital, including the management of pharmaceuticals in crash carts.
2205	(iii) Distributes and administers the drugs in compliance with generally accepted standards of practice;	An example of current generally accepted standards of practice would be published protocols and standards from the American Society of Hospital Pharmacists.
2206	(iv) Tracks the receipt and disposition of all scheduled drugs;	These systems should be based on DEA requirements, specifically the requirements of the Georgia Controlled Substances Act and the federal Controlled Substances Act (CSA), 21 USC Chapter 13.
2207	(v) Staffs pharmaceutical services to provide sufficient qualified personnel to respond to the pharmaceutical needs of the patient population being served, including twenty-four (24) hours per day, seven (7) days per week emergency coverage;	The Director is responsible for establishing and verifying the qualifications of all pharmacy staff in accordance with the requirements of Chapter 480-13.
2208	(vi) Labels and dispenses drugs, including a requirement that only licensed pharmacists or properly supervised licensed pharmacy interns are permitted to compound, label, and dispense drugs or biologicals;	Per OCGA Sec. 16-4-77 pharmacy interns may perform these duties if supervised by a licensed pharmacist. The requirements for labeling should reflect the requirements in the Pharmacy Regulations for Hospitals, Chapter 480-13. The system must be applicable to all areas of the hospital.
2209	(vii) Manages drug recalls;	
2210	(viii) Addresses the removal of drugs when a pharmacist is not available;	Specifics should be in compliance with rules chapter 480-13, providing for access by an individual designated in the policy and medical staff bylaws and/or rules and regulations.
2211	(ix) Compiles and reports data related to drug ordering, dispensing and administration errors, and possible adverse drug reaction to the hospital's quality management program; and	

2212	(x) Reviews all activities and functions of the hospital's pharmaceutical services.	Inspection of all functions is required by Rules and Regulations for Hospital Pharmacies, Chapter 480-13-.10.
2213	(b) **Management of Drugs.** The pharmacist shall be responsible for the management of drugs within the hospital.	
2214	1. The hospital's pharmaceutical services shall access, compile, and make available to medical and professional staff information relating to drug or food interactions, drug therapy, side effects, toxicology, dosage indicators, and routes of administration.	Best practice would be to have this information available for practitioners in each treatment area, and to include the information on the Medication Administration Record.
2215	2. Loss and theft of controlled substances shall be reported to the pharmacy director, to the hospital administration, and to others as required by applicable laws and regulations.	Current Georgia law requires that loss or theft of controlled substances be reported to the Georgia Drugs and Narcotics Agency and to the federal Drug Enforcement Agency on DEA Form 106.
2216	3. All drugs and pharmaceuticals shall be stored in an area or on a cart which shall be locked when unattended to prevent access by unauthorized individuals.	Storage areas shall be locked at all times when not attended by authorized personnel.
2217	4. Outdated, mislabeled, or otherwise unusable drugs and pharmaceuticals shall not be available for patient use.	
2218	5. Certain drugs and pharmaceuticals not specifically prescribed as to limitation of time or number of doses shall be automatically discontinued after a specified time pursuant to guidelines developed by the medical staff in conjunction with the pharmacy director.	Pharmacy services must identify the specific drugs and pharmaceuticals that will be automatically discontinued at designated times where the order for the medication does not specify the duration of the order or the number of doses of the medication to be administered.
2219	6. Drug administration errors, adverse drug reactions, and drug incompatibilities shall be immediately reported in a timely manner to the attending physician and the pharmacist.	It is the pharmacy director's responsibility to see that this information is compiled and reported also to the hospital's quality management program.
2220	7. Drugs brought into the hospital by a patient may be administered to the patient only if the medications can be accurately identified, properly stored and secured, and ordered by the attending physician for the patient's hospitalization. If the drugs cannot be administered to the patient, the drugs shall be returned to an adult member of the patient's immediate family or returned to the patient upon discharge unless otherwise prohibited by law. Authority O.C.G.A. Secs. 16-4-77, 16-13-20, et seq., and 31-7-2.1.	Patients may not bring their own drugs or medications into the hospital for their use unless these requirements can be met. This includes medications the patient regularly takes for conditions unrelated to the reason for hospitalization.

2300	**290-9-7-.23 Food and Dietary Services.** The hospital shall have an organized food and dietary service that is directed and staffed by an adequate number of qualified personnel to meet the nutritional needs of hospital patients. All hospital food service areas and operations shall comply with current federal and state laws and rules concerning food service.	Hospital food service areas include cafeterias, snack bars, and all areas where food is prepared, stored, or served by the hospital.
2301	(a) **Organization of Food and Dietary Services.** 1. **Food Service Manager.** The hospital shall have a manager of food and dietary services who has training and experience in management of a food service system in a health care setting and receives on-going training. The responsibilities of the manager shall include:	
2302	(i) Overall coordination and integration of the therapeutic and administrative aspects of the service;	
2303	(ii) Development and implementation of policies and procedures concerning the scope and conduct of dietary services, including food preparation and delivery systems;	"Best practice" would be to adopt monitoring procedures from the HACCP (Hazardous Analysis Critical Control Points) Manual developed by Food Service Associates or Safe Serve Certification.
2304	(iii) Orientation and training programs for dietary service personnel and other hospital personnel involved in food delivery on all applicable dietary services policies and procedures, including personal hygiene, safety, infection control requirements, and proper methods of waste disposal;	
2305	(iv) The implementation of a system to ensure that prescribed diets are delivered to the correct inpatients;	
2306	(v) Maintenance of a staff of sufficient numbers of administrative and technical personnel competent in their assigned duties to carry out the dietary service program;	
2307	(vi) Procurement of food, paper, chemical, and other supplies sufficient to meet the anticipated food service needs of the hospital; and	
2308	(vii) Implementation of procedures to rotate all food items to ensure use in a timely manner.	There should be a system to rotate foods for use in a first-in, first-out method.

2309	2. **Dietitian.** Clinical supervision of the hospital's dietary service shall be provided by a dietitian on a full-time, part-time, or consultant basis, as determined by the needs of the hospital**.** If supervision by the dietitian is provided by a contractual arrangement or on a consultation basis, such services shall occur at least once per month for not less than eight hours. The dietitian shall be responsible for:	
2310	(i) Evaluation of inpatients' nutritional status and needs. If the admission screening identifies that an inpatient may be nutritionally at risk, the follow-up evaluation by the dietitian must be performed within twenty-four (24) hours of determination of the need for evaluation of the patient;	The admissions screenings of nutritional status or needs is performed by a nurse within 24 hours of admission. If the patient is found to be nutritionally at-risk, the follow-up evaluation must be performed by a dietitian.
2311	(ii) Review and approval of all menus, including menus for therapeutic or prescribed diets;	
2312	(iii) Participation in the development, revision, and review of policies and procedures for dietary services;	
2313	(iv) Guidance to the manager of dietary services and to the staff of the service on methods for maintaining nutritionally balanced meals that meet the needs of each patient and in maintaining sanitary dietary practices; and	There must be evidence of an active liaison with the manager of dietary services to coordinate the therapeutic aspects of the food service.
2314	(v) Appropriate documentation in the inpatients' medical records of any evaluation of nutritional status or needs.	Dietitians, dietary technicians or food service managers or nursing staff may be the persons designated by the hospital to provide monitoring of the patient's response to diet or nutritional status during hospitalization.
2315	(b) **Physical Environment Requirements for Food Service Areas.** The hospital shall provide adequate space, equipment, and supplies for efficient, safe, and sanitary receiving, storage, refrigeration, preparation, and service of food. The physical environments for food service activities must meet the requirements of state regulations for food service.	The state regulations for food handling, storage, and preparation are contained in Chapter 290-5-14. Public health regulations for Georgia currently require that all walls, ceilings, and floors be covered with or constructed of smooth, non-absorbent materials that can be cleaned
2316	(c) **Delivery of Dietary Services.** Dietary services shall be delivered in accordance with the nutritional needs of the hospital's patients.	
2317	1. There shall be a mechanism in place for the evaluation of nutritional needs for inpatients identified during admission as needing further assessment. The mechanism shall require that such evaluations be completed promptly, with modifications to patients' diets, if any,	Due to the brief length of hospital stays, and because dietary needs must be met immediately following admission, it is essential that the nutritional evaluations be

2317 contd	recorded in the patients' medical records within twenty-four (24) hours of notification of the need for the evaluation.	completed promptly for patients identified as having or at-risk for special nutritional needs.
2318	2. A current therapeutic diet manual, approved by the dietitian and medical staff, shall be readily available to all medical, nursing, and dietary service personnel.	The hospital's diet manual should reflect current standards for nutrition management, such as those published by the ADA (American Dietetics Association) or the current edition of the diet manual published by the Georgia Dietetic Association (GDA).
2319	3. Therapeutic diets shall be prescribed by the member of the medical staff responsible for the care of the inpatient.	
2320	4. A written order for the modified diet prescription as recorded in the inpatient's medical record shall be readily available to dietary service personnel throughout the duration of the order.	
2321	5. When clinically indicated, the dietary staff shall provide education for inpatients regarding their diets and nutritional needs. This training shall be documented in the inpatients' medical records.	A training need would be indicated if the patient did not demonstrate knowledge of proper management of their nutritional needs, or on physician order.
2322	6. Unless medically contraindicated, at least three (3) meals a day shall be provided for inpatients, with no more than fifteen (15) hours elapsing between dinner and breakfast.	
2323	7. There shall be a system for providing meals for inpatients outside the normal meal service hours, when necessary.	For example, if a patient had a procedure requiring that he go NPO through the regular mealtime, and needed his meal afterward, or if someone was admitted after mealtime and hadn't eaten, there would need to be some way to access meals for them.
2324	8. A system for meal requisition shall be in place and shall require a notation regarding the inpatients' food allergies, if any.	
2325	9. Snacks shall be available between meals and at night, as appropriate to each inpatient's needs and medical condition.	

2326	10. The dietary service shall follow policies and procedures approved by the medical staff for the management of possible food and drug interactions.	
2327	11. Pertinent observations and information related to special diets, the inpatients' food habits, and response to dietetic treatment or diet modifications shall be recorded in the inpatients' medical records. Authority O.C.G.A. Sec. 31-7-2.1.	Pertinent observations would include weight information, food allergies, food intake, etc.
2400	**290-9-7-.24 Imaging and Therapeutic Radiology Services.** (1) **Imaging Services.** The hospital shall maintain or arrange for effective imaging services to meet the needs of patients. The radiological imaging services shall be provided by the hospital in accordance with the rules under Chapter 290-5-22 Rules and Regulations for X-rays, where applicable.	See ORS Web page for copy of rules http://ors.dhr.georgia.gov
2401	(a) **Organization and Staffing for Imaging Services**. The hospital shall have an organizational plan for imaging services that identifies the scope of the services provided and the qualifications of the individuals necessary for the performance of various aspects of imaging services and delineates the lines of authority and accountability.	
2402	1. There shall be a qualified director of imaging services who is a member of the medical staff and a licensed doctor of medicine or osteopathy with knowledge and experience in imaging services to supervise the provision of imaging services on a full-time or part-time basis.	
2403	2. The director shall be responsible for all clinical aspects of the organization and delivery of imaging services, including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program.	
2404	3. Basic radiological imaging services shall be available at all times, or there shall be an on-call procedure to provide access to qualified x-ray personnel within thirty (30) minutes.	Basic services are plain x-ray films.
2405	4. The hospital shall have qualified staff performing imaging services.	
2406	(b) **Orders of Imaging Procedures.** No imaging procedures shall be performed without an order or referral from a licensed doctor of medicine or osteopathy, chiropractor, dentist, podiatrist, physician assistant or nurse with advanced training where such order is in	

2406 contd	conformity with an approved job description or nurse protocol, and as authorized under state law for such licensed healthcare professionals.	
2407	1. Verbal/telephone orders for imaging services shall be given only to health care professionals licensed or certified by state law or authorized by medical staff rules and regulations and other hospital policy to receive those orders, in accordance with these rules, and shall be entered into the patient's medical record by those licensed, certified, or authorized health care professionals.	See guidelines under 290-9-7-.18 (2)(b).
2408	(2) **Reports of Imaging Interpretations.** Interpretation of imaging test results or procedures shall be made only by those medical staff designated as qualified to interpret those tests or procedures. Interpretations must be signed and dated by the medical staff providing the interpretation.	
2409	(a) Reports of all imaging interpretations and consultations shall be included in the patient's medical record.	
2410	(b) The hospital shall have an effective procedure for notifying in a timely manner the patient's physician and responsible nursing staff of critical interpretations identified through imaging tests.	
2411	(c) Films, scans, and other images shall be retained by the hospital for at least five years after the date of the procedure unless the release of the original images is required for the care of the patient. When original images are released, documentation of the disposition of the original images shall be retained for the applicable five-year period. If the patient is a minor, the records shall be retained for at least five years past the age of majority.	This is the same retention requirement as for other medical records. The age of majority in Georgia is 18 (eighteen) years. Storage of films, scans, and other images may be at off-site locations so long as the films, scans, and other images are retrievable.
2412	(3) **Therapeutic Radiology Services.** Radiation oncology services, if provided, must be directed by a physician with training and experience in therapeutic radiology. The service must have a medical oncologist and hematologist available for consultation.	
2413	(a) Therapeutic radiology procedures shall be ordered by a licensed doctor of medicine or osteopathy and administered by persons trained and qualified for those procedures and as required under current state law and regulations.	
2414	(b) Reports of all imaging interpretations, consultations, and therapies shall be included in the patient's medical record.	

2415	(c) Radiation Safety. If the hospital is providing diagnostic or therapeutic radiological services, hospital policies and procedures shall be implemented to ensure that patients and hospital staff are not exposed to unnecessary or unsafe levels of radiation. All imaging staff and therapeutic radiology staff shall be trained in these policies and procedures.	
2416	(d) Medical Emergencies. The hospital shall have written protocols for managing medical emergencies in the imaging area and therapeutic radiology area.	
2417	(e) Infectious Disease. The hospital shall have written protocols for managing patients with infectious diseases and critical care patients in the imaging area, or wherever imaging services are provided, and in the therapeutic radiology area. Authority O.C.G.A. Secs. 31-7-2.1 and 31-13-1, et seq.	
2500	**290-9-7-.25 Laboratory Services.** The hospital shall maintain or arrange for clinical laboratory services to meet the needs of hospital patients.	
2501	(a) **Organization and Staffing for Clinical Laboratory Services.** The administration, performance, and operation of all laboratories used by the hospital, as well as any laboratory functions performed by the hospital, shall conform to the Rules and Regulations for Licensure of Clinical Laboratories, Chapter 290-9-8.	
2502	1. The hospital shall have an organizational plan for laboratory services that identifies the scope of the services provided and the qualifications of the individuals necessary for the performance of various aspects of clinical laboratory services and delineates the lines of authority and accountability.	
2503	2. There shall be a qualified director of clinical laboratory services who is a member of the medical staff and meets the requirements for a director set forth in the Rules and Regulations for Clinical Laboratories, Chapter 290-9-8.	
2504	3. The director shall be responsible for the administration of clinical laboratory services, including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program.	
2505	(b) The hospital shall have emergency laboratory services available at all times.	The 24 hour availability may be arranged through callback systems.

2506	(c) The hospital shall provide for medical staff a written description of all laboratory services available.	
2507	(d) Reports of laboratory procedures and results shall be included in the patient's medical record.	
2508	(e) The hospital shall have an effective procedure for notifying in a timely manner the patient's physician and responsible nursing staff of critical values from laboratory tests.	Extremely low hemoglobins and hematocrits, abnormal prothrombin times, and electrolytes out of balance are examples of critical lab values which would be reported to the physician and/or the nursing staff responsible for the patient's care by whatever system the hospital established. There must be a mechanism to communicate this alert in a timely fashion even if the patient has been discharged. Best practice, would be for the hospital to send copies of all lab results that were received after the patient's discharge to the patient's attending physician.
2509	(f) The hospital shall require that the laboratory report any epidemiologically significant pathogens to the hospital's infection control program.	The lab should work with infection control personnel to establish a list of microorganisms they want to be alerted to. Examples of these may be Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Staphylococcus Aureus (VRSA) and Vancomycin Resistant Enterococcus (VRE).
2510	(g) **Tissue Pathology.** Hospitals which provide surgery services shall have or arrange for tissue pathology services through a licensed or certified clinical laboratory which has a system for:	
	1. Designation of those tissue specimens which require examination and for procedures for maintaining a tissue file; and	
	2. Directing pathology reports to the patient's medical record and for reporting unusual or abnormal results to the attending physician in a timely manner. Authority O.C.G.A. Chapter 31-22 and Sec. 31-7-2.1.	
2600	**290-9-7-. 26 Respiratory/Pulmonary Services.** The hospital shall provide or arrange for effective services to meet the respiratory/pulmonary needs of patients and shall define in writing the scope and complexity of the respiratory/pulmonary services offered by the	

2600 contd	facility.	
2601	(a) **Organization and Staffing for Respiratory/Pulmonary Services.** 1. The hospital shall have an organizational plan for respiratory/pulmonary services that clearly defines the necessary staff for the services and the lines of authority and accountability.	
2602	2. **Director.** There shall be a qualified director of respiratory/pulmonary services who is a member of the medical staff and a licensed doctor of medicine or osteopathy with knowledge, experience, and capability to supervise the services on a full-time or part-time basis including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program.	Qualifications for the director should be defined by the medical staff. Best practice would be to have a physician director who is board certified or board eligible in pulmonary medicine. The hospital may, in addition to the physician director, have an administrative director for respiratory care. Best practice would be to require the administrative director be registered by the National Board for Respiratory Care, and a state certified respiratory care professional.
2603	(i) The director shall be responsible for all clinical aspects of the organization and delivery of clinical respiratory care services, including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program.	Lines of responsibility and accountability includes provision for supervision of respiratory care professionals as required by the state rules and regulations for implementation of the "Respiratory Care Practices Act", O.C.G.A. 43-34. The rules relating to availability of staff for supervision of respiratory care professionals can be found in the Georgia Administrative Rules, Chapter 360-13-.02.
2604	(ii) The director shall be responsible for the development, implementation, and periodic review of policies, procedures, and protocols for respiratory/pulmonary care, which shall reflect the scope of services offered, including at least:	
	(I) Routine inspection, cleaning, and maintenance procedures for respiratory equipment, as well as protocols for their assembly and operation;	
	(II) Adverse reaction protocols;	
	(III) Safety practices and interventions;	

2604 contd	(IV) Staff participation in emergency situations at the facility;	
	(V) Infection control procedures;	
	(VI) Procedures for the handling, storage, and dispensing of therapeutic gases;	
	(VII) Procedures for obtaining blood samples and analysis of samples, as applicable;	
	(VIII) Procedures for testing of pulmonary function, as applicable;	
	(IX) Procedures for therapeutic percussion and vibration and for broncho-pulmonary drainage, as applicable;	
	(X) Procedures for mechanical ventilation and oxygenation support and for administration of aerosol, humidification, and therapeutic gases, as applicable;	
	(XI) Policies for administration of medications;	
	(XII) A system for the reissuing and discontinuing of respiratory therapy orders; and	
	(XIII) Procedures for verbal/telephone orders taken by state-certified respiratory care professionals.	
2605	3. There shall be a sufficient number of qualified competent professionals and support personnel to respond to and meet the respiratory/pulmonary care needs of the patients.	Qualifications for respiratory/pulmonary care staff must meet the requirements from the Composite Board of Medical Examiners: they must be Georgia-certified respiratory care professionals, licensed nurses, physician's assistants, or physicians. Specialized qualification requirements for treating specific conditions should be defined. For example, there would be special training required for those administering care with mechanical ventilators. Records should reflect that patients receive all services as ordered in a timely manner.
2606	(b) Delivery of Respiratory/Pulmonary Services. **Respiratory/Pulmonary services shall be delivered in accordance with the needs of the patients.**	

2607	1. Respiratory services shall be provided only in response to medical orders. Medical orders for services shall include the modality to be used, the type, frequency, and duration of treatment, and the type and dose of medications, including dilution ratios. Verbal/telephone orders for respiratory service shall be dated, timed, and given only to appropriately licensed or otherwise qualified individuals as determined by the medical staff in accordance with state law and these rules and shall be entered into the patient's medical record by those appropriately licensed or otherwise qualified individuals.	See guidelines under 290-9-7-.18 (2)(b).
2608	2. The hospital shall provide equipment and supplies sufficient to support the scope of the respiratory services offered.	Equipment must be provided not only for service provision but also for service support. For example, pulse oximeters and end-tidal carbon dioxide monitors would need to be available for patients who have a medical condition that requires oxygen and carbon dioxide monitoring.
2609	3. All respiratory care services provided shall be documented in the patient's medical record, including the type of therapy, date and time of administration, effects of therapy, and any adverse reactions.	Records should reflect that patients receive all services as ordered in a timely manner.
2610	4. If blood gases or other clinical laboratory tests are performed by respiratory care staff, those staff shall have demonstrated competency in the administration of the tests as point-of-care technicians. Authority O.C.G.A. Chapter 31-22 and Sec. 31-7-2.1.	Records for these personnel should reflect competency testing for these activities.
2700	**290-9-7-.27 Organ, Tissue, and Eye Procurement and Transplantation.** The hospital shall participate, as appropriate, in the procurement of anatomical gifts.	If the hospital participates in the Medicare program, they are required to meet the COPs regarding organ donation and must be registered as a donee. They must also be a member of the Organ Procurement and Transplantation Network.
2701	(a) **Receipt of Donations.** The hospital shall receive donations of organs or tissues for the purposes of medical or dental education, research, advancement of medical or dental science, therapy, or transplantation only in accordance with the provisions of the "Georgia Anatomical Gift Act," O.C.G.A. Section 44-5-140, and the applicable rules of Chapter 290-5-50.	
2702	(b) **Voluntary Expression of Intent to Donate.** The hospital shall establish and implement policies and procedures for documenting requests by patients regarding their intentions for disposition of their bodies or organs and for seeing that these expressed intentions are honored upon death when possible.	This requirement arises where the patient has initiated the request.

2703	(c) **Hospital Requests for Anatomical Gifts.** The hospital shall establish and implement policies and procedures for requesting anatomical gifts on or before the occurrence of death in the absence of a patient's expressed intentions.	
2704	1. Policies and procedures shall provide for a written agreement(s) with an organ bank or storage facility with the provisions specified in Rules for Anatomical Gifts, Chapter 290-5-50-.07, and provisions for the training of staff authorized to request the gifts, when applicable.	In Georgia, organ banks are required to be those designated as Organ Procurement Organizations by CMS, tissue banks licensed in Georgia as a clinical laboratory, or licensed eye banks. Training would be applicable when it's the hospital staff handling the donations in lieu of OPO.
2705	2. Where the hospital does not have the Organ Procurement Organization handle requests for anatomical gifts, the hospital shall designate staff authorized to make requests for anatomical gifts, and such staff shall be appropriately trained in the following areas:	Currently Georgia law does not require the limiting of these duties to any specific profession. These training areas are currently required by the Rules for Anatomical Gifts, Chapter 290-5-50-.11. Other training may be provided in connection with these duties. Currently, this training is provided by OPO.
	(i) Psychological and emotional considerations when dealing with bereaved families;	
	(ii) Social, cultural, ethical, and religious factors affecting attitudes toward donations;	
	(iii) General medical concepts and issues in organ, tissue, and eye donations;	
	(iv) Procedures for declaring death and collecting and preserving organs, tissues, and/or other body parts and for how these procedures are to be explained to decedents' families;	
	(v) Procedures for notifying and involving banks or storage facilities; and	
	(vi) Procedures for recording the outcomes of requests.	
2706	3. If the hospital engages in harvesting tissue and/or transplanting organs and tissues from living donors, the hospital shall develop a living donor organ/transplants policy that addresses the issues related to such donations.	This is an optional policy depending upon the scope of services provided by the hospital.
2707	(d) **Physicians Participating in the Removing or Transplanting of Organs or Tissues.** Where the medical staff participates in organ recovery, the hospital shall designate which	Physicians authorized to perform the procedures may also authorize other non-physicians to perform them, such as

2707 contd	medical staff members may not participate in the procedures for removing and transplanting of organs and body parts in accordance with the Rules for Anatomical Gifts, Chapter 290-5-50.08. Authority O.C.G.A. Secs. 31-7-2.1 and 44-5-140, et seq.	an RN, PA, technician, or other individual trained in the procedures. When medical staff participates in organ recovery in the hospital, it should be spelled out in the bylaws and/or rules and regulations. Hospitals may wish to include in their bylaws and/or rules and regulations language to require that the bodies be treated with respect during and following the removal of organs and tissues. Hospitals may wish to establish credentialing requirements for individuals authorized to participate in organ procurement or transplantation. See also Georgia law on anatomical gifts, O.C.G.A. Sec. 44-5-140.
2800	**290-9-7-.28 Surgical Services.** If the hospital provides surgical services, the services shall be provided in a manner which protects the health and safety of the patients and follows current accepted standards of medical and surgical practice. Personnel, equipment, policies and procedures, and the number of operating rooms shall be appropriate for the scope of services offered.	The hospital's governing body must clearly define the scope of services provided. For example, some hospitals offer elective surgery but not emergency surgery. Some surgical services, such as cardiac surgery, require approval via the CON process.
2801	(a) **Organization of Surgical Services.** The hospital shall have an organizational plan which defines lines of authority, responsibility, and accountability within all operating room areas where surgical procedures are performed.	
2802	1. There shall be a current roster of the surgical privileges granted each medical staff member available to nursing and scheduling staff in the surgical services area(s).	The roster available to the surgical area must be current and reflect the information documented in the credential files. Electronic access to rosters in surgical area is acceptable.
2803	2. The hospital shall have bylaws, rules, or policies and procedures developed by the medical staff which require that within twenty-four (24) hours prior to surgery either a history and physical examination or an update of a previous history and physical is completed for every surgical patient. Where an update is used, the previous history and physical examination must not have occurred more than thirty (30) days prior to surgery.	
2804	3. Roles, responsibilities, and qualifications for any non-physician first and second assistants participating in surgery shall be defined by the hospital medical staff, including any limitations to their roles in patient care.	

2805	4. **Chief(s) of Surgery.** Physician member(s) of the medical staff, who have been appropriately trained in the provision of surgical services, shall be designated by the medical staff to direct the hospital's surgical services, and shall be responsible for all clinical aspects of organization and delivery of the particular surgical services including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program.	"Clinical aspects" refers to the services provided by physicians. The medical staff bylaws and/or rules and regulations would outline the responsibilities for the direction of surgical services. The list of current medical staff appointments should identify the current chief of surgery.
2806	(i) The chief(s) of surgery shall be responsible for implementation of hospital policy related to medical staff utilizing the surgical suite.	
2807	(ii) In conjunction with the hospital's medical staff, the chief(s) of surgery shall implement procedures requiring an operative report for each surgery performed.	
2808	(I) The operative report shall describe techniques, findings, complications, tissues removed or altered, and the general condition of the patient during and following surgery.	
2809	(II) The full operative report shall be written or dictated immediately after surgery and signed or authenticated by the surgeon. Where the full operative report is not available to be placed immediately in the record, an operative/progress note by the surgeon must be entered into the medical record immediately.	
2810	5. **Nurse Manager.** A licensed registered nurse, who has been appropriately trained in the provision of surgical nursing services, shall manage the surgical suite(s) and shall be responsible for:	
2811	(i) Ensuring that a sufficient number of nursing personnel are on duty in the surgical suite to meet the needs and safety of the patients;	
2812	(ii) Ensuring that surgical technicians perform scrub functions only under the supervision of a licensed registered nurse who is immediately available to respond to emergencies;	Job descriptions should define functions of staff in the O.R.
2813	(iii) Delineating the duties of scrub personnel and circulating registered nurses in the surgical suite;	Scrub personnel may be RNs, LPNs, or surgical technicians. Circulating nurses must be licensed registered nurses.

2814	(iv) Providing for orientation and on-going education and training of surgical personnel providing services within the surgical suite, to include at least equipment usage and inspections, infection control and safety in the surgical area, cardiopulmonary resuscitation, patient rights, and informed consent;	
2815	(v) Ensuring that patients are monitored and provided with nursing care from the time they enter the surgical suite to the time they exit the area;	
2816	(vi) Developing criteria for the use of equipment and supplies brought into the surgical suite from other areas; and	
2817	(vii) Ensuring that the operating room register is current and complete.	Typically, the register will include name of patient, date, time and tissue removed**.**
2818	(b) **Infection Control in the Surgical Suite.** The hospital shall develop and implement infection control procedures specific to the surgical services areas, which include at least requirements for:	The hospital would use input from the infection control program personnel in the development of these policies and procedures.
	1. Surgical attire;	
	2. Surgical scrub procedures;	
	3. Housekeeping functions;	
	4. Cleaning, disinfecting, and sanitizing the area;	
	5. Appropriate maintenance of the heating, ventilation, and air conditioning systems for the surgical suite;	
	6. Packaging, sterilizing, and storage of equipment and supplies;	
	7. Waste disposal;	
	8. Traffic control patterns, including who may enter the operating room areas and under what circumstances; and	
	9. A surgical site surveillance system appropriate to the population served.	

2819	(c) **Minimum Equipment for the Surgical Suite**. The following emergency equipment shall be available and functional for the operating room(s) and for the post-anesthesia area, as appropriate:	
	1. A call system;	
	2. Cardiac monitors;	
	3. Resuscitation equipment;	Resuscitation equipment could be a mechanical ventilator or a respirator.
	4. A defibrillator;	
	5. Aspiration/suction equipment;	
	6. A traecheostomy kit;	
	7. A pulse oximeter; and	
	8. An end-tidal carbon dioxide monitor.	
2820	(d) **Post-Anesthesia Care Unit.**	
	1. The post-anesthesia care unit shall be located in an area of the hospital in close proximity to but physically separated from the operating room.	The location should allow for rapid access to the OR if necessary, or access to the emergency equipment in the surgical suite.
2821	2. Policies and procedures for the post-anesthesia care unit shall include at a minimum the criteria for admission to and discharge from the unit.	
2822	3. If patients are not transferred to the post-anesthesia care unit following surgery, provisions shall be made for monitoring the patient until it is determined that the patient is stable. Authority O.C.G.A. Secs. 31-7-2.1 and 31-9-6.1.	
2900	**290-9-7-.29 Anesthesia Services.** Any hospital offering surgical or obstetrical services shall have an organized anesthesia service which shall be responsible for all anesthesia	If the hospital scope of services includes obstetrics and/or surgical services, it must also include anesthesia services.

2900 contd	delivered at the hospital. The anesthesia services will be provided in a manner which protects the health and safety of patients in accordance with generally accepted standards of practice.	
2901	(a) **Organization of Anesthesia Services.** 1. Anesthesia services shall be directed by a qualified physician member of the medical staff who is responsible for organizing the delivery of anesthesia services provided by the hospital in accordance with generally accepted standards of practice.	This rule does not require the hospital to have anesthesia services directed by an anesthesiologist. Many hospitals will have anesthesiologists directing the service. Other hospitals, which offer limited surgical services for example, may determine that one of the physicians who perform operations is qualified to direct the service. Surveyors will check to see whether the hospital has appointed a director who is a physician member of the medical staff, whether the service is organized hospital-wide and whether there are appropriate quality assurance activities taking place in the service areas.
2902	2. The anesthesia director shall be responsible for monitoring the quality and appropriateness of anesthesia services and for ensuring that identified problems are addressed through the quality management program.	The quality management program for each organized service is to be integrated into the hospital-wide program.
2903	3. The anesthesia director shall be responsible for establishing an orientation and continuing education program for anesthesia services staff that include, at a minimum, instruction in safety precautions, emergency patient management, equipment use and inspections, and infection control procedures in the surgical suite.	Best practice would be to require consideration of completion of the training programs at the time of reappointment or performance evaluation. Examples of safety precautions are listed under the guidelines for (c) 5. In this section of the rules.
2904	(b) **Anesthesia Service Delivery.**	
	1. Anesthesia shall be administered only by qualified members of the medical staff or qualified individuals who have been granted clinical privileges to administer anesthesia in accordance with these rules and as permitted by state laws and regulations. Persons qualified to administer anesthesia may include:	
	(i) Anesthesiologists;	Surveyor will check to see that anesthesiologist is a member of the medical staff and has been credentialed to provide anesthesia services.

2904 cont	(ii) Physicians;	Surveyor will check to see that physician providing anesthesia services is a member of the medical staff and has been credentialed to provide the same.
	(iii) Dentists or oral surgeons possessing an active permit for administration of general anesthesia as issued by the State of Georgia;	Per O.C.G.A. Sec. 43-11-21.1, and Rules of the Georgia Board of Dentistry, Chapter 150. Surveyor will check to see that the dentist or oral surgeon has been credentialed in accordance with these rules to provide anesthesia.
	(iv) Certified registered nurse anesthetists administering such anesthesia under the direction and responsibility of duly licensed physicians who are members of the medical staff; and	Per O.C.G.A. Sec. 43-26-11.1 and the Regulation of Advanced Nursing Practice Rule 410-12-04 *et seq.* The surveyor will verify that both the CRNA and operating physician have been determined qualified to perform their respective roles by the medical staff. The CRNA administers the anesthesia and the operating physician provides direction and is responsible for the same. Any physician who has been credentialed by the hospital through the medical staff to perform surgery in the hospital's surgical suites and serve as the operating physician responsible for the CRNA may supervise the CRNA's administration of anesthesia.
	(v) Physician's assistants licensed by the State of Georgia with approved job descriptions as anesthesia assistants functioning under the direct supervision of anesthesiologists who are members of the medical staff and as otherwise authorized by applicable laws and regulations.	Per O.C.G.A. Sec. 43-34-100 and the Rules of the Composite State Board of Medical Examiners, Chapter 360-5. Surveyors will check to see that the P.A. and the anesthesiologist have been credentialed in accordance with these rules.
2905	2. A pre-anesthesia patient evaluation shall be completed for each patient by a person qualified and granted privileges to administer anesthesia within a reasonable period of time preceding the surgery. The patient evaluation shall be updated immediately prior to induction. The pre-anesthesia evaluation must include review of heart and lung function, diagnostic data (laboratory, x-ray, etc., as applicable), medical and anesthesia history, notation of anesthesia risk, any potential anesthesia problems identified, and notation of patient's condition immediately prior to induction.	

2906	3. Checks of all anesthesia equipment shall be performed and documented immediately prior to each anesthesia administration.	
2907	4. A person qualified and granted privileges to administer anesthesia shall be continuously present throughout the administration of all general anesthesia or major regional anesthesia and monitored anesthesia care.	Anesthesia needs to be monitored wherever it is administered**.**
2908	5. During the administration of anesthesia, patients shall be monitored as appropriate for the nature of the anesthesia. Such monitoring shall include as appropriate:	
	(i) Heart and breath sounds, using a precordial or esophageal stethoscope;	
	(ii) Oxygenation levels;	
	(iii) Ventilation;	
	(iv) Circulatory function;	
	(v) The qualitative content of expired gases, if the patient has an endotracheal tube; and	
	(vi) The patient's temperature.	
2909	6. The intraoperative anesthesia record shall document all pertinent actions and events that occur during the induction, maintenance, and emergence from anesthesia.	Customarily, the documentation of pertinent events must include the name, dosage, route, and time of administration of drugs and anesthesia agents, IV fluids administered, estimated blood loss, any blood or blood products given, recordings of blood pressure, total intake and output, heart and respiration rate, any problems occurring during anesthesia, treatment given to address problems, and patient response to treatment.
2910	7. The person qualified and granted privileges to administer anesthesia shall remain immediately available until the patient has been determined to be stable and is ready for discharge or transfer from the post-anesthesia care unit.	"Immediately available" is currently interpreted to mean, in this case, on the hospital grounds and able to be present in the PACU within 10 minutes.
2911	8. A person qualified and granted privileges to administer anesthesia shall complete the post-anesthesia evaluation for each patient receiving anesthesia, and it shall be included in	

2911 contd	the patient's medical record.	
2912	(i) The post-anesthesia evaluation shall note at a minimum the presence or absence of anesthesia-related abnormalities or complications, the patient's level of consciousness and cardiopulmonary status, and any follow-up care needed.	
2913	(ii) For outpatients, the post-anesthesia evaluation shall be performed prior to hospital discharge to check for anesthesia recovery in accordance with procedures and timelines established by the hospital's medical staff.	The procedures for post-operative evaluation for the outpatient may differ depending on the complexity or length of the surgical procedure, and may or may not contain all of the items required for the inpatient evaluation.
2914	(c) **Anesthesia Safety Precautions.** Safety precautions related to the administration of anesthesia shall be clearly identified in written policies and procedures which are enforced and shall include at a minimum:	
	1. Routine maintenance and inspection of anesthesia equipment, recorded in a service record for each machine;	Inspection should include assessment for proper functioning and proper grounding.
	2. Emergency preparedness plans;	There should be procedures handling emergency situations such as loss of power in the OR, and preferably documentation of drills.
	3. Life safety measures, including alarm systems for ventilators capable of detecting disconnection of any components, monitoring for scavenger gases, and a system for internal reporting of equipment malfunctions and unavailability;	
	4. Infection control procedures sufficient to adequately sterilize or appropriately disinfect all equipment components; and	For example, endotracheal tubes or tracheotomy tubes would require special disinfection/sterilization procedures.
	5. Procedures for ensuring patient safety.	Patient safety measures would include monitoring patient body alignment, positioning, and managing transfers, assessing patient's risk factors, anesthesia-reversal

2914 cont		procedures, or detection and management of adverse drug reactions.
2915	(d) **Conscious sedation.** The hospital shall develop and implement, with the assistance of the anesthesia services director, policies and procedures for the administration of conscious sedation, which shall be applicable hospital-wide. These policies and procedures shall be approved by appropriate members of the medical staff and shall include at least the following:	For the purposes of these rules, "conscious sedation" refers to the medically controlled state of reduced consciousness which allows the patient's protective reflexes to be maintained, retains the patient's ability to keep a patent airway independently, and permits easy patient arousal and patient response to physical stimulation or some simple verbal commands. (Note: language is very similar to JCAHO language for moderate sedation/analgesic.
	1. Designation of the licensed personnel authorized to administer conscious sedation and/or monitor the patient during conscious sedation;	
	2. Drugs approved for use in administering conscious sedation;	
	3. Patient monitoring requirements; and	
	4. Criteria for discharge. Authority O.C.G.A. Secs. 31-7-2.1, 43-22-21, and 43-26-11.1.	
3000	**290-9-7-.30 Nuclear Medicine Services.** If the hospital provides nuclear medicine services, those services shall be organized and effective. The nuclear medicine services shall be provided in a manner consistent with applicable state laws and regulations and generally accepted standards of practice.	
3001	(a) Radioactive materials used in the provision of nuclear medicine services shall be prepared by personnel authorized as defined by state law to prepare radiopharmaceuticals and shall be labeled, used, transported, stored, and disposed of in a manner consistent with the "Georgia Radiation Control Act," O.C.G.A. Chapter 31-13, et seq., and applicable rules.	
3002t	(b) If a clinical laboratory is utilized in the provision of nuclear medicine services, the laboratory shall be licensed to perform these services as required by the Rules and Regulations for Clinical Laboratories, Chapter 290-9-8.	

3003	(c) Nuclear medicine services shall be directed by a doctor of medicine or osteopathy, who is a member of the medical staff qualified to perform and supervise those services. The director shall be responsible for the administration of nuclear medical services, including the evaluation of the effectiveness of the services in coordination with the hospital's quality management program	
3004	(d) Nuclear medicine procedures shall be administered and/or supervised by licensed doctors of medicine or osteopathy as authorized by state law. Authority O.C.G.A. Secs. 31-7-2.1, 31-13-1, et seq., and 31-22-1, et seq.	
3100	**290-9-7-.31 Emergency Services.** The hospital shall provide, within its capabilities, services to persons in need of emergency care.	
3101	(a) **Full-time Emergency Services.** If the hospital offers emergency care as an organized service and/or holds itself out to the public as offering emergency services, the service shall be included in the scope of services submitted with the application for the hospital permit and shall be offered twenty-four (24) hours per day.	
3102	1. **Organization.** Supervision and organization of emergency services shall be under the direction of a qualified member of the medical staff.	
3103	(i) The director shall be responsible for the development of policies and procedures related to emergency services and the review and update of policies as necessary. The policies and procedures shall be approved by appropriate members of the medical staff.	Appropriate members would include sub-committees of the medical staff**.**
3104	(ii) The director shall implement systems to assess the effectiveness of the emergency service and to address improvement issues through the hospital's quality management program.	
3105	(iii) Staffing assignments shall provide for sufficient nursing, medical, and technical staff to meet the anticipated needs for emergency patient care. There shall be available to emergency room staff procedures for accessing additional staff on an as-needed basis to meet unanticipated needs.	"Anticipated needs" should be based on historical data. Procedures must be in place for notification of primary care physicians and specialty physicians available to respond for emergency patient care. Emergency services staff must be trained in the approved procedures.

3106	(iv) Patient care responsibilities for emergency services staff shall be specified by written policies and procedures, which shall include training and experience requirements appropriate to the assigned responsibilities, and clearly defined lines of authority.	
3107	2. **Delivery of Services.** Where the hospital provides emergency services, the services shall comply with the following:	
	(i) Policies and procedures for processing patients presenting for emergency care shall be in writing and shall include the procedures for initial patient assessment, prioritization for medical screening and treatment, and patient reassessment and monitoring;	There should be specific protocols in the emergency room for assessing pediatric patients, per 290-9-7-.35 (c).
3108	(ii) There shall be a central log of all patients presenting for emergency care, with the presenting complaint and the level of acuity or triage documented. Entries in the log must be retrievable by the date and time the patient presents for treatment;	Where the patient leaves prior to triage, the hospital's documentation that the patient left without being seen will satisfy the requirements of this rule.
3109	(iii) An emergency medical record shall be maintained for each patient which includes all assessment and treatment information about the patient from the time of presentation until the time of discharge or transfer;	The emergency medical record would contain patient identifying information, presenting complaint, all clinical observations, results of diagnostic assessments or tests, a record of treatment administered and outcome(s), the names of treating or responsible practitioners, condition on discharge and discharge destination and instructions. (See Outpatient Records for additional requirements).
3110	(iv) Written protocols and standards of practice to guide emergency interventions by non-physician staff shall be available in the emergency services area;	These must be approved by the medical staff or appropriate member(s) of the medical staff.
3111	(v) A licensed physician shall be available to cover basic emergency room services either on-site or by telephone. Where the licensed physician is providing such coverage by telephone, the physician must be able to arrive in the emergency room within thirty (30) minutes of the need for physician services having been determined;	The physician could be contacted by telephone and make a medical decision as to whether or not physician services for a patient are necessary, or whether the patient's condition can be managed by other emergency room staff.
3112	(vi) The emergency services area shall have operable equipment and sufficient and appropriate supplies and medications to support emergency care for patients of all ages, including at least:	
	(I) An emergency call system;	
	(II) Oxygen;	The oxygen supplies may be centralized or on cylinder. A system for monitoring supply and quantity levels must be

3112 cont		evident.
	(III) Manual breathing bags and masks;	Breathing equipment must be maintained in a state of readiness for patient use. Bags and masks usable with infants and children must be available.
	(IV) Cardiac monitoring and defibrillator equipment;	Staff on duty must be knowledgeable in operating the cardiac equipment. The equipment must be in a state of readiness for patient use.
	(V) Laryngoscopes and endotracheal tubes;	Scopes and tubes appropriate for use with children must be available.
	(VI) Suction equipment; and	Suction equipment must be appropriately cleaned and in a state of readiness for use.
	(VI) Emergency drugs and supplies as specified by the medical staff;	A list and current inventory of approved drugs must be maintained.
3113	(vii) The hospital shall integrate functions of the emergency services with other services of the hospital to ensure appropriate patient care and treatment including those patients awaiting admission or transfer to another facility, placement in a hospital bed, or transfer to another facility;	Procedures must integrate services of the laboratory, radiology, and surgical areas with the emergency services to ensure access to necessary diagnostic tests and emergency surgical procedures.
3114	(viii) Policies and procedures shall be developed and implemented for the appropriate transfer of emergency patients to other facilities or other areas of the hospital when appropriate;	
3115	(ix) The hospital shall have policies and procedures for the management of mass casualty situations which may require the coordination of the hospital's emergency services with other facilities, the local Emergency Management Agency (EMA), and local ambulance service providers;	
3116	(x) Emergency Services Where Maternity Services Are Customarily Offered. In addition to applicable federal laws regarding the treatment of persons requesting treatment for emergency medical conditions that are enforced by the federal government, state law requires any hospital which operates an emergency service to provide appropriate and necessary emergency services to any pregnant woman who is a resident of this state and who presents herself in active labor to the hospital, if those services are usually and customarily provided in that facility. Such services shall be provided within the scope of generally accepted practice based upon the information furnished the hospital by the pregnant woman, including such information as the pregnant woman reveals concerning her prenatal care,	

3116 cont	diet, allergies, previous births, general health information, and other such information as the pregnant woman may furnish the hospital. If, in the medical judgment of the physician responsible for the emergency service, the hospital must transfer the patient because the hospital is unable to provide appropriate treatment, the hospital shall provide appropriate treatment as set forth in O.C.G.A. Sec. 31-8-42; and	
3117	(xi) Diversion Status—Inability to Deliver Emergency Services. The hospital shall develop and implement a diversion policy in consultation with the medical staff which describes the process for handling those times when the hospital must temporarily divert ambulances from transporting patients requiring emergency services to the hospital. The policy must include the following: when diversion is authorized to be called, who is authorized to call and discontinue diversion, efforts the hospital will make to minimize the usage of diversion, and how diversion will be monitored and evaluated. In connection with going on diversion status, the hospital shall: (I) Notify the ambulance zoning system when it is temporarily unable to deliver emergency services and is declaring itself on diversion; (II) Notify the ambulance zoning system when diversion status is no longer determined to be necessary; and (III) Monitor and evaluate its usage of diversion status and make changes within its control to minimize the use of diversion status.	
3118	(b) **Hospitals Without Organized Emergency Services.** Hospitals not providing an organized emergency service shall have current policies and procedures and sufficient qualified staff to provide for the appraisal and initial treatment of any patients or persons presenting with an emergency medical or psychiatric condition, within the capabilities of the hospital, and for referral of the patient for further treatment when appropriate. Authority O.C.G.A. Secs. 31-7-2.1, 31-7-3.1,31-8-42, and 31-11-82.	Initial treatment must be provided within the resources of the hospital. While these hospitals may not offer emergency services, the hospital staff should be familiar with the procedures to be followed when a person presents requesting or in need of emergency treatment.
3200	**290-9-7-.32 Outpatient Services.** Outpatient services offered by the hospital, including but not limited to ambulatory care services and off-campus clinics, shall be integrated with other hospital services and systems and shall be provided in accordance with applicable rules in this Chapter for the specific service.	The hospital must define in writing the scope of their outpatient services and the lines of accountability in place to assure that the services comply with other hospital policies and procedures, including infection control, quality management, and records management. (Records requirements specific to outpatient records are found in this section.) Rule 290-9-7-.03 requires that any addition

3200 cont		of organized services, including any new outpatient services or service locations, must be reported in writing to the Department.
3201	(a) **Organization of Outpatient Services.**	
	1. The hospital shall develop and implement policies and procedures to ensure that outpatient care provided meets the needs of patients in accordance with generally accepted standards of practice.	
3202	2. Each outpatient service shall be staffed with sufficient qualified personnel to promptly, safely, and effectively meet the care needs of patients. Staff providing care to outpatients shall meet the same qualification requirements as staff providing similar services to inpatients of the hospital.	Different services may require different staffing ratios in terms of patient acuity.
3203	3. The hospital shall assign responsibility for the periodic assessment of the quality and effectiveness of the outpatient services provided, and this assessment shall be a part of the hospital's quality management program.	
3204	(b) **Outpatient Service Delivery.**	
	1. Hospital services for outpatients shall be provided only on the order of a licensed physician, dentist, osteopath, physician's assistant, or advanced practice nurse as permitted by law in accordance with the system of accountability established by the medical staff.	See Rule 290-9-7-.11(b)(2)
3205	2. Outpatient services shall be provided in a manner which ensures the privacy of each patient and the confidentiality of the patient's disclosures. Private rooms or cubicles shall be provided for the use of outpatients and staff for consultation purposes, as appropriate to the needs of the service.	Any outpatient service area should have at least one private consultation room or cubicle available. Areas serving larger numbers of outpatients would need more such consultation areas in order to be able to provide prompt service. Screens or curtains can be used to provide visual privacy in outpatient service areas.
3206	3. Hospitals shall provide waiting areas for outpatients with sufficient seating for the expected volume of patients.	
3207	4. Each outpatient shall have an outpatient record, which shall be maintained and stored in a manner to be available for subsequent outpatient or inpatient hospital visits.	Specific requirements for outpatient records are included in rules under 290-9-7-.18(3)(b).

Authority O.C.G.A. Sec. 31-7-2.1.

3300	**290-9-7-.33 Rehabilitation Services.** The hospital shall define the scope of rehabilitation services provided to patients. The hospital may offer limited or comprehensive rehabilitation services including such services as physical therapy, occupational therapy, audiology, speech-language pathology, or other services.	
3301	(a) **Organization of Limited Rehabilitation Services.** Where a hospital chooses to offer limited rehabilitation services, which are typically single or stand-alone therapy discipline(s), the rehabilitation service(s) shall be coordinated by an appropriately qualified individual assigned responsibility for the clinical aspects of organization and delivery of the rehabilitation service(s) provided by the hospital. The coordinator shall be responsible for monitoring the quality and appropriateness of rehabilitation services and for ensuring that identified problems are addressed through the quality management program.	Each service may have a director, or there may be one director of multiple services.
3302	(b) **Organization of Comprehensive Rehabilitation Services.** Where a hospital chooses to offer a comprehensive rehabilitation service program which provides integrated and coordinated multi-disciplinary therapy services as an organized inpatient service, the director must be a qualified member of the medical staff with appropriate training and experience.	
3303	(c) Professional and paraprofessional staff providing patient care shall meet licensing or registration requirements consistent with state law.	Some positions may require special qualifications, such as specialized training in cardiac care for those providing cardiac rehab, or training and experience with pediatrics for those providing services to that population.
3304	(d) Rehabilitation services shall be provided in accordance with orders from the licensed practitioner responsible for the patient's care. Orders for services shall be entered in the patient's medical record with the date of the order and shall be signed by the person giving the order. If rehabilitation services are provided by the hospital on an outpatient basis, the hospital shall specify how orders from outside sources will be managed.	Prescriptions for therapy will be put into the medical board.
3305	(e) Following assessment, treatment services shall be provided according to a written treatment plan, which specifies the goals of treatment and the frequency and expected duration of services.	The treatment plan should be developed with collaboration between the rehab staff member, the patient or the patient's representative and the physician responsible for the patient's treatment.
3306	(f) There shall be a functional system for recording in the patient's medical record the patient's response to treatment and for communicating information regarding the patient's	Entries in the medical record should reflect that treatment was given as ordered, and progress reports should be

3306 cont	response or progress to the ordering licensed practitioner. Authority O.C.G.A. Sec. 31-7-2.1.	present as specified by policies and procedures and the treatment plan.
3400	**290-9-7-.34 Maternal and Newborn Services.** (1) No later than 90 days after the effective date of these rules, if the hospital offers an organized service for the provision of care for expectant mothers and newborns, it shall clearly define the level of services provided according to the levels described in these rules (basic, intermediate, or intensive) and comply with the rules set forth in this section.	The terminology for the levels of care for these rules corresponds with the terminology used in the rules for the Division of Health Planning, Department of Community Health. As they are there, the "basic" level of services is comparable to the "basic" level of services described in the *Recommended Guidelines for Perinatal Care in Georgia* prepared by the Council on Maternal and Infant Health of the State of Georgia (available from the following address: Council on Maternal and Infant Health, Division of Public Health, 2 Peachtree St., NW, Atlanta30303), the "intermediate" level of services is comparable to the "specialty" level in those guidelines, and the "intensive" level is comparable to the "subspecialty" level in those guidelines.
3401	(a) The hospital shall establish and utilize admission criteria for the maternal and newborn services that reflect the level of services offered by the hospital.	
3402	(b) The hospital shall have established mechanisms, through written agreement or other arrangement, for transfers to or consultations with facilities providing services at the higher levels of care for those maternal and newborn patients who require such care. The agreements or arrangements shall ensure that there is collaboration between the sending and receiving hospital concerning the transfer of such patients prior to the actual need for transfer and shall include mechanisms for the communication of information regarding the outcome of each transfer and for periodic review of the agreements or arrangements.	Agreements, arrangements, or affiliations may be with one or more hospitals, and may include participation in a network of affiliations designed to provide a continuum of services. Communication of information regarding outcomes of transfers may be as simple as sending a copy of the discharge summary to the sending facility, or may require more immediate communications as indicated by the transfer situation.
3403	(c) All hospitals offering obstetrical care shall have facilities, staff, and equipment necessary for delivery, management, and stabilization of expectant women who present at the hospital in active labor and for whom delivery is imminent, regardless of the level of care anticipated for the newborn. The hospital shall have in place a system for communication and consultation with a board certified obstetrician or maternal-fetal medicine specialist and a board certified neonatologist for situations where transport of high-risk patients prior to delivery is not feasible.	It is anticipated that there will be situations where a patient at high-risk for complications of delivery or for the newborn, presents at the hospital emergency room. If the range of maternal and newborn services of the hospital is less than the level of care anticipated for this patient, the hospital must have access to appropriate consultation for the delivery and for management of the neonate until

3403 cont		transfer can be made to a facility with a higher level of care.
3404	(d) The hospital shall establish a system for receipt of prenatal records for admissions to the maternal and newborn service other than emergency admissions to include the results of any routine laboratory tests as required by the hospital.	Best practice for management of high-risk or complicated deliveries or newborns is for transfer while the infant is in-utero, so it is advantageous to review prenatal records and identify, before the mother delivers, those cases for whom a higher level of care is anticipated.
3405	(e) The hospital shall have written plans and procedures for transfer of expectant mothers or newborns presenting at the hospital who exceed the criteria for admission, which shall include mechanisms for accessing transportation appropriate to the needs of the patient(s).	Transport plans should include access to a registered neonatal transport service as described in 290-5-30-.06.
3406	(f) The hospital shall include in the internal quality management program a systematic review of the admissions and transfers for maternal and newborn services, with comparison to the established admission criteria, which shall prompt corrective action when indicated.	If the review of the admissions shows that admissions are routinely not meeting the established admission criteria, the hospital should consider efforts for improvement, which may include education for medical staff or physicians granted privileges at the hospital for the provision of maternal-fetal or obstetrical care.
3407	(g) With the exception of hospitals permitted as specialized children's hospitals, hospitals shall offer a level of services for maternal care comparable to the level of services offered for neonatal care.	
3408	(2) The hospital shall have sufficient staff, space, facilities, equipment, and supplies to support the range of maternal and infant services offered, according to generally accepted standards of practice.	Current guidelines containing best practices for various levels of care can be found in the *Guidelines for Perinatal Care* published jointly by the American College of Obstetricians and Gynecologists (http://www.acog.org/), and the American Academy of Pediatrics (http://www.aap.org/) and available through their websites, and in the *Recommended Guidelines for Perinatal Care in Georgia* prepared by the Council on Maternal and Infant Health of the State of Georgia, and available from the following address: Council on Maternal and Infant Health, Division of Public Health, 2 Peachtree St., NW, Atlanta 30303.

3409	(3) **Basic Maternal and Newborn Services.** All hospitals offering maternal and newborn services shall offer at least a basic level of those services. The basic level of maternal and newborn services shall provide comprehensive care for women with low-risk pregnancies, anticipated uncomplicated deliveries, and apparently normally developing fetuses with estimated gestation of thirty-six (36) weeks or greater and for newborns with anticipated birth weights of 2500 grams or greater. The maternal and newborn services of these hospitals shall meet the following minimum requirements:	
3410	(a) **Organization of Basic Maternal and Newborn Services.**	
	1. The director of obstetrical services shall be a board eligible or board certified obstetrician, or a board eligible or board certified family practitioner with obstetrical privileges, or shall be a credentialed member of the medical staff with obstetrical privileges with access to such board eligible or board certified specialists by consultation.	
3411	2. The director of newborn services shall be a member of the medical staff who is a board eligible or board certified pediatrician, or a board eligible or board certified family practitioner, or shall be a credentialed member of the medical staff with access to such specialists by consultation. The director of newborn services shall be responsible for ensuring that medical care is provided for all newborns.	The newborn services director is responsible for providing or assigning medical responsibility for newborns who arrive at the facility without a physician assigned to their care. The medical staff should give the director of the newborn nursery authority to act in emergency situations which are not covered by written policy, for the benefit of the patient, when the responsible physician is not available.
3412	3. The perinatal nurse manager shall be a licensed registered nurse with education and demonstrated knowledge and experience in perinatal nursing;	
3413	(b) **Delivery of Basic Maternal and Newborn Services.**	
	1. **Staffing Plan.** The hospital shall follow a staffing plan that ensures the availability of appropriate numbers of qualified staff for the perinatal services offered, according to generally accepted standards of practice and state licensing regulations.	Current standards can be found in the current editions of *Guidelines for Perinatal Care* prepared and published jointly by the American College of Obstetricians and Gynecologists (http://www.acog.org/), and the American Academy of Pediatrics (http://www.aap.org/).
3414	(i) **Staffing for the Labor and Delivery Area.** For the delivery of newborns, the hospital shall provide for at least the following:	

3414 cont	(I) A birth attendant, who may be an obstetrician, a physician with obstetrical privileges, or a certified nurse midwife who has been granted clinical privileges in accordance with these rules, present at the hospital or immediately available by telephone and able to be on-site within thirty (30) minutes;	Certified nurse midwives may only manage low-risk deliveries, and only then following the stipulations of their practice agreements. Such practice agreements may not exceed their allowable practice under state professional licensing laws.
3415	(II) A registered nurse present to assist with each delivery;	The documentation of the education, training, and competency evaluation for neonatal resuscitation should be in the personnel file for any staff member used for this function.
3416	(III) An individual credentialed in neonatal resuscitation to be present in the delivery room for each delivery for the purpose of receiving the newborn;	Examples of support staff would be LPNs, OB technicians, and others sufficiently qualified to assist with deliveries.
3417	(IV) For Cesarean deliveries, an additional physician or certified nurse midwife, a registered nurse, or a surgical assistant or technician, able and qualified to assist with a Cesarean section, on-site or able to arrive in sufficient time to accommodate the time limit for emergency Cesarean section of thirty (30) minutes from the physician's decision to operate to the initial incision; and	Non-emergency Cesarean section procedures do not require the thirty-minute time limit, but these practitioners must be available in a timeframe to accommodate that window should the need arise.
3418	(V) Professional staff qualified to administer anesthesia, on-site or able to arrive in sufficient time to accommodate the time limit for emergency Cesarean section of thirty (30) minutes from the physician's decision to operate to the initial incision.	This may be a physician or a certified nurse anesthetist.
3419	(ii) **Staffing for the Newborn Nursery.** The hospital shall provide for at least:	
	(I) A qualified registered nurse with experience or training in the care of newborns to supervise and be responsible for the quality of nursing care given to newborns, for nursing in-service programs in nursery issues, for assisting the director of the newborn nursery in carrying out his or her duties, and for the maintenance of the nursery records. In hospitals with more than 500 deliveries per year, this individual shall not be assigned additional administrative responsibilities;	
3420	(II) A licensed nurse on duty in the nursery at all times in hospitals with a daily newborn nursery census greater than ten (10) newborns; and	This licensed nurse, without supervisory duties, may be a RN or a LPN.

3421	(III) A staff member trained in newborn service provision present in the newborn nursery when it is occupied by any newborn.	This staff member/attendant shall not be assigned any administrative responsibilities, so that they are free to be attentive to the needs of the newborn(s).
3422	2. The directors of obstetrical and newborn services shall develop and implement written policies, procedures, and guidelines for the services that reflect current standards of practice and address at least:	Current standards can be found in the current editions of *Guidelines for Perinatal Care* prepared and published jointly by the American College of Obstetricians and Gynecologists (http://www.acog.org/), and the American Academy of Pediatrics (http://www.aap.org/).
	(i) Admission criteria for the services based on the level of service provided;	
3423	(ii) Guidelines and mechanisms for specialty consultations and transfer for high-risk patients whose needs exceed the range of services offered at the hospital;	For necessary transfers, either pre- or post-partum for the mother and/or for the high-risk newborn, policies, procedures, and guidelines should address pre-transport stabilization, access of appropriate transportation, and communication between the referring and receiving physicians.
3424	(iii) The orientation program for maternal and newborn services staff;	
3425	(iv) Patient care requirements for mothers and newborns, including but not limited to nursing assessments, gestational age assessment, newborn assessments including Apgar scoring immediately after delivery, assessment and management of nutritional needs including feedings for the newborn whether normal or gavage, umbilical and circumcision care, assessment of thermoregulation by the newborn, prevention of blindness, hypoglycemia, and hemorrhagic disease for the newborn, use of appropriate prophylaxes, patient monitoring needs, and assessment of educational needs of the mother;	Guidelines for routine vital signs, recording pertinent observations, the regulation of oxygen administration and concentration, should all be included in the care requirements. Current standards of care suggest that for the neonate whose Apgar score at five minutes after delivery is less than 7, repeat Apgar determination should be made every five minutes until the score is 7 or greater, or until twenty minutes have elapsed.
3426	(v) Procedures for a family-centered environment (rooming-in) as an option for each patient unless contraindicated by the medical condition of the mother or infant or unless the hospital does not have sufficient facilities to accommodate all such requests;	

3427	(vi) Room assignments and procedures for traffic control and security, including such security measures as are necessary to limit access to newborns by unauthorized persons and to prevent kidnapping of newborns;	
3428	(vii) Guidelines for the use of anesthetic agents for pain management and the requirements for the qualifications and responsibilities of persons who administer the agents and the required patient monitoring;	
3429	(viii) Guidelines for induction and augmentation of labor and for designation of qualified personnel who must be in attendance during these procedures;	
3430	(ix) Indicators and procedures for vaginal birth after Cesarean section (VBAC);	
3431	(x) Guidelines for indicators and procedures for operative vaginal deliveries;	
3432	(xi) Staffing and procedural guidelines for management of obstetrical and newborn emergencies, including the availability of staff competent to manage such emergencies twenty-four (24) hours per day;	Competency for such emergencies should include demonstrated competency for endotracheal intubation, short-term respiratory support and mask ventilation, and umbilical vessel catheterization.
3433	(xii) Guidelines for the monitoring of newborns during the first twelve (12) hours after birth and until discharge;	The neonate who appears healthy should not need to leave the mother for this period, if the mother opts for a family-centered environment (rooming-in), and if facilities needed for observation are in the mother's recovery or postpartum area and there are adequate nursing personnel to observe and document the status of the neonate. Current standards of care should be reflected in the guidelines, e.g. the guidelines should require that infants be place on their backs to sleep.
3434	(xiii) Procedures for infection control, including isolation procedures, visiting privileges, individualized infant hygiene care, and specific policies regarding the prevention and management of infectious diseases, including but not limited to Hepatitis B, Hepatitis C, Group B Streptococcal infections, tuberculosis, human immunodeficiency virus (HIV), and sexually transmitted diseases;	"Individualized hygiene care" means bathing procedures for infants should not include bathing in common areas, or bathing together.
3435	(xiv) Requirements for newborn screening tests for metabolic disorders and hemoglobinopathies and other screenings, as required by law;	Newborn screening tests required in Georgia are currently defined in the Rules and Regulations from the Division of

3435 cont		Public Health, Chapter 290-5-24-.01 through .03, along with timelines for the administration of the tests. Although not currently required by Georgia law, best practice would be to also provide a hearing screening using auditory evoked potentials or otoacoustic emissions for all newborns prior to discharge. A Best Practice suggestion is to provide Hepatitis B vaccination for the newborn before discharge, per the recommendation of the Advisory Committee on Immunization Practices (ACIP), a committee of the American Academy of Pediatrics.
3436	(xv) Procedures for continuous and unquestionable identification of newborns;	
3437	(xvi) Procedures for completing birth and death certificates in accordance with Georgia's official vital records registration system; and	
3438	(xvii) Guidelines for discharge for mothers and newborns, including early discharge, and for assessment of education and other discharge needs;	Insurers in Georgia are required to provide for a minimum hospital stay of 48 hours following a normal vaginal delivery and 96 hours following a normal cesarean delivery. The decision for earlier discharge must be made by medical personnel or a midwife after consultation with the mother (reference O.C.G.A. Section 33-24-58.2, the Georgia "Newborn Baby and Mother Protection Act"). Hospital guidelines for discharge should reflect this law. Best practice guidelines for criteria for discharge can be found in the references previously cited from the American Academy of Pediatrics and the Georgia Council on Maternal and Infant Health.
3439	(c) **Physical Environment for Maternal and Newborn Services.**	The design and construction of the areas are reviewed as a part of the initial permitting process by the architect at the Division of Health Planning, since the services are listed in the scope of services at the time the application for permit is submitted. This review will assure that the physical facilities meet the current "*Guidelines for Design*

3439		*and Construction of Hospital and Healthcare Facilities"* from the American Institute of Architects, as required for the rest of the hospital. The requirements listed in these rules are specific to the maternal and newborn area and may not have been reviewed at that time.
	1. Obstetrical and newborn service areas shall be located, arranged, and utilized so as to provide for every reasonable protection from infection and from cross-infection. The physical arrangements shall separate the obstetric patients from other patients with the exception of non-infectious gynecological patients.	Arrangement to prevent infection would include provision of scrub sinks as necessary with other than hand controls, separate clean and dirty utility rooms, janitor's closets with dedicated sink and equipment, separate clean and dirty linen storage or bins, and all other requirements of this chapter for maintenance of a clean and sanitary environment.
3440	2. Rooms used for patients in labor shall be located with convenient access to the delivery room(s). If labor rooms also serve as birthing rooms, the rooms shall be equipped to handle obstetric and neonatal emergencies.	Patients in labor should not have to cross other patient areas to reach the delivery room.
3441	3. Delivery suites shall be used for no purpose other than for the care of obstetrical patients. Each room shall have the necessary equipment and facilities for infection control and for the management of obstetric and neonatal emergencies. Delivery suites shall be designed to include an anesthesia supply and equipment storage room and a communication system to ensure that emergency back-up personnel can be summoned when needed.	
3442	4. A newborn stabilization area shall be located within each delivery room or birthing room and shall be equipped with oxygen and suction outlets.	The newborn stabilization area may be a mobile unit which can be moved from room to room.
3443	5. The newborn nursery shall have an air temperature maintained at 75-80 degrees Fahrenheit, with a relative humidity of thirty percent to sixty percent (30% - 60%).	Though these temperature/humidity requirements are for the nursery area only, best practice would be to implement systems for monitoring the body temperatures of newborns who are in family-centered environments (rooming-in), so that appropriate adjustments can be made in those room temperatures.
3444	6. Air from other areas of the hospital shall not be recirculated into the newborn nursery. Ventilation of the nursery suite(s) shall provide the equivalent admixture of a minimum of	Seven (7) recirculation changes of inside air are permitted if there are filters having ninety percent (90%) efficiency

3444 cont	six (6) total air changes per hour.	installed in the ventilation system and this efficiency is maintained.
3445	7. Life-sustaining nursery equipment and lighting for the nursery areas shall be connected to outlets with an automatic transfer capability to emergency power.	
3446	8. Each labor room, delivery room, birthing room, and nursery station shall be equipped with sufficient power outlets to handle the equipment required for the provision of patient care without the use of extension cords, "cheater" plugs, or multiple outlet adapters, which are prohibited;	The prohibition extends to "rated" extension cords.
3447	(d) **Clinical Laboratory, X-Ray, and Ultrasound Services.** Diagnostic support services such as laboratory, x-ray, and ultrasound, shall be available on an on-call basis, with the capability to perform studies as needed for maternal and newborn care; and	Best practice would be to have micro-technique capability. Needed diagnostic studies must be available within necessary timelines; for instance, basic lab work should be available within one hour.
3448	(e) **Records Requirements.**	
	1. The medical record for each maternity patient shall be maintained in accordance with Section 290-9-7-.18 of these rules, with the following additions:	
	(i) The medical record for each maternity patient shall contain a copy of the patient's prenatal records, submitted at or before the time of admission;	When a patient presents to the emergency room for an unanticipated delivery, the emergency staff shall document efforts to obtain as much prenatal information as possible. For example, attempts should be made to reach the patient's prenatal care provider to obtain the information. For regular deliveries, the hospital should require that a copy of the prenatal records be submitted by 34 weeks gestation, to allow for adequate risk assessment and for the planning of case management. Best practice: Prenatal information submitted should reflect the ongoing assessments of fetal growth and development, maternal health status during the prenatal period, the patient's blood group and Rh factor, the presence of irregular antibodies or Hepatitis B surface antigens, the results of testing for sexually transmitted

3448 cont		diseases or other diagnostic tests during pregnancy, and HIV status.
3449	(ii) The admission data shall include the date and time of notification of the birth attendant, the condition on admission of the mother and fetus, labor and membrane status, presence of bleeding, if any, fetal activity level, and time and content of the most recent meal ingested; and	
3450	(iii) Labor and postpartum care notes shall be included.	
3451	2. The medical record for each newborn shall be cross-referenced with the mother's medical record and shall contain the following additional record information:	
3452	(i) Physical assessment of the newborn, including Apgar scores, presence or absence of three cord vessels, and vital signs;	
3453	(ii) Accommodation to extra uterine life including the ability to feed and description of maternal-newborn interaction;	
3454	(iii) Treatments and care provided to the newborn to include the specimens collected, newborn screening tests performed, and appropriate prophylaxes;	
3455	(iv) The infant's footprint and mother's fingerprint, or comparable positive newborn identification information; and	
3456	(v) Report of the physical examination of the newborn prior to discharge, performed by an appropriately credentialed physician, physician's assistant, nurse practitioner, or nurse midwife.	
3457	3. The hospital shall maintain a register of births, in which is recorded the name of each patient admitted for delivery, the date of admission, date and time of birth, type of delivery, names of physicians or other birth attendants, assisting staff and anesthetists, the sex, weight, and gestational age of the infant, the location of the delivery, and the fetal outcome of the delivery.	
3458	4. The hospital shall maintain annual statistics regarding the number of births and number of infant deaths. Death statistics for infants shall include birth weights, gestational ages, race, sex, age at death, and cause of death.	

3459	(4) **Intermediate Maternal and Newborn Services.** The hospital offering intermediate maternal and newborn services shall offer comprehensive care for women with the potential or likelihood for only certain pre-defined high-risk complications and with anticipated delivery of a newborn at greater than thirty-two (32) weeks' gestation and birth weight greater than 1500 grams who are anticipated to have only such medical conditions which can be expected to resolve rapidly. The maternal and newborn service shall meet all of the requirements for provision of the basic services as described above in these rules, with the following additions or exceptions:	The hospital providing this level of service defines in their description of the scope of the service which specific pre-determined high-risk maternal complications it is equipped and staffed to handle, and the admission criteria for the maternal and newborn services should reflect these specific conditions. It is recognized that the ability of the facility to manage the condition may vary according to the severity of the complication with any individual patient. With the required agreements in place for higher levels of care, the hospital should be prepared by policy and admission procedures to adjust expectations for admission based on the patient's condition.
3460	(a) **Organization of Intermediate Maternal and Newborn Services.**	
	1. The director of obstetric services shall be a member of the medical staff who is a board eligible or board certified obstetrician or board eligible or board certified maternal-fetal medicine specialist; provided, however, within five (5) years from the effective date of these rules, the director of obstetric services shall be a board certified obstetrician or board certified maternal-fetal medicine specialist.	
3461	2. The director of newborn services shall be a member of the medical staff who is a board eligible or board certified pediatrician or board eligible or board certified neonatologist; provided, however, within five (5) years from the effective date of these rules, the director of newborn services shall be a board certified pediatrician or board certified neonatologist.	
3462	3. A board eligible or board certified neonatologist shall be available to participate in care for the neonates.	Availability may be by telephone, but there should be evidence of consultation, referrals, and participation by the neonatologist in the intermediate nursery.
3463	4. The perinatal nurse manager shall be a licensed registered nurse with training and demonstrated knowledge and experience in care of high-risk maternal care and moderately ill newborns.	
3464	5. When a neonate is on mechanical ventilation or when a high-risk maternity patient is being managed, a respiratory therapist, certified lab technician/blood gas technician, and an x-ray technologist shall be on-site and available to the maternal and newborn services area on a twenty-four (24) hour basis.	

3465	6. If the facility offers care for newborns requiring parenteral support, a licensed dietitian and a licensed pharmacist with parenteral experience shall be on staff.	
3466	(b) **Delivery of Intermediate Maternal and Newborn Services.** Service delivery shall meet the requirements of the basic maternal and newborn services, with the following additions or exceptions:	
	1. The hospital shall provide care for expectant mothers and newborns requiring the basic level of maternal and newborn services, as well as for those requiring an intermediate level of care;	
3467	2. Portable x-ray and ultrasound equipment and services shall be available on a twenty-four (24) hour basis;	
3468	3. The intermediate level nursery shall provide care to neonates expected to require no more than short-term mechanical ventilation or parenteral support. Such support, if needed for more than forty-eight (48) hours, shall be authorized daily by the consulting neonatologist, or the neonate shall be transferred to a facility with a higher (intensive) level of care; and	As appropriate, the intermediate level nursery may be expected to provide care for moderately ill newborns with conditions that are expected to resolve quickly, or for neonates who have been stabilized and are eligible for discharge from the intensive-level nursery but continue to require monitoring.
3469	4. Written policies, procedures, protocols, and guidelines shall reflect the pre-defined level of care provided. Criteria for admission to and discharge from the intermediate level nursery shall be defined in the written policies and procedures.	
3470	(c) **Physical Environment for Intermediate Maternal and Newborn Services.** The physical environment shall meet the requirements of the basic maternal and newborn services, with the following additional requirements:	
	1. There shall be provided in the intermediate level nursery sufficient space between each patient station to allow for easy access for staff and visitors on three (3) sides of the patient bed and to allow for easy access with portable diagnostic and support equipment as may be required;	Best practice would be to provide at least 3- 4 feet of space on either side of each bassinette or isolette, with wider aisles down the center of the nursery.
3471	2. Each patient station in the intermediate level nursery shall have at least two (2) oxygen outlets, two (2) compressed air outlets, and two (2) suction outlets;	
3472	3. There shall be adequate lighting provided for patient care while avoiding extra	Ambient lighting levels optimally should be adjustable

3472 cont	illumination of adjacent neonates; and	through a range, to provide for lower levels when bright lighting is not needed. Light sources should have controls that allow for immediate darkening of any bed position, sufficient for transillumination. Special procedure lighting should be available to each patient care position.
3473	4. The patient bed areas shall be designed to minimize the impact of noise on the infants.	Peak noise levels are recommended to be below 95dB, with a mean level below 75dB.
3474	(5) **Intensive Maternal and Newborn Services.** The hospital offering an intensive level of maternal and newborn services shall provide services for normal and high-risk maternal, fetal, and newborn conditions. The hospital providing the intensive level of services shall meet all requirements for basic and intermediate maternal and newborn services, with the following additions and/or exceptions:	
3475	(a) The director of intensive obstetric services shall be a member of the medical staff who is a board certified obstetrician or board certified maternal-fetal medicine specialist;	
3476	(b) The director of intensive newborn services shall be a member of the medical staff who is a board certified pediatrician or board certified neonatologist.	
3477	(c) The hospital shall have on call, on a twenty-four (24) hour basis, a board certified obstetrician or maternal-fetal medicine specialist to provide on-site supervision and management of maternal patients;	
3478	(d) The hospital shall have available for consultation a maternal-fetal medicine specialist;	
3479	(e) The hospital shall have on call, on a twenty-four (24) hour basis, a board certified neonatologist to provide on-site supervision and management of neonates;	
3480	(f) The hospital shall provide pediatric subspecialties on staff or have a mechanism to provide consultation and care from pediatric subspecialties in a timely manner;	The hospital may have arrangements for consultation and transfer with other facilities offering intensive level maternal and newborn services whose subspecialty staff have expertise beyond that available in the hospital. The hospital should have access to the subspecialties of genetics and endocrinology as well as a full range of pediatric subspecialties such as pediatric surgery,

3480 cont		pediatric cardiology, pediatric neurology, pediatric hemotology, pediatric nephrology, etc.
3481	(g) The nursery manager of the intensive care nursery shall have demonstrated knowledge, training, and experience in neonatal intensive care nursing and shall have a dedicated assignment to the intensive care nursery;	
3482	(h) The hospital shall have on staff pharmacology personnel competent in perinatal pharmacology. Total parenteral nutrition shall be available; and	
3483	(i) The hospital shall have on staff a licensed physical therapist or occupational therapist and a licensed dietitian with training and experience in neonatal care. Authority O.C.G.A. Sec. 31-7-2.1.	
3500	**290-9-7-.35 Pediatric Services.** Any hospital providing care to infants and children shall have facilities, equipment, and policies and procedures specific to the provision of services for pediatric patients.	
3501	(a) Hospital policies shall define the ages of patients considered to be appropriate for pediatric services and the scope of services to be provided to them.	This is typically through age 14 years, but may extend through age 17 years.
3502	(b) Staff providing services to pediatric patients shall have experience and training in serving the pediatric population and shall have documented in-service training at least annually on age-specific care issues for the pediatric population served by the hospital.	This rule applies to all staff providing healthcare services, including rehab, lab, x-ray, surgery, and anesthesia staff. Annual training may include general topics such as review of developmental milestones, or the contrast of social and emotional needs of children at different ages, or topics more specific to a service area, such as new techniques for service delivery specific to different age children.
3503	(c) Protocols for screening and assessment of pediatric patients shall be approved by the medical staff and shall be individualized for the age and presenting signs and symptoms of the patient. In addition to the screening and assessment information required for all patients, the general screening and assessment protocol for pediatric patients shall include at a minimum:	There should be specific assessment protocols for age groups. Screening protocols for emergency services may differ from other admission assessment protocols. Best practice for medical screenings and assessments would be the use of protocols established by the American Academy of Pediatrics. Specialized assessments, such as OT, PT, Speech Pathology or other rehab services, should also be specifically designed for the pediatric patient.

3503 cont	1. Chronological age, weight, and length or height;	Age and weight are critical as a basis for medication dosage, intake and output measurements, and assessment of nutritional needs.
	2. For infants and young children, a measurement of head circumference;	Head circumference can be important to diagnosis in infants and very young children, but may not be necessary as children grow older.
	3. Immunization history;	
	4. A statement as to the developmental age and growth of the child as related to established norms; and	
	5. Family relationships, including expected family involvement during treatment.	
3504	(d) The hospital shall establish and implement policies and procedures to prohibit access to pediatric patients by unauthorized persons and to prevent kidnapping or elopement of pediatric patients.	Contracts with parents to provide some oversight to children are reasonable.
3505	(e) The hospital shall provide space and equipment to allow for visitation of family members in the patient rooms and to allow for overnight stay of a parent or guardian where the parent or guardian's presence does not interfere with the course of treatment. The pediatric patient's medical record shall clearly indicate persons who are not permitted to visit the pediatric patient.	
3506	(f) Medical supplies and equipment including emergency equipment appropriate to the size and age of the pediatric patient shall be available in all areas of the hospital providing services to pediatric patients.	Cribs, pediatric beds, beds with locking side rails, etc. should be provided as appropriate. Pediatric beds should not be used with adolescents. Adult supplies should not be used with pediatric patients unless the size of the patient makes such use appropriate.
3507	(g) The phone number for the Poison Control Center shall be available in a conspicuous place in the pediatric service area(s).	
3508	(h) Where pediatrics is provided as an organized service, there must be a qualified physician member of the medical staff with experience or training in pediatrics assigned	

3508 cont	responsibility for directing the clinical aspects of organization and delivery of all pediatric services provided by the hospital. The pediatric medical director shall be responsible for monitoring the quality and appropriateness of pediatric services in coordination with the hospital's quality management program and for ensuring that identified opportunities for improvement are addressed.	
3509	(i) Hospitals providing services to pediatric patients as an organized service shall have space, facilities, and appropriately sized equipment for providing those services apart from adult patient rooms and newborn units and shall provide for regular and routine cleaning of play equipment in the pediatric area according to protocols established for that purpose by the hospital's infection control program. Authority O.C.G.A. Sec. 31-7-2.1.	Play equipment used by a patient should be cleaned at least prior to use or availability for use by another patient. Play equipment not cleaned after use should be stored in a location inaccessible to other children.
3600	**290-9-7-.36 Dialysis Services.** If the hospital provides acute inpatient dialysis services or outpatient services either directly or through contract arrangements, the scope and organization of those services shall be defined.	
3601	(1) **Organization and Administration of Renal Dialysis Services.** The hospital shall have an organizational plan for dialysis services which clearly defines lines of authority, responsibility, and accountability and which includes provision for adequate staffing to provide dialysis care according to generally accepted standards of practice.	The organizational plan shall indicate if the services will be provided directly by hospital staff or by a contracted service. If services are provided by a contract, the plan must specify how the coordination of patient care will be accomplished.
3602	(a) **Medical Director.** The medical director for dialysis services shall be a physician member of the medical staff qualified to provide oversight to the specialized care required for dialysis patients and the medical director shall have at least one-year's experience in care for patients with end stage renal disease.	This requirement applies to medical directors for contracted services or medical directors of acute inpatient dialysis units.
3603	(b) **Nursing Services.** A registered nurse with demonstrated clinical competencies in providing dialysis services for patients shall be available during all dialysis treatments. Nursing staff and dialysis care technicians providing dialysis services shall have evidence of education, training, and demonstrated competencies in the provision of appropriate dialysis services and emergency care of patients receiving dialysis.	If the hospital provides dialysis services by contract only, the qualified nurse may be available by phone. However, nursing staff at the hospital must be competent to assist in emergency situations related to dialysis.
3604	(c) **Policies and Procedures for Dialysis Services.** Where the hospital provides dialysis services directly to its patients, the hospital shall develop and implement policies and procedures that address the special needs of dialysis patients and shall include at least the following:	

3604 cont	1. Maintenance of dialysis equipment;	
	2. Water treatment system safety;	The testing of chlorine/chloramine, water quality, and cultures should be addressed related to frequency and process.
	3. Infection control;	Procedure should address screening for HBV, water cultures, and access infections.
	4. Reuse of dialyzers and dialysis supplies, if applicable; and	
	5. Care of dialysis patients experiencing common complications of dialysis treatments.	
3605	(d) **Contracted Services.** Where the hospital provides dialysis services through a contract arrangement, the hospital must contract with a Georgia-licensed End Stage Renal Disease Facility. The contract must outline what specific services will be provided and include who will be responsible for the maintenance of the dialysis equipment, the water treatment safety system, infection control, reuse of dialyzers and supplies if applicable, the clinical qualifications of staff to be provided, and the clinical supervision that will be provided to dialysis patients during the administration of dialysis treatments.	
3606	(2) **Appropriate Treatment.** The hospital shall provide dialysis services in accordance with accepted standards of care for the persons requiring dialysis services.	
3607	(3) **Quality Improvement.** The hospital shall ensure that problems identified during the on-going monitoring of the dialysis services are addressed in the hospital quality improvement program. Contracted services must participate in the hospital quality improvement program.	
3608	(4) **Outpatient Chronic Dialysis Services.** A hospital choosing to provide outpatient dialysis services directly as an integral part of the hospital to persons with end stage renal disease on a regularly recurring basis must meet the rules set forth in the Rules and Regulations for End Stage Renal Disease Facilities, Chapter 290-9-9, which are herein incorporated by reference, except for .03, .04, and .19. Authority O.C.G.A. Sec. 31-7-2.1.	
3700	**290-9-7-.37 Psychiatric and Substance Abuse Services.** If the hospital provides psychiatric and/or substances abuse treatment services as an organized service**,** the scope of	A hospital providing primarily or solely psychiatric treatment services may be classified by the Department as

3700 cont	those services, including whether the services are provided for inpatients, outpatients, or both, shall be defined in the hospital's application for permit and meet the requirements set forth in this section and generally accepted standards of care.	a specialized hospital. Psychiatric hospitals must meet the rules and regulations for all hospitals, with the exception of rules for optional services not provided by the psychiatric hospital, such as surgery or anesthesia. The scope of services offered by the hospital must be clearly indicated on the application.
3701	(1) **Organization and Administration of Psychiatric and Substance Abuse Services.** The hospital shall have a plan for the service which clearly defines lines of authority, responsibility, and accountability and which includes provision for adequate staffing to provide patient care according to generally accepted standards of practice.	Accepted standards of practice for organization and staffing of psychiatric and substance abuse programs would be, for example, guidelines such as those published by the American Nurses Association, the American Psychiatric Association, and the American Society of Addiction Medicine.
3702	(a) **Director of Psychiatric and Substance Abuse Services.** The director of psychiatric and substance abuse services shall be a licensed physician member of the medical staff appropriately trained and qualified to supervise the provision of these services.	The American College of Neuropsychiatry is the Board-certifying body for this specialty area for the American Osteopathic Association. For Medicare purposes, Board eligible or Board certified by the American Board of Psychiatry and Neurology or the American College of Neuropsychiatry, except as allowed in 290-9-7-.36(1)(a) 1 below.
3703	1. If the hospital offers substance abuse services only, the director shall be a licensed physician member of the medical staff certified or eligible for certification in addiction medicine by the American Society of Addiction Medicine or the American Osteopathic Academy of Addiction Medicine or a licensed physician member of the medical staff appropriately trained and qualified to supervise the service. If the director of the substance abuse services meets this certification requirement but is not board certified in psychiatry, the hospital must have a board eligible or board certified psychiatrist on staff to be utilized for psychiatric consultation as needed.	
3704	2. The director of the psychiatric and/or substance abuse services shall be responsible for all clinical aspects of the organization and delivery of services and for the evaluation of the effectiveness of the services in coordination with the hospital's quality management program.	

3705	(b) **Staffing for Psychiatric and Substance Abuse Services.** The hospital shall provide sufficient clinical and support staff to assess and address the needs of psychiatric and substance abuse patients and to ensure the maintenance of a safe therapeutic environment for patients and staff.	Qualifications for all positions serving this program should include requirements for specialized education and training in mental health and/or substance abuse, as applicable to the hospital's scope of services. Positions providing services to children or adolescents should require age-specific competencies for assessment and treatment of those patients.
3706	1. **Nursing Manager/Director.** The nursing care for the psychiatric and/or substance abuse services shall be supervised by a licensed registered nurse with at least three (3) years of clinical psychiatric and/or substance abuse experience. Authorization from the Georgia Board of Nursing to practice as a Clinical Nurse Specialist, Psychiatric/Mental Health may substitute for two (2) years of the required clinical experience.	
3707	2. **Counseling Services.** Counseling services for the psychiatric and substance abuse services shall be supervised by a master's level clinician licensed in social work, marriage and family therapy, professional counseling, or a clinical nurse specialist, psychiatric mental health.	Hospitals that are Medicare-certified, free-standing psychiatric hospitals, and psychiatric units that are Medicare prospective-payment exempt, must have their social work activities supervised by a licensed clinical social worker.
3708	3. **Clinical Psychologist.** A licensed clinical psychologist shall be available to provide testing and treatment consultation for patients as needed.	
3709	4. **Child Psychiatrist.** If psychiatric services are provided for children, a board eligible or board certified child psychiatrist shall be on staff.	
3710	5. **Special Staffing Requirements for Inpatient Psychiatric or Substance Abuse Services.** Hospitals providing inpatient psychiatric and/or substance abuse care shall provide:	
	(i) A physician, with training and qualifications appropriate to the services offered, present in the hospital or available on call on a twenty-four (24) hour basis;	
	(ii) At least one registered nurse on duty at all times; and	
	(iii) Rehabilitative and therapeutic activity staff, trained and qualified to meet the needs of the patients as specified in the patients' individualized service plans.	

3711	(c) **Policies and Procedures for Psychiatric and Substance Abuse Services.** In addition to hospital policies and procedures otherwise required by these rules, the hospital providing psychiatric and/or substance abuse services shall develop and implement policies and procedures that address the special needs of the population served, to include at least: 1. Admission and discharge criteria and procedures, which comply with Georgia laws concerning involuntary admissions or treatment;	See H & P requirements under Patient Care Assessment**.** Admission and discharge criteria should be specific to the area of services needed by the patient. If the hospital handles involuntary as well as voluntary admissions, and/or has a forensic unit, there should be admission and discharge criteria specific to each. If the hospital provides services only to voluntary admissions, there should be procedures in place for the transfer of patients to involuntary admissions when needed. The hospital should be able to demonstrate that criteria are applied as intended and appropriate for each patient. Admission and discharge criteria and procedures must be in compliance with requirements of O.C.G.A. Chapter 37-3 as relates to mentally ill patients and Chapter 37-7 as relates to substance abuse patients.
3712	2. Safety and security precautions for the prevention of suicide, assault, and patient injury;	
3713	3. The handling of medical emergencies, including but not limited to suicide attempt, cardiac arrest, aspiration, or seizures;	
3714	4. Special procedures, such as electro convulsive therapy (ECT) and medical detoxification, as applicable; and	
3715	5. Procedures for the use of seclusion and restraint in accordance with O.C.G.A. Chapters 3 and 7 of Title 37 and these rules.	Hospitals certified to receive Medicare funds must also comply with the Condition of Participation: Patients Rights § 482.13.
3716	(2) **Patient's Rights in Psychiatric and Substance Abuse Services.**	
	(a) In addition to the rights afforded all patients at the hospital, the hospital shall ensure that patients served by the psychiatric and substance abuse shall have the right to: 1. Receive treatment in the hospital using the least restrictive methods possible; and	The determination that a patient is receiving treatment utilizing the least restrictive methods shall be based in the context of ongoing individual patient assessments, interventions, evaluations, and reassessments. When assessments indicate that a restriction is needed for the protection and safety of the patient or others, there should be evidence that the least restrictive methods were

3716 cont		utilized. Additionally, there should be evidence that the restrictions(s) were removed when the behavior(s) causing the safety concerns are no longer present. Locking down a unit initiated as the result of the behavior of one patient would raise serious concerns about whether treatment was being provided to the remainder of the patients in the least restrictive method. Assessments of whether a restraining device should be used on a patient should include how the device would benefit the patient and whether a less restrictive device/intervention could offer the same benefit at less risk to the patient.
3717	2. Participate to the extent possible in the development, implementation, and review of their individualized service plan.	
3718	(b) Any permissible restriction of patient rights by the hospital program shall be imposed only in order to protect the health and safety of the patient or others and shall be temporary. The nature, extent, and reason for the restriction shall be entered into the patient's medical record as a written order by a physician or licensed psychologist and reviewed for necessity as required by state law.	This rule reflects the requirements in the rules and regulations for Patients Rights, Chapter 290-4-6.
3719	(3) **Patient Assessment and Treatment.**	
	(a) In addition to other assessment and treatment procedures otherwise required by these rules, psychiatric and substance abuse service programs at the hospital shall provide:	
	1. For inpatients:	
	(i) With the admission assessments performed within twenty-four (24) hours of admission, a psychiatric or a substance abuse evaluation as indicated by the reason for admission; and	A mental status evaluation in all cases should include an evaluation of suicidal/homicidal potential.
3720	(ii) An individualized service plan, initiated within the first twelve (12) hours after admission and updated as needs are identified through assessments;	
3721	2. For outpatients:	

3721 cont	(i) Within seven (7) days following the initiation of outpatient services, a complete assessment of patient needs, including an evaluation sufficient to identify significant medical conditions which may impact the course of treatment; and	If transferred from an inpatient status, a medical history and physical examination and discharge summary should be on the record and the outpatient facility may rely on the evaluation unless contraindicated.
3722	(ii) Within ten (10) days following initiation of outpatient services, an individualized service plan developed and implemented to address needs identified;	While the hospital is permitted ten days to develop the individualized service plan for outpatient psychiatric patients, an initial care plan must be developed to direct patient care immediately upon admission, based on the information then available, as for all hospital patients.
3723	3. Each patient's individualized service plan shall be developed from the patient's needs as identified through psychological, medical, and social assessment and shall be an organized statement of the proposed treatment process which serves to guide the providers and patient through the duration of the service provision. The service plan shall reflect the following:	Members of the treatment team responsible for the development and implementation of the individualized plan should be clearly indicated in the plan.
	(i) The patient's participation, to the extent possible, in the development of the individualized service plan;	There should be documentation of the patient's participation in the development of the plan, or of the attempts to include the patient in its development.
3724	(ii) Measurable goals and/or objectives to be met toward the established discharge criteria; and	
3725	(iii) Regular review of the patient's progress toward goals and/or objectives in the individualized service plan, with modifications to the plan made in response to progress or lack of progress as reflected in progress notes recorded at each visit which document the patient's status and response to treatment;	
3726	4. At the time of development of the patient's treatment plan and with the participation of the patient, a discharge plan shall be developed for each inpatient or an aftercare plan for each outpatient. The discharge/aftercare plan shall be re-evaluated periodically during treatment to identify any need for revision; and	
3727	5. All medications administered or prescribed for psychiatric or substance abuse patients shall be solely for the purpose of providing effective treatment or habilitation as described in the individualized service plan and/or for protecting the safety of the patient or others and shall not be used for punishment or for the convenience of staff.	This rule mirrors that in the rules and regulations for Client's Rights, Chapter 290-4-9.

3728	(b) If the hospital is not able to meet patient needs as identified, including any acute medical or surgical needs, the hospital shall assist the patient in locating and accessing services to meet those needs, which may include transfer to another facility.	
3729	(4) **Physical Space and Design Requirements for Inpatient Psychiatric and Substance Abuse Services.** Hospitals providing inpatient psychiatric and substance abuse services shall have:	
	(a) At least one seclusion area must be available to be used for the involuntary confinement of patients when necessary. The seclusion area shall be large enough to provide access to the patient from all sides of the bed or mattress and to accommodate emergency life-sustaining equipment, have a door that opens outward, and have provision for direct patient observations at all times by staff;	
3730	(b) A design conforming to the suicide prevention recommendations from the *Guidelines for Design and Construction of Hospital and Healthcare Facilities*, produced by the American Institute of Architects' Academy of Architecture for Health with the assistance of the U.S. Department of Health and Human Services, which are hereby adopted by reference;	These guidelines are published by the American Institute of Architects Press, 1735 New York Ave., NW, Washington, D.C. 20006.
3731	(c) A day room that allows for social interaction, dining, and group therapy activities;	
3732	(d) Space for storage of patient's personal belongings and for securing valuables; and	
3733	(e) A system for summoning help from within the immediate service area or other areas of the hospital in the event of an emergency. Authority O.C.G.A. Sec. 31-7-2.1.	
3800	**290-9-7-.38 Special Requirements for Critical Access Hospitals.** Critical access hospitals (CAHs) shall be required to comply with the entirety of this chapter, as applicable to the scope of services offered, with the following exceptions and/or additions:	
3801	(a) Prior to application for a hospital permit, the hospital shall be approved for critical access hospital status by the Georgia Department of Community Health.	
3802	(b) The CAH shall be a member of a rural health network having at least one (1) additional hospital that furnishes acute care hospital services, which will serve as an affiliate hospital for the CAH**.** The CAH shall have current written agreement(s) with affiliate hospital(s) which include provisions for:	

3802 cont	1. Patient referral and transfer between the facilities, with the use of emergency and non-emergency transportation;	
	2. Credentialing of medical and professional staff; and	
	3. Participation in quality management activities.	
3803	(c) The CAH's organization, scope, and availability of patient care services shall be defined and approved by the governing body, medical staff, and affiliate hospital. The CAH shall have:	
	1. Operational policies for the CAH shall be developed with participation from one (1) or more licensed physicians, one (1) or more healthcare practitioners if on the staff of the critical access hospital, and at least one (1) member of the affiliated hospital's staff who is not on the staff of the CAH;	Healthcare practitioners may be nurse practitioners or PAs. There should be evidence of policy development and review that reflects the participation of at least one licensed physician who is on staff at the CAH and one professional member of the affiliate hospital's staff who is not on staff at the CAH. If the CAH utilizes healthcare practitioners, such as physician assistants or nurse practitioners, there should be evidence that at least one of those healthcare practitioners participated in the development of operational policies. Evidence of participation may include committee meeting minutes or policy approval/sign-off sheets.
3804	2. Operational policies for the CAH which describe the patient care services the CAH will provide directly and those that will be provided through contract or other arrangement;	
3805	3. No more than twenty-five (25) inpatient beds or as currently defined in federal regulations**.** Of these beds, at least two (2), but no more than fifteen (15), shall be used for acute inpatients. If the CAH has approved swing bed services, a maximum of twenty-three (23) beds may be utilized for swing bed patients;	
3806	4. An average length of stay for patients of no more than ninety-six (96) hours or as currently defined in federal regulations;	Currently this "96 hours" is interpreted to be on an annual basis.

3807	5. A mechanism in place to ensure that emergency care is available twenty-four (24) hours per day. The CAH shall not be required to remain open twenty-four (24) hours per day when it does not have inpatients.	
3808	(i) The CAH shall, in coordination with the local emergency response systems, establish procedures under which a physician is immediately available by telephone or radio contact, on a 24-hour per day basis, to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate location for treatment.	
3809	(ii) A physician or limited health care practitioner with training in emergency care shall be on-call and immediately available by telephone or radio contact and available to be on-site at the CAH within thirty (30) minutes.	The on-call schedules must be available to all staff at the critical access hospital.
3810	(iii) The CAH shall have equipment, supplies, and medications available for treating emergencies, as are required of other organized hospital emergency services.	Equipment requirements for emergency services are delineated in rules 290-9-7-.31 (a)2(*v*) *et seq.*
3811	(iv) Staff assigned to provide emergency patient care shall have training in handling medical and non-medical emergencies; and	Training for staff in BCLS and management of routine emergencies should be documented for all staff. Non-medical emergencies include fires, tornado or other disasters, evacuation of patients and cooperation with fire and disaster authorities.
3812	6. A registered nurse or licensed practical nurse shall be on duty whenever the critical access hospital has one (1) or more inpatients. Authority O.C.G.A. Sec. 31-7-2.1.	Staffing schedules should reflect that required staff has been on duty. The physician's assistant on-duty does not satisfy the nursing staff requirement. If the on-duty nurse is a LPN, the hospital must be able to demonstrate how a RN is providing supervision of patient care (as is required by law).
3900	**290-9-7-.39 Physical Plant Design and Construction.**	
	(1) **General.** The hospital shall be designed and constructed in accordance with the needs of the patients being served.	
3901	(a) The design and construction specifications for the hospital shall conform to those nationally accepted standards for hospital design and construction as set forth in the	Currently the Department requires conformance with the standards in *"Guidelines for Design and Construction*

3901 cont	*Guidelines for Design and Construction of Hospital and Healthcare Facilities*, published by the American Institute of Architects Press, which have been accepted for use by the Department and which are current, as determined by the Department to be applicable, at either:	*of Hospital and Healthcare Facilities"*, produced by the American Institute of Architects Academy of Architecture for Health with the assistance of the U.S. Department of Health and Human Services. These guidelines are published by the American Institute of Architects Press, 1735 New York Ave., NW, Washington, D.C. 20006.
	1. The time of construction of the hospital when the initial permit was obtained; or	
	2. The time of request for approval for renovation(s) or addition(s) to areas of the hospital which impact patient care.	
3902	(b) Compliance with standards acceptable to the Department shall be determined by a state architect designated by the Department to review hospital design and construction specifications.	
3903	1. All parts of the facility shall be subject to the architect's review, including new and existing buildings, additions, alterations, or renovations to existing structures, any mobile, transportable, or relocatable units, and any off-site structures intended to house hospital services or functions.	There may be some structures of a hospital complex, such as parking areas or buildings used solely for administrative functions, which would not be included in the architect's review.
3904	2. The hospital shall notify the Department prior to initiating new construction, modifications, or additions and shall submit plans for such new construction for review and approval by the state architect designated by the Department.	If the hospital requests approval for a renovation or addition, only that portion of the hospital involved in the project would be subject to additional review by the architect. If the project will impact the number of patient beds available, the Department should be notified of this impact and its expected duration. Maintenance activities, such as repainting, flooring repair, etc., would not require approval. If there is a question about whether a particular activity would require approval by the architect, the Department should be contacted for clarification.
3905	(c) The hospital shall have evidence of a satisfactory inspection of all buildings and	Mobile or transportable structures used to provide hospital

3905 cont	structures, including any mobile units, by the local representative of the state fire marshal, the local fire and building authorities (where required by local ordinance), and the state architect.	services are included in the requirement for inspection by the Fire Marshal's office. The current applicable *Life Safety Code*® is found in NFPA 101®.
3906	(d) Designated space for the laundry, power plant, mechanical equipment, ambulance entrance, autopsy or morgue, loading dock, incinerator, garbage can cleaning, and storage areas for garbage and trash shall be constructed or arranged to avoid unreasonable noise, steam, odors, hazards to patients, and unsightliness relative to patient bedrooms, dining rooms, and lounge areas.	
3907	(e) Electrical, mechanical, and plumbing work and equipment shall be designed and installed in accordance with local and state ordinances.	For a copy of "Georgia's Mandatory Minimum Standard Codes" contact the Ga. Dept. of Community Affairs, (404) 679-3118.
3908	(2) **Special Requirements for Mobile, Transportable, and Relocatable Units.** If the hospital utilizes, by ownership or contract, mobile, relocatable, or transportable units for the provision of hospital services, the units shall meet the following requirements:	
	(a) If the unit is used to provide routine ancillary services for hospital inpatients or to provide services for the hospital emergency room, there shall be a covered or enclosed walkway from the hospital to the unit to ensure patient safety from the outside elements;	"Routine" services would be those services used or arranged for on a regular basis, as opposed to those used, for example, to fill-in while a hospital's own equipment is being repaired. Enclosure of walkways should be sufficient to protect patients from extreme temperatures or precipitation. The distance traveled through the corridor may be considered by surveyors in determining if the enclosure is adequate for patient protection.
3909	(b) The unit shall be located so as to prevent diesel or exhaust fumes from the tractor or unit generator from entering the fresh air intake of either the unit or the facility;	
3910	(c) The unit shall have means of preventing unit movement, either by blocking the wheels or use of pad anchors;	
3911	(d) The hospital shall provide waiting areas for the unit and, in close proximity to the unit, patient and staff toilet facilities for use by the staff providing services from the unit and for use by the patients accessing the services in the unit;	
3912	(e) Each unit shall be accessible to wheelchair or stretcher-bound patients;	

3913	(f) The hospital shall provide access to hand washing facilities for staff in the unit, as appropriate to the services provided in the unit and sufficient to allow compliance with the hospital's infection control program;	
3914	(g) The hospital shall have a plan for the handling of emergencies that may occur in the unit. The unit shall be connected to the hospital communication system for access to emergency response services;	Telephone systems or a connection to a PA system would be adequate to fulfill this requirement.
3915	(h) Waste lines to the unit shall be designed and constructed to discharge into an approved sewage system. The hospital shall ensure that back-flow prevention is installed at the point of water connection on the unit;	The waste disposal system must conform to the requirements of the hospital's infection control program, and, as for other hospital waste disposal, conform to OSHA's Bloodborne Pathogen Rule and requirements of the state Environmental Protection Division (Chapter 391-3 of the Administrative Rules).
3916	(i) If stairs are used to access the unit, they shall have stable handrails; and	
3917	(j) The hospital shall ensure that approaches to the unit have adequate lighting for safe negotiation at all hours of operation.	
3918	(3) **Emergency Lighting and Power**. The hospital shall have access to emergency lighting and electrical power meeting the following requirements:	This emergency power source may be internal to the unit. It would not have to be connected to the hospital's emergency power system if contained internally.
	(a) Functioning automatic emergency lighting equipment in all corridors in nursing units and in each operating room, delivery room, emergency room, exit, elevator, and stairway; and	
3919	(b) A functioning emergency electrical system. The emergency electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency and connected within ten (10) seconds through one or more primary automatic transfer switches to all emergency lighting; all alarms; blood banks; nurses' call; equipment necessary for maintaining telephone service; pump for central suction system; and receptacles in operating rooms and delivery rooms, patient corridors, patient rooms, recovery rooms, intensive care nursing areas, and nurseries. All other lighting and equipment required to be connected to the emergency system shall either be connected through the above-described primary automatic transfer switching or shall be subsequently connected through other automatic or manual transfer switching. Receptacles	

3919 cont	connected to the emergency system shall be distinctively marked for identification. Storage-battery-powered lights, provided to augment the emergency lighting during the interim of transfer switching immediately following an interruption of the normal service supply, shall not be used as a substitute for the requirement of a generator. Where fuel is normally stored on the site, the storage capacity shall be sufficient for twenty-four (24) hour operation. Where fuel is normally piped underground to the site from a utility distribution system, storage facilities on the site will not be required. Authority O.C.G.A. Sec. 31-7-2.1.	
4000	**290-9-7-.40 Requests for Waiver or Variance.** A hospital may request a waiver or variance of a specific rule by application on forms provided by the Department. A waiver or variance may be granted in accordance with the following considerations:	
4001	(a) The Department may grant or deny the request for waiver or variance at its discretion. If the waiver or variance is granted, the Department may establish conditions which must be met by the hospital in order to operate under the waiver or variance. Waivers or variances may be granted with consideration of the following:	
4002	1. **Variance.** A variance may be granted by the Department upon a showing by the applicant that the particular rule or regulation that is the subject of the variance request should not be applied as written because strict application would cause undue hardship. The applicant must also show that adequate standards exist for affording protection for the health, safety, and care of patients, and these existing standards would be met in lieu of the exact requirements of the rule or regulation.	
4003	2. **Waiver.** The Department may dispense altogether with the enforcement of a rule or regulation by granting a waiver upon a showing by the applicant that the purpose of the rule or regulation is met through equivalent standards affording equivalent protection for the health, safety, and care of the patients.	
4004	3. **Experimental Waiver or Variance.** The Department may grant a waiver or variance to allow experimentation and demonstration of new and innovative approaches to delivery of services upon a showing by the applicant that the intended protections afforded by the rule or regulation in question are met and that the innovative approach has the potential to improve service delivery;	
4005	(b) Waivers and variances granted by the Department shall be for a time certain, as determined by the Department; and	

4006	(c) Waivers and variances granted to a facility shall be recorded and shall be available to interested parties upon request. Authority O.C.G.A. Sec. 31-2-4.	
4100	**290-9-7-.41 Enforcement of Rules and Regulations.** A hospital that fails to comply with these rules and regulations shall be subject to sanctions and/or permit revocation as provided by law. The enforcement and administration of these rules and regulations shall be as prescribed in the Rules and Regulations for Enforcement of Licensing Requirements, Chapter 290-1-6, pursuant to O.C.G.A. Sec. 31-2-6. Authority O.C.G.A. Sec. 31-2-6.	Copies of the enforcement regulations, which specify types of violations, sanctions to be imposed (including fines, revocation, suspension), and due process requirements for notice, hearings, and appeals, are available from the Department. Rules may also be viewed via the state website, at http://www.ganet.org/rules/.
4200	**290-9-7-.42 Severability of These Rules.** In the event that any rule, sentence, clause or phrase of any of these rules and regulations may be construed by any court or competent jurisdiction to be invalid, illegal, unconstitutional, or otherwise unenforceable, such determination or adjudication shall in no manner affect the remaining rules or portions thereof. The remaining rules or portions of rules shall remain in full force and effect, as if such rule or portions thereof so determined, declared, or adjudged invalid or unconstitutional were not originally a part of these rules. Authority O.C.G.A. Secs. 31-2-1, et seq., and 31-7-1, et seq.	

SURVEY MATERIAL

1. Governing Body Bylaws
2. Minutes of the governing body and its committees, if any.
3. Copy of the hospital's organizational chart.
4. Current contracts or plans for building modifications.
5. Most recent fire inspection reports.
6. Record of fire and disaster drills.
7. Current fire, evacuation and disaster plans.
8. Copy of the hospital's floor plan indicating locations of patient care areas and departments.
9. Diet manual.
10. If food service is contracted, the current contract governing such arrangements.
11. Employee list with job titles.
12. Infection control plan.
13. CLIA Certificate.
14. Medical staff bylaws, rules, and regulations.
15. Minutes of meetings of the medical staff and its committees, if any.
16. Minutes of recent departmental meetings, if any.
17. Current list of medical staff and specialty.
18. Current policy and procedural manuals.
19. List of all contracted services and copies of the contracts.
20. List of all off-site locations that will provide services under hospital permit with their addresses and names of department head.
21. List of all locations that will provide any form of surgery/anesthesia.
22. List of all locations for pharmacies and satellite pharmacies.

23. List of all locations where radiologic services will be performed.

24. List of all locations for satellite dietary kitchens.

25. List of all locations for satellite rehabilitation services.

26. List of all locations for satellite respiratory care services.

27. List of all locations where any procedures will be performed, i.e., nursery, GI Lab, Interventional Radiology, cath lab, etc.

28. Designated contact person for each area, with phone/pager number.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

David A. Cook, Commissioner

Nathan Deal, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia,gov

HEALTHCARE FACILITY REGULATION DIVISION

Initial State Licensure Hospital Application Checklist

Six (6) to eight (8) weeks prior to targeted opening date, submit to Health Care Section of the Healthcare Facility Regulation Division (HFRD) the following:

	Item		Done?
1	From Division of Health Planning (DHP) in the Department of Community Health – copy of Certificate of Need (CON)		
2	From State Architect in Division of Health Planning – Construction Plan Approval Letter		
3	Completed Application for a Permit to Operate a Hospital		
4	Completed Notarized Affidavit(s) RE: Personal Identification **FOR EACH OWNER**		
5	Completed Application and Initial License Fee Coupon with payment as directed on the coupon.		
6	Written request to conduct an initial licensure survey–include date hospital will be ready for survey		
7	Upon Completion (may be faxed):		
	a	Final occupancy approval letter from State Architect	
	b	Statement from the local (city or county) fire safety authority stating that an inspection has been made of the premises and that state and local fire safety requirements have been met and the facility is approved for occupancy.	
	c	Certificate of Occupancy for the hospital	

***NOTE**: All projects are subject to review and approval of the State Fire Marshal's Office, (404) 656-7087, and any local fire and/or building authorities. If you anticipate participating in the Medicare Program, the hospital must meet Federal Life Safety Codes and Conditions of Participation for Medicare. The Code of Federal Regulations, 42 CFR Section 416.44 (b), requires new facilities meet applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association.

For more information, please call, write or logon to the following:

G. Erik Hotton Jr., State Architect
Georgia Department of Community Health
Office of General Counsel
Division of Health Planning
5th Floor, 2 Peachtree Street, NW
Atlanta, Georgia 30303
Phone: 404/656-0457
Fax: 404/656-0654
E-Mail: ehotton@dch.ga.gov

Georgia Department of Community Health
Office of General Counsel
Division of Health Planning
5th Floor, 2 Peachtree Street, NW
Atlanta, GA 30303-3159
404-656-0655
(Fax) 404-656-0654
http://dch.ga.gov/

Info for Design and Construction: http://dch.ga.gov/00/channel_title/0,2094,31446711_32464575,00.html

Acute Care Section
Healthcare Facility Regulation Division
Georgia Department of Community Health
2 Peachtree Street, NW Suite 31.447
Atlanta, GA 30303-3142
404-657-5430
(Fax) 404-657-8934
http://dch.georgia.gov

Health and Human Services Section
Georgia State Fire Marshall's Office
Safety Fire Division
Office of Commissioner of Insurance and Safety Fire
Suite 620, West Tower
2 Martin Luther King, Jr. Drive
Atlanta, GA 30334
404-657-9602
hhs@mail.oci.state.ga.us

STATE OF GEORGIA)
)
COUNTY OF _____)

AFFIDAVIT RE: PERSONAL IDENTIFICATION FOR LICENSURE/REGISTRATION

PERSONALLY APPEARED before the undersigned officer, duly authorized to administer oaths, came the undersigned, who after having been duly sworn, states under oath, the following:

1. That my name is _____and that I am who I say I am;

2. That my address is_____;

3. That I have presented sufficient personal identification to the notary that is true and accurate;

4. That I am legally in the United States of America;

5. That I am applying to the Georgia Department of Community Health, Healthcare Facility Regulation Division, to operate a business/activity that is subject to regulation by the Department of Community Health; and that this affidavit is a material part of the application; and

6. That if the Department subsequently determines that the material information contained in this affidavit is false, I will be in violation of licensing/registration requirements, which may result in revocation of my license or registration.

Sworn to and subscribed before me)
This _____day of _____,___.)
)
)
)_____
_____) Affiant
NOTARY PUBLIC)
STATE OF GEORGIA)

My commission expires:_____.

LIST B

Documents That Establish Identity

For individuals 18 years of age or older

- Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
- ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address (including U.S. Citizen ID Card [INS Form I-197] and ID Card for use of Resident Citizen in the U.S. [INS Form 1-179])
- School identification card with photograph
- Voter's registration card
- United States military card or draft record
- Military dependent's identification card
- United States Coast Guard Merchant Mariner Card
- Native American tribal document
- Driver's license issued by a Canadian government authority

Source: http//uscis.gov/graphics/lawsregs/handbook/hand_emp.pdf US Handbook for Employers, page 23.

RULES
OF
DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION DIVISION

CHAPTER 111-8-68
RESIDENTIAL MENTAL HEALTH FACILITIES FOR CHILDREN AND YOUTH

111-8-68-.01 Legal Authority.

These rules are adopted and published pursuant to the Official Code of Georgia Annotated § 31-7-1 *et seq.*

Authority O.C.G.A. Secs. 31-7-1, 31-7-2, 31-7-2.1, 31-7-3. **History.** Original Rule entitled "Legal Authority" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.02 Title and Purposes.

These rules shall be known as the Rules and Regulations for Residential Mental Health Facilities for Children and Youth. The purposes of these rules are to emphasize the programmatic requirements necessary to meet the needs of patients in a safe, therapeutic environment, and to set forth the minimum requirements that Residential Mental Health Facilities for Children and Youth shall meet.

Authority O.C.G.A. Secs. 31-7-1, 31-7-2, 31-7-2.1. **History.** Original Rule entitled "Title and Purpose" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.03 Definitions.

(1) “Abuse” means any unjustifiable intentional or grossly negligent act, exploitation or series of acts, or omission of acts which causes injury to a person, including but not limited to verbal abuse, assault or battery, failure to provide treatment or care, or sexual harassment.

(2) “Administrator” means the person, by whatever title used, whom the governing body has delegated the responsibility for the management and operation of the facility including the implementation of the rules and policies adopted by the governing body.

(3) “Behavior management” means those principles and techniques used by a facility to assist a patient in facilitating self-control, addressing inappropriate behavior, and achieving positive outcomes in a constructive and safe manner. Behavior management principles and techniques shall be used in accordance with the patient’s treatment plan, written policies and procedures governing service expectations, treatment goals, safety, security, and these rules and regulations.

(4) “Board” means the Board of the Department of Community Health.

(5) “Board certified child psychiatrist” means a child psychiatrist who has successfully met the training and experience requirements and passed the examination in child psychiatry by the American Board of Psychiatry and Neurology.

(6) “Board eligible child psychiatrist” means a child psychiatrist who has successfully met the training and experience requirements sufficient to be eligible for the examinations of the board.

(7) “Child care staff” means those staff members who provide direct care to patients twenty-four (24) hours a day under professional supervision.

(8) “Child psychiatrist” means a physician who successfully completed an accredited training program in child psychiatry consisting of two (2) years general psychiatry and two (2) years child psychiatry.

(9) “Department” means the Department of Community Health of the State of Georgia.

(10) “Emergency safety interventions” means those behavioral intervention techniques that are authorized under an emergency safety intervention plan and are utilized by properly trained staff in an urgent situation to prevent a patient from doing immediate harm to self or others.

(11) “Emergency safety intervention plan” means the plan developed by the facility utilizing a nationally recognized, evidence-based, training program for emergency safety intervention. The plan shall clearly identify the emergency safety interventions staff may utilize and those that may never be used.

(12) “Exploitation” means the illegal or improper use of a person or that person’s resources through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for another person’s profit or advantage.

(13) “Governing body” means the treatment facility authority created by the Georgia Hospital Authorities Act, O.C.G.A. § 31-7-72, the board of trustees, the partnership, the corporation, the association, the person or the group of persons who maintain and control the facility. The governing body may or may not be the owner of the properties in which the facility services are provided.

(14) “Hospital” means any institution designed, equipped and staffed to receive two (2) or more persons for diagnosis, treatment and other health services under the supervision of a practitioner for periods continuing twenty-four (24) hours or longer, and in which professional policies are adopted by the governing body after consultation with the active professional staff.

(15) “Manual hold” means the application of physical force, without the use of any device, for the purpose of restricting the free movement of a patient’s body and is considered a form of restraint. A manual hold does not include briefly holding the patient without undue force to calm or

comfort the patient, holding the patient by the hand or by the shoulders or back to walk the patient safely from one area to another where the patient is not forcefully resisting the assistance, or assisting the patient in voluntarily participating in activities of daily living or other functional activities.

(16) “Mechanical restraint” means a device attached or adjacent to the patient’s body that is not a prescribed and approved medical protection device, and that he or she cannot easily remove, that restricts freedom of movement or normal access to his or her body. A mechanical restraint does not include devices used to assist patients with appropriate positioning or posture secondary to physical impairments or disabilities.

(17) “Multidisciplinary staff” means staff of various disciplinary backgrounds who can address the physical, social, mental, educational, recreational and other needs of the patient.

(18) “Neglect” means the absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a person.

(19) “Patient” means any person residing in a treatment facility for the express purpose of receiving diagnostic, treatment or other health services for physical or mental conditions.

(20) “Patient safety interventions” means the safety observations, supervision, and methods developed and implemented by the facility to ensure the safety of patients.

(21) “Patient safety plan” means the plan developed by the facility that outlines the requirements for patient monitoring to ensure the continuous provision of sufficient regular, special, and emergency observation and supervision of all patients twenty-four (24) hours a day.

(22) “Permit” means authorization granted by the department to the governing body to operate a treatment facility and signifies substantial compliance with these rules and regulations.

(23) “Plan of correction” means a written plan submitted by the governing body and acceptable to the Department. The plan shall identify the existing noncompliance of the treatment facility, the proposed procedures, methods, means and period of time to correct the noncompliance.

(24) “Practitioner” means physician, dentist or osteopathic physician authorized to provide care in Georgia.

(25) “Provisional permit” means authorization granted by the department to the governing body to operate a treatment facility on a conditional basis to allow a newly established treatment facility a reasonable but limited period of time to demonstrate operational procedures in substantial compliance with these rules and regulations; or to allow an existing treatment facility a reasonable length of time to comply with these rules and regulations, provided said treatment facility shall first present a plan of improvement acceptable to the department.

(26) “Pharmacist” means any person who is licensed to practice in this State under the provisions of the Georgia Pharmacy Practice Act, O.C.G.A. § 26-4-5.

(27) “Physician” means any person who is authorized to practice medicine in this State under the provisions of the Composite State Board of Medical Examiners, O.C.G.A. § 43-34- 20 et seq.

(28) “Psychiatrist” means a physician who has successfully completed an accredited training program in psychiatry.

(29) “Qualified psychiatric nurse” means a nurse who holds a masters degree in psychiatric nursing from an accredited school of nursing.

(30) “Qualified psychologist” means any person who is licensed to practice in this State under the provisions of the Georgia Board of Examiners of Psychologists, O.C.G.A. § 43-39-1 and who has training and experience in child and adolescent psychology.

(31) “Qualified social worker” means a social worker who has a masters degree in social work from an accredited school of social work.

(32) “Registered Nurse” (R.N.) means any person who holds a current license as a registered nurse issued by the State of Georgia.

(33) “Record(s)” means the individual files established and maintained by a facility which include data concerning a patient.

(34) “Residential mental health facility for children and youth” or “facility” is a sub classification of a “Specialized Hospital” and is defined as a facility providing twenty-four (24) hour care and having the primary functions of diagnosing and treating patients to age twenty-one (21) with psychiatric disorders to restore them to an optimal level of functioning.

(35) “Seclusion” means the involuntary confinement of a patient away from other patients, due to imminent risk of harm to self or others, in a room or an area from which the patient is physically prevented from leaving.

(36) “Shall” means a mandatory requirement.

(37) “Specialized hospital” means any hospital which limits its admissions to persons whose physical or mental disability is of a specific class or type. The department shall use a sub classification which adequately describes the proposed service. This service shall be under the supervision of physicians.

(38) “Supervision” means the continued responsibility of the facility to take reasonable action to provide for the health, safety, and well-being of a patient while under the supervision of the facility or the agent or employee of the facility, including protection from physical, emotional, social, moral, financial harm, and personal exploitation while in care. The facility is responsible for providing the degree of supervision indicated by the patient’s age, developmental level, physical, emotional, and social needs.

(39) “Time out” means a behavior management technique that restricts a patient for a brief period of time to a designated area from which the patient is not physically prevented from leaving, for the purpose of

permitting the patient to de-escalate and for providing an opportunity for the patient to regain self-control.

Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Definitions" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.04 General Policies.

(1) **Application**. An application to operate a licensed facility must comply with the following:

(a) The governing body of the facility shall submit to the department an application for a permit. Such application shall be signed by the executive officer of the governing body.

(b) The application for a permit shall be prepared in duplicate on forms provided by the department. The original copy shall be forwarded to the department and the copy retained by the governing body.

(c) The application for an original permit shall be accompanied by a program narrative of the service or services provided, a copy of the bylaws of the governing body and a copy of the policies and procedures adopted by the professional staff and approved by the governing body.

(d) The application for an original permit shall be submitted to the department not later than thirty (30) days prior to the anticipated date of the opening and commencement of operation of the facility.

(e) Application for change in status of a facility shall be submitted to the department not later than thirty (30) days prior to the effective date proposed.

(f) Proof of ownership and a notarized personal identification form shall accompany the application.

1. Corporations shall submit a copy of their charter and the name and address of all owners with ten (10) percent or more of the stock and shall identify each corporate officer;

2. Non-profit associations and facility authorities shall submit legal proof of the organization, the name and address of each trustee and the office held, if any; and

3. All other types of facilities shall submit the name and address of each person with ownership interests in the facility.

(2) **Permits**. The following requirements pertain to the permit to operate the licensed facility:

(a) The facility must be in substantial compliance with these rules and regulations and the provisions of law which apply to the location, construction and maintenance of treatment facilities and the safety of the patients therein. A permit shall remain in force and effect unless suspended or revoked or otherwise removed as hereinafter provided.

(b) Prior to the issuance of a permit and at the request of the department, the governing body shall furnish the department evidence of compliance with any laws or regulations thereunder applicable to facilities but the enforcement of which is the responsibility of a department or agency of government other than the department.

(c) The permit shall show the classification of the facility, and shall specify the number of beds designated for such treatment facility.

(d) The permit shall be framed and publicly displayed at all times.

(e) Permits are not transferable from one governing body to another, nor valid when the facility is moved from one location to another.

(f) The permit shall be returned to the department when the facility ceases to operate, or is moved to another location, or the ownership changes, or the governing body is significantly changed, or the permit is suspended or revoked.

(g) A permit shall be required for each facility. At the request of the governing body of multi-building facilities, a single permit may be issued to include all buildings provided that each building is in substantial compliance with these rules and regulations.

(3) **Provisional Permits.** The following requirements pertain to the issuance of a provisional permit to operate the licensed facility:

(a) Provisional permits may be granted to the governing body of a new or established facility to demonstrate operational procedures in substantial compliance with these rules and regulations.

(b) A provisional permit may be granted to the governing body of an existing facility to give reasonable time to comply with regulations and standards, which relate to the structural or physical condition of the treatment facility.

(c) Provisional permits granted to allow reasonable time to demonstrate satisfactory compliance with operational procedures shall be limited to periods of not more than six (6) months.

(d) Provisional permits granted to allow reasonable time to correct noncompliances relating to the structural or physical condition of the facility shall be limited to a period of not more than twelve (12) months; provided, however, that the department may extend such period for a period not to exceed another twelve (12) months.

(e) No provisional permits shall be granted to the governing body of a newly established facility which is not in substantial compliance with these rules and regulations, and standards relating to the structural or physical condition of the facility.

(f) A provisional permit shall not be issued when there is noncompliance of any type which present an immediate hazard to the life, health or safety of patients.

(g) No provisional permit shall be granted unless the governing body first presents to the department a plan of correction which shall list each noncompliance to be corrected, the time required to correct noncompliance which relates to the structural or physical condition of the facility and the means, methods and procedures to be used in the correction of the noncompliance.

(h) The governing body shall make periodic reports to the department regarding the progress being made in correcting noncompliance as agreed to by the terms of the plan of correction.

(i) The governing body of a facility operating under a provisional permit may petition the department for an extension of time, if needed, to correct noncompliance where the failure to make such corrections within the time allotted is due to an extenuating circumstance beyond the control of the governing body. Such petition shall be submitted to the department as agreed to by the terms of the plan of correction.

(4) **Patient Capacity**. The number of patients receiving care within the facility shall not exceed the number of residential mental health beds shown on the permit.

Authority O.C.G.A. Secs. 19-7-5, 31-7-2.1, 31-7-3. **History.** Original Rule entitled "General Policies" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.05 Organization and Administration.

(1) **Incorporation**. All facilities shall be incorporated unless operated by a local or state governmental authority. The purpose or function of the facility shall be stated in the charter of incorporation.

(2) **Governing Body**. The governing body must ensure that the following requirements are met:

(a) Every facility shall have a governing body which has responsibility for the overall operation of the facility. Each governing body shall establish and be operated by a set of bylaws and guidelines.

(b) Bylaws or rules and regulations shall be in accordance with legal requirements and shall assure the quality of patient care. They shall also include:

1. a definition of powers and duties of the governing body, its officers and committees;

2. a statement of the qualifications of members, method of selection, numbers and terms of appointments, or election of officers and committees;

3. a determination of frequency of meetings, which shall be at least quarterly, attendance requirements and quorums at meetings;

4. provision for the appointment of a full-time administrator with a description of the qualifications, authority and responsibilities of such a person;

5. provision for the appointment of a clinical director with a description of the qualifications, authority and responsibilities of such a person;

6. a mechanism by which the administrative and clinical staff consult with and report to the governing body;

7. an effective, formal means by which the administrative and clinical staff may participate in the development of the facility's policies relative to both facility management and patient care; and

8. provision to establish rules and regulations that are not limited to, but shall include:

(i) a statement of the regulations by which the clinical staff and administrative staff shall function;

(ii) a requirement that controls are established for insuring that each professional member of the staff will observe all the ethical principles and standards of his profession, and will assume and carry out clinical and/or administrative functions consistent with local, state and federal laws and regulations; and

(iii) a requirement that the evaluation and authentication of psychiatric and medical histories, the performance and recording of physical examinations, and the prescribing of medication be carried out by physicians with appropriate qualifications, licenses and clinical privileges within his/her sphere of authorization.

9. For a facility whose governing body does not solely function in support of the residential mental health facility, then an advisory board shall also be appointed to advise and advocate for the residential mental health program for children and youth. This board's members shall be selected with a broad community representation with specific expertise and/or interest in the mental health of children and youth. The advisory board shall meet at regular intervals, not less often than quarterly.

(3) **Finances**. The facility shall be operated in a fiscally responsible manner and addresses the following:

(a) Each facility shall have a sound plan for financing, which assures sufficient funds to enable it to carry out its defined purposes.

(b) A new facility shall have sufficient funding assured to carry it through its first year of operation.

(c) An accounting system shall be maintained that produces information reflecting fiscal experience and the current financial position of the facility.

(d) The facility shall employ a system of accounting that clearly indicates the cost elements for assessment and therapeutic services for each program.

(e) All accounts shall be audited at least annually by a certified public accountant and the report made a part of the facility's records. A copy of this report shall be made available to the department upon request if the facility is subsidized by state or federal funds.

(4) **Goals, Policies and Procedures.** The facility shall develop and update as necessary, goals, policies and procedures which address the following:

(a) Each facility shall have a clear written statement of its purpose and objectives, with a formal, long-range plan adapted to guide and schedule steps leading to attainment of its projected objectives. This plan shall include a specifically delineated description of the services the facility offers. The plan shall also include:

1. the population to be served, age groups and other limitations;

2. an organizational chart with a description of each unit or department and its services, its relationship to other services and departments and how these are to contribute to the priorities and goals of the facility; and

3. plans for cooperation with other public and private agencies to assure that each patient will receive comprehensive treatment. Ongoing working arrangement contracts with agencies, such as schools and/or welfare agencies, shall be included as indicated, as well as regularly planned interagency conferences, which shall be documented.

(b) The facility shall develop and implement effectively policies and procedures for operations, including but not limited to:

1. the initial screening process;

2. the intake or admission process;

3. the development of treatment plans, including the involvement of the patient, parent(s), and/or legal guardian;

4. the appropriate use of behavior management techniques and emergency safety interventions;

5. the appropriate use of patient safety methods to ensure the continuous provision of sufficient regular, special, and emergency observation and supervision of all patients;

6. the provision of any community education consultation programs; and

7. the provision or arrangement for services required by the patient:

(i) other medical, dental, special assessment and therapeutic services, which shall become a part of the clinical services plan;

(ii) medical emergency services;

(iii) educational services for all patients; and

(iv) discharge and follow-up care and evaluation.

(5) **Personnel**. The facility shall meet the following personnel requirements:

(a) **Composition**. The composition of the staff shall be determined by the needs of the patients being served and the goals of the facility, and shall have available a sufficient number of mental health professionals, child care workers and administrative personnel to meet these goals.

1. The administrator of the facility shall have a master's degree in administration or a professional discipline related to child and adolescent mental health, and have at least three (3) years administrative experience. A person with a baccalaureate degree may also qualify for administrator with seven (7) years experience in child and adolescent mental health care with no less than three (3) year's administrative experience.

2. The clinical director shall be at least board eligible in psychiatry with experience in child and adolescent mental health.

3. If the clinical director is not full-time, then there shall also be a full-time service coordinator who is a professional person experienced in child and adolescent mental health and is responsible for the coordination of treatment aspects of the program.

4. Mental health professionals shall include, but are not limited to, child psychiatrists, qualified psychologists, qualified social workers and qualified psychiatric nurses. These persons, if not on a full-time basis, must be on a continuing consulting basis. The authority and participation of such mental health professionals shall be such that they are able to assume professional responsibility for supervising and reviewing the needs of the patients and the services being provided. Such individuals shall participate in certain specific functions, e.g., assessment, treatment planning, treatment plan and individual case reviews, and program planning and policy and procedure development and review.

5. Other professional and paraprofessional staff shall include, but not be limited to, physicians, registered nurses, educators and twenty-four (24) hour child care staff. Also included on a regular basis, or as consultants on a continuing basis shall be activity therapists and vocational counselors.

6. Consultation shall be available as needed from dietitians, speech, hearing and language specialists, and other therapeutic professionals.

(b) **Organization**. The facility shall have an organizational plan which clearly explains the responsibilities of the staff. This plan shall also include:

1. lines of authority, accountability and communication;

2. committee structure and reporting or dissemination of material; and

3. established requirements regarding the frequency of attendance at general and departmental/service and/or team/unit meetings.

(c) **Policies and Records**. Personnel policies and practices shall be designed, established and maintained to promote the objectives of the facility and to ensure that there are sufficient qualified personnel to provide for the needs, care, safety, and supervision of patients.

1. Each facility shall have written personnel policies covering at least the following areas: job classifications; personnel selection; procedures and requirements for health evaluations; staff orientation and training programs; the maintenance and content of personnel records and, for all persons employed after effective date of these rules, the use of employment and criminal background checks to ensure that the employee has no history of violent or abusive behavior. Each new employee shall be given a copy of personnel practices when hired, including the policy to conduct employment and criminal background checks.

2. All prospective personnel must be checked against state sex offender registries where the applicant has lived since becoming an adult or have satisfactory criminal records check information on file prior to

employment by the facility. The facility shall not hire or retain staff who have a history of violent or abusive behavior.

3. There shall be clear job descriptions for all personnel. Each description shall contain the position title, immediate supervisor, responsibilities and authority. These shall also be used as a basis for periodic evaluations by the supervisor.

4. Accurate and complete personnel records shall be maintained for each employee and include at least the following:

(i) current background information, including the application, employment references, the results of employment and criminal background checks, and any accompanying documentation sufficient to justify the initial and continued employment of the individual and the position for which he was employed. Applicants for positions requiring a license shall be employed only after the facility has obtained verification of the license. Where certification is a requirement, this shall also be verified. Evidence of renewal of a license or certification shall be maintained in the employee's personnel record;

(ii) current information relative to work performance evaluations, including any records of employee discipline arising from the inappropriate use of behavior management techniques and/or emergency safety interventions;

(iii) records of initial, regular, and targeted health screenings, sufficient in scope to ensure that all facility personnel who are employed or under contract with the facility who may have patient contact or are providing patient care services do not have conditions that may place patients or other personnel at risk for infection, injury, or improper care; and

(iv) records of orientation training and any continuing education or staff development programs completed.

(d) **Staff Development**. The facility shall provide and document completion of orientation programs and other staff training.

1. There shall be appropriate orientation and training programs provided for all new employees. Prior to working with patients, all employees, including administrative staff who work with the patients shall complete an orientation program which includes at a minimum instruction in:

(i) the employee's assigned duties and responsibilities;

(ii) facility policies and procedures for receiving and handling family and patient grievances and complaints;

(iii) policies and procedures related to child abuse, neglect and exploitation including reporting requirements.

(iv) policies and procedures regarding appropriate behavior management and emergency safety interventions; and

(v) policies and procedures to protect the confidentiality of patient records.

2. The staff development program shall be facility-based with a designated person or committee who is responsible, on a continuing basis, for planning and insuring that training programs are implemented. The facility shall also make use of educational programs outside the facility.

(6) **Volunteer Program**. When volunteers are utilized in a program, a qualified staff member of the facility shall be designated to plan, supervise and coordinate the volunteer's functions as well as an appropriate training program.

(7) **Research and Human Rights Review**. Research practices involving human subjects shall comply with the State of Georgia agency policy on "Protection of Human Subjects."

(8) **Reporting**. Written summary reports shall be made to the department in a form acceptable to the department within twenty-four (24) hours (with a detailed investigative report to follow in five working days if not provided initially) regarding the following serious occurrences involving patients in care:

(a) Serious injury which causes any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else;

(b) deaths;

(c) suicide attempts;

(d) emergency safety interventions resulting in any injury of a patient requiring medical treatment beyond first aid;

(e) elopements when the patient cannot be located within twenty-four (24) hours or where there are circumstances that place the health, safety, or welfare of the patient or others at risk; or

(f) any incident which results in any federal, state, or private legal action by or against the facility which affects any patient or the conduct of the facility. However, legal action involving the juvenile justice system is not required to be reported.

(9) **Child Abuse Reports**. Whenever the facility has reason to believe that a patient in care has been subjected to abuse, neglect or exploitation, the facility shall make a report of such abuse to the child welfare agency providing protective services as designated by the Department of Human Services (Division of Family and Children Services) or in the absence of such an agency to an appropriate police authority or district attorney in accordance with the requirements of O.C.G.A. § 19-7-5. A copy of the report shall also be filed with the Division of Healthcare Facility Regulation, Department of Community Health.

Authority O.C.G.A. Secs. 19-7-5, 31-7-2.1. **History.** Original Rule entitled "Organization and Administration" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.06 Facilities.

(1) **General Requirements**. The facility shall provide an environment that is therapeutic to and supportive of all the

patients, their healthy development and their changing needs. The therapeutic environment shall take into consideration the architecture of the facility, indoor and outdoor activity areas, furnishings, equipment, decorations and all other factors that involve the physical environment.

(a) Facilities shall be designed to meet the needs of the age group of the patients and the objectives of the program.

(b) Facilities shall be maintained in a safe and clean manner and must meet fire, safety, health and sanitation regulations.

(c) There shall be adequate and appropriate space and equipment for all facility programs and their various functions within the facility.

(d) Facilities shall provide sufficient space and equipment to ensure housekeeping and maintenance programs sufficient to keep the building and equipment clean, tidy and in a state of good repair.

(2) **Disaster Preparedness.** The facility shall prepare for potential emergency situations that may affect patient care by having an effective disaster preparedness plan that identifies emergency situations and outlines an appropriate course of action. The plan must be reviewed and revised at least annually, as appropriate, including any related written agreements.

(a) The disaster preparedness plan shall include at a minimum plans for the following emergency situations:

1. local and widespread weather emergencies or natural disasters, such as tornadoes, hurricanes, earthquakes, ice or snow storms, or floods;

2. man-made disasters such as acts of terrorism and hazardous materials spills;

3. unanticipated interruption of service of utilities, including water, gas, or electricity, either within the facility or within a local or widespread area;

4. loss of heat or air conditioning;

5. fire, explosion, or other physical damage to the facility; and

6. pandemics or other situations where the community's need for services exceeds the availability of beds and services regularly offered by the facility.

(b) There shall be plans to ensure sufficient staffing and supplies to maintain safe patient care during the emergency situation.

(c) There shall be plans for the emergency transport or relocation of all or a portion of the facility patients, should it be necessary, in vehicles appropriate to the patient's condition(s) when possible, including written agreements with any facilities which have agreed to receive patients in these situations.

(d) The facility shall document participation of all areas of the facility in quarterly fire drills.

(e) In addition to fire drills, the facility shall have its staff rehearse portions of the disaster preparedness plan, with a minimum of two (2) rehearsals each calendar year either in response to an emergency or through planned drills, with coordination of the drills with the local Emergency Management Agency (EMA) whenever possible.

(f) The facility shall provide a copy of the internal disaster preparedness plan to the local Emergency Management Agency

(EMA) and shall include the local EMA in development of the facility's plan for the management of external disasters.

(g) The facility's disaster preparedness plan shall be made available to the department for inspection upon request. In addition, when provided with sixty (60) days notice in writing, the department may direct the facility to submit and periodically update the disaster preparedness plan electronically in a format acceptable to the department.

(h) The department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared a state of emergency.

(3) **Construction**. The plan, design and construction of the facility must meet the following requirements:

(a) All plans and specifications for the construction of new facilities shall be approved by the department prior to commencing work on the building. Such construction includes new buildings, additions, alterations, or renovations to existing buildings.

(b) A program narrative shall be submitted prior to or along with the submission of schematic plans for proposed new construction, additions or conversions. The program narrative shall contain information regarding:

1. sponsorship;

2. community needs;

3. program of service;

4. type of construction; and

5. financing for the construction and operation of the facility.

(c) Any individual or group planning construction of a facility shall submit schematic and/or preliminary plans to the department for review and counsel in the interpretation of these rules and regulations. Completed or final plans and specifications shall be submitted for final review and approval; including site, driveways and parking areas, type of construction, mechanical and electrical systems, the type and location of major equipment, the intended use of each room, the proposed system of garbage and refuse disposal.

(d) Plans for additions and/or alterations to an existing building shall be submitted in sufficient detail to include type of construction and layout of the existing building to show overall relationship.

(e) Approved final plans shall not be materially changed without prior approval of such changes by the department.

(4) **Location and Site.**

(a) The site shall be approved by the department; and

(b) The site shall have proper drainage, sewage disposal, water, electrical, telephone and other necessary facilities available to the site.

Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Facilities" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.07 Services.

(1) **Intake and Admission.** Services shall be designed to meet the needs of the patient and must conform to the stated purposes and objectives of the facility.

(a) Acceptance of a child or adolescent for inpatient treatment shall be based on the initial assessment, arrived at by a multidisciplinary team of clinical staff, and clearly explained to the patient, parent(s), and/or legal guardian.

1. Whether the family voluntarily requests services or the patient is referred by the court, the facility shall involve the family's participation to the fullest extent possible.

2. Acceptance of the child or adolescent for treatment shall be based on the determination that the child or adolescent requires treatment of a comprehensive and intensive nature and is likely to benefit by the programs that the residential mental health facility has to offer.

3. Admission shall be in keeping with stated policies of the facility and shall be limited to those patients for whom the facility has qualified staff, program and equipment available to give adequate care.

4. Staff members who will be working with the patient, but who did not participate in the initial assessment, shall be oriented regarding the patient and the patient's anticipated admission prior to meeting the patient. When the patient is to be assigned to a group, the other patients in the group shall be prepared for the arrival of the new member. There shall be a specific staff member assigned to the new patient to observe the patient and help with the orientation period.

5. The admission procedure shall include communication with parent(s) and/or legal guardian, and documentation of such communication, concerning:

(i) responsibility for financial support including medical and dental care;

(ii) consent for medical and surgical care and treatment;

(iii) arrangements for appropriate family participation in the program, phone calls and visits when indicated;

(iv) arrangements for clothing, allowances and gifts;

(v) arrangements regarding the patient leaving the facility with or without medical consent;

(vi) description of the facility's services and the daily routines of patients;

(vii) the facility's policies and procedures for discipline and grievances;

(viii) patient rights; and

(ix) the facility's policy and procedures for the use of emergency safety interventions with written acknowledgment that the patient, parent(s), and/or legal guardian has been informed of these procedures and has been provided a copy of the procedures along with contact information for the Georgia protection and advocacy agency, currently designated as the Georgia Advocacy Office.

6. Decisions for admission shall be based on the initial assessment of the patient made by the appropriate multidisciplinary team of clinical staff. This assessment shall be in writing and recorded on admission. The initial assessment shall clearly indicate the patient's needs as related to the services offered by the facility.

7. The admission order must be written by a physician.

(2) **Assessment and Treatment Planning Including Discharge.** The facility shall provide to families at the time of initial assessment a description of the treatment services it provides,

including content, methods, equipment and personnel involved. Each patient's treatment program must be individualized, and must describe which of the offered services are needed and are to be provided.

(a) **Assessment.** The facility is responsible for a complete assessment of the patient, some of which may be completed prior to admission, by reliable professionals acceptable to the facility's staff. The complete assessment shall include but is not limited to:

1. Physical examination, which includes at least a general physical examination and neurological assessment, performed within twenty-four (24) hours after admission by a licensed physician or a nurse practitioner or physician's assistant working under the direction of a licensed physician who is on staff at the facility. However, in lieu of performing the required physical examination; the staff physician, nurse practitioner or physician's assistant working under direction of the physician may examine and update the patient's physical condition within twenty-four (24) hours after admission where an appropriate physical examination completed by any licensed physician or a nurse practitioner or physician's assistant working under the direction of the licensed physician was performed within forty-eight (48) hours prior to admission.

2. Assessment of motor development and functioning;

3. Dental assessment;

4. Speech, hearing and language assessment;

5. Vision assessment;

6. Review of immunization status and completion according to the U.S. Public Health Service Advisory Committee on Immunization Practices and the Committee on Control of Infectious Diseases of the American Academy of Pediatrics;

7. Laboratory workup including routine blood work and urinalysis;

8. Chest x-ray and/or tuberculin test;

9. Serology;

10. Follow-up testing and/or treatment by appropriately qualified and/or trained clinicians where any of the physical health assessments indicate the need for further testing or definitive treatment with any plans for treatments coordinated with the patient's overall treatment plan;

11. Psychiatric/psychological examination, including but not limited to:

(i) Direct psychiatric evaluation and behavioral appraisal, evaluation of sensory, motor functioning, a mental status examination appropriate to the age of the patient and a psychodynamic appraisal. A psychiatric history, including history of any previous treatment for mental, emotional or behavioral disturbances shall be obtained, including the nature, duration and results of the treatment, and the reason for termination. An initial and ongoing assessment of the patient's potential risks of harm to self and others is also required;

(ii) Appropriate psychological testing;

(iii) An initial and ongoing assessment of the need for safety supervision and monitoring.

(iv) Developmental/social assessment, including but not limited to:

(I) The developmental history of the patient including the prenatal period and from birth until present, the rate of progress, developmental milestones, developmental problems, and past

experiences that may have affected the development. The assessment shall include an evaluation of the patient's strengths as well as problems. Consideration shall be given to the healthy developmental aspects of the patient, as well as to the pathological aspects, and the effects that each has on the other shall be assessed. There shall be an assessment of the patient's current age, appropriate developmental needs, which shall include a detailed appraisal of his peer and group relationships and activities.

(II) A social assessment including evaluation of the patient's relationships within the structure of the family and with the community at large, an evaluation of the characteristics of the social, peer group, and institutional settings from which the patient comes. Consideration shall be given to the patient's family circumstances, including the constellation of the family group, their current living situation, and all social, religious, ethnic, cultural, financial, emotional and health factors. Other factors that shall be considered are past events and current problems that have affected the patient and family; potentialities of the family's members meeting the patient's needs; and their accessibility to help in the treatment and rehabilitation of the patient. The expectations of the family regarding the patient's treatment, the degree to which they expect to be involved, and their expectations as to the length of time and type of treatment required shall also be assessed.

12. Nursing. The nursing assessment includes, but is not limited to the evaluation of:

(i) Self-care capabilities including bathing, sleeping, eating;

(ii) Hygienic practices such as routine dental and physical care and establishment of healthy toilet habits;

(iii) Dietary habits including a balanced diet and appropriate fluid and caloric intake;

(iv) Responses to physical diseases such as acceptance by the patient of a chronic illness as manifested by his compliance with prescribed treatment;

(v) Responses to physical handicaps such as the use of prostheses or coping patterns used by the visually handicapped; and

(vi) Responses to medications such as allergies or dependence.

13. Educational/Vocational. The patient's current educational/vocational needs in functioning, including deficits and strengths, shall be assessed. Potential educational impairment and current and future educational/vocational potential shall be evaluated using, as indicated, specific educational testing and special educators or others.

14. Recreational. The patient's work and play experiences, activities, interests and skills shall be evaluated in relation to planning appropriate recreational activities.

(b) **Treatment Planning**. An initial treatment plan shall be formulated, written, and interpreted to the staff and patient within forty-eight (48) hours of admission. The comprehensive treatment plan shall be formulated for each patient by a multidisciplinary staff, written, implemented, and placed in the patient’s records within fourteen (14) days of admission. This plan must be reviewed at least monthly, or more frequently to meet the needs of the patients or if the objectives of the program indicate. Review shall be noted in the record. A psychiatrist as well as multidisciplinary professional staff must participate in the preparation of the plan and any major revisions.

1. The initial treatment plan shall be based on screening and initial assessments and shall reflect the reasons for admission, significant problems, and preliminary treatment and medication modalities to be used pending completion of the comprehensive treatment plan.

2. The comprehensive treatment plan shall outline an active treatment program and be based on the assessment of the physical; developmental; psychological; chronological and developmental age; family; educational; vocational; social; and recreational needs of the patient. The reason for admission should be specified as should specific treatment goals, stated in measurable terms, including a projected timeframe; treatment modalities to be used; staff who are responsible for coordinating and carrying out the treatment; and expected length of stay and designation of the person or agency to whom the patient will be discharged. The comprehensive treatment plan shall be reviewed and revised at least monthly or more frequently to meet the needs of the patients.

3. The degree of the patient's family's involvement (parent or parent surrogates) shall be defined in the treatment plan.

4. Collaboration with resources and significant others shall be included in treatment planning, when appropriate.

(c) **Discharge.** Discharge planning begins at the time of admission. A discharge date shall be projected in the treatment plan. Discharge planning shall include a period of time for transition into the community, e.g., home visits gradually lengthened, schools, etc. for those patients who have been in the facility for an extended period of time. The facility shall provide clinical or other patient information as required for the receiving organization to provide appropriate follow-up care.

(3) **Staff Coverage**. There shall be a master clinical staffing plan which provides for the continuous provision of sufficient regular, special, and emergency supervision and observation of all patients twenty-four (24) hours a day to meet their physical, mental, social, and safety needs.

(a) There shall be a registered nurse on duty at all times. Services of a registered nurse shall be available for all patients at all times. An exception may be permitted in facilities having less than a daily average of twenty (20) patients or less than twenty-five (25) beds, in that a registered nurse will not be required to be on duty at all times. In such cases, a licensed practical nurse shall be on duty and shall be assigned responsibility for the care of the patient, and a physician or registered nurse shall be on call and available for emergencies.

(b) A physician shall be on call twenty-four (24) hours a day and accessible to the facility within sixty (60) minutes. The physician's name and contact information shall be clearly posted in accessible places for all staff.

(c) Assessments of staffing needs shall be made on an ongoing basis but minimally every twenty-four (24) hours. Staffing patterns shall be adjusted to meet the assessed needs of patients. Special attention shall be given to times which probably indicate the need for increased direct care, e.g., weekends, evenings, during meals, transition between activities, awaking hours, numbers of patients requiring special observations, etc.

(d) Staff interaction shall ensure that there is adequate communication of information regarding patients, e.g., between working shifts or change of personnel, with consulting professional staff at routine planning and patient review meetings, etc. These shall be documented in writing.

(4) **Program Activities**. Program goals of the facility shall include those activities designed to promote the "normal" growth and development of the patients, regardless of pathology or age level. There should be positive relationships with general community resources, and the facility staff shall enlist the support of these resources to provide opportunities for patients to participate in normal community activities as they are able. All labeling of

vehicles used for transportation of patients shall be such that it does not call unnecessary attention to the patients.

(a) **Group Size.** The size and composition of each living group shall be therapeutically planned and depend on the age, developmental level, sex and clinical conditions. It shall allow for appropriate staff-patient interaction, security, close observation and support.

(b) **Daily Routine.** A basic routine shall be delineated in a written plan which shall be available to all personnel. The daily program shall be planned to provide a consistent well structured yet flexible framework for daily living and shall be periodically reviewed and revised as the needs of individual patients or the living group change. A basic daily routine shall be coordinated with special requirements of the patient's treatment plan.

(c) **Social and Recreation Activities.** Programs of recreational, physical, and social activities shall be provided for all patients for daytime, evenings, and weekends, to meet the needs of the patients and goals of the program. Programs should be designed to assist patients to develop a sense of confidence, individuality, self-esteem, and establish appropriate skills for living within the community. There shall be documentation of these activities as well as schedules maintained of any planned activities.

(d) **Religious Activities.** Opportunity shall be provided for all patients to participate in religious services and other religious activities within the framework of their individual and family interests and clinical status. The option to celebrate holidays in the patient's traditional manner shall be provided and encouraged.

(e) **Education.** The facility shall arrange for or provide an educational program for all patients receiving services in that facility. The particular educational needs of each patient shall be considered in both placement and programming.

(f) **Vocational Programs**. The facility shall arrange for or provide some degree of vocational and/or prevocational training for patients in the facility for whom it is indicated.

1. If there are plans for work experience developed as part of the patient's overall treatment plan the work shall be in the patient's interest with payment where appropriate, and never solely in the interest of the facility's goals or needs.

2. Patients shall not be responsible for any major phase of the facility's operation or maintenance, such as cooking, laundering, housekeeping, farming and repairing. Patients shall not be considered as substitutes for employed staff.

3. Adequate attention shall be paid to federal wage and hour laws.

(5) **Nutrition**. Food services must comply with the Rules and Regulations for Food Service, Chapter 290-5-14. There must be a provision for planning and preparation of special diets as needed. Menus shall be evaluated by a consultant dietitian relative to nutritional adequacy at least monthly, with observation of food intake and changes seen in the patient.

(6) **Physical Care**. The facility shall have available, either within its own organizational structure or by written arrangements with outside clinicians or facilities, a full range of services for the treatment of illnesses and the maintenance of general health. The facility's written plan for clinical services shall delineate the ways the facility obtains or provides all general and specialized medical, surgical, nursing and dental services. Definite arrangements shall be made for a licensed physician to provide medical care for the patients. This shall include arrangements for necessary visits to the facility as well as office visits. Each patient shall have a primary physician who maintains familiarity with the patient's physical health status.

(a) Patients who are physically ill shall be cared for in surroundings that are familiar to them as long as this is medically feasible. If medical isolation is necessary, there shall be sufficient and qualified staff available to give appropriate care and attention.

(b) Arrangements shall be made in writing for patients from the facility to receive care from outside clinicians and at appropriate hospital facilities in the event a patient requires services that the facility cannot properly handle.

(c) Every patient shall have a complete physical examination annually and more frequently if indicated. This examination shall be as inclusive as the initial examination. Efforts shall be made by the facility to have physical defects of the patients corrected through proper medical care. Immunizations shall be kept current (DPT, polio, measles, rubella), appropriate to the patient's age.

(d) Each member of the staff shall be able to recognize common symptoms of the illnesses of patients, and to note any marked defects of patients. Staff shall be able to provide nursing care under the supervision of a registered nurse.

(e) Staff shall have knowledge of basic health needs and health problems of patients, such as mental health, physical health and nutritional health. Staff shall teach attitudes and habits conducive to good health through daily routines, examples and discussion, and shall help the patients to understand the principles of health.

(f) Each facility shall have a definitely planned program of dental care and dental health which shall be consistently followed. Each patient shall receive a dental examination by a qualified dentist and prophylaxis at least twice a year. Reports of all examinations and treatment should be included in the patient's clinical record.

(7) **Emergency Services**. All clinical staff shall have training in matters related to handling emergency situations.

(a) Policies and procedures shall be written regarding handling and reporting of emergencies and these shall be reviewed at least quarterly by all staff.

(b) All patient care staff must have an up-to-date first-aid certificate and certification in basic cardiopulmonary resuscitation (CPR). The facility must maintain suction equipment and an automatic external defibrillator (AED). All patient care staff must have training in the use of oral suction and the use of an AED.

(c) There shall be an emergency kit made up under the supervision of a physician and inspected regularly with documentation of inspections. This kit shall include emergency drugs, equipment, etc. This kit shall be stored in a locked area, easily accessible to appropriate staff.

(d) There shall be an adequate number of appropriately equipped first aid kits stored with appropriate safeguards but accessible to staff in appropriate locations such as living units, recreation and special purpose areas, buses, vans, etc.

(8) **Pharmaceutical Services**. Policies and procedures related to pharmaceutical services shall include but are not limited to:

(a) The facility shall have a pharmacy or drug room onsite that shall be directed by a registered pharmacist.

1. The pharmacy or drug room shall be under competent supervision.

2. The pharmacist shall be responsible to the administration of the facility and for developing, supervising and coordinating all activities of the pharmacy.

(b) If there is a drug room with no pharmacist, prescription medication shall be dispensed by a qualified pharmacist elsewhere and only storage and distribution shall be done at the facility. A designated person shall have responsibility for the day-to-day operation of the drug room. A consulting pharmacist shall assist in developing policies and procedures for the distribution of drugs, and shall visit the facility as needed.

(c) Special locked storage space shall be maintained at the facility to meet the legal requirements for storage of narcotics and other prescribed drugs.

(d) Written arrangements with outside pharmacies, clinicians or facilities shall be made for emergency pharmaceutical service.

(e) Establishment and maintenance of a satisfactory system of records and bookkeeping in accordance with the policies of the facility.

(f) An automatic stop order on all prescribed drugs not specifically prescribed as to time and number of doses. These stop orders shall be in accordance with federal and state laws. Individual drug plans shall be reviewed by a physician weekly or more frequently as needed.

(g) A drug formulary accepted for use in the facility which is developed and amended at regular intervals by medical staff in cooperation with the pharmacist.

(h) Drugs may be administered only by a licensed nurse, in accordance with the Nurse Practice Act, O.C.G.A. § 43-26-12 et seq. relating to the practice of nursing in Georgia.

(i) Intravenous medications and fluids shall be administered in accordance with Georgia law. If administered by licensed nurses,

they shall be administered only by those who have been trained and determined competent to perform this duty.

(j) Each facility shall provide pharmaceutical services in compliance with State and federal laws and regulations.

(9) **Medical orders** shall be in writing and signed by the physician. Telephone/verbal orders shall be used sparingly and given only to a licensed nurse or otherwise qualified individual as determined by the medical staff in accordance with State law. The individual receiving the telephone/verbal order shall immediately repeat the order and the prescribing physician shall verify that the repeated order is correct. The individual receiving the order shall document, in the patient's clinical record that the order was repeated and verified. Telephone/verbal orders must be signed by the physician within the timeframe designated in the facility's policies and procedures which ensure that it is done as soon as possible. Where telephone/verbal orders are routinely not being signed within the timeframe designated in the policy, the facility will take appropriate corrective action.

(10) **Laboratory and Pathology Services**. Provision shall be made for those services within the facility or with an outside facility to meet the needs of the patient. These services shall be provided by a CLIA certified facility. Laboratory and pathology tests to be performed require an order from a qualified physician and reports from such tests shall be part of the patient's clinical records. Abnormal laboratory and pathology reports shall be followed up appropriately.

(11) **Patients' Rights**. Every effort shall be made to safeguard the legal and civil rights of patients and to make certain that they are kept informed of their rights, including the right to legal counsel and all other requirements of due process when necessary.

(a) **Treatment**. Each patient shall be provided treatment and care in the least restrictive environment as possible; each patient, parent(s), and/or legal guardian shall be encouraged to participate in the development of the patient's individualized treatment plan; and each patient shall be provided treatment and care in a manner that respects the patient's personal privacy and dignity.

(b) **Visitors.** Policies shall allow visitation of patient's family and significant others unless clinically contraindicated. Appropriate places for visits shall be provided.

(c) **Telephone and Mail**. Patients shall be allowed to conduct private telephone conversations with family and friends and to send and receive mail. When restrictions are necessary because of therapeutic or practical reasons, such as expense, these reasons shall be documented, explained to the patient and family and re-evaluated at least monthly.

(d) **Behavior Management.** Behavior management techniques shall be fair and consistent and must be applied based on the individual's needs and treatment plan, and following established and approved behavior management techniques in accordance with the Rule 111-8-68-.08.

(e) **Restraint and Seclusion**. Each patient has the right to be free from restraint or seclusion, in any form, used as a means of coercion, discipline, convenience, or retaliation.

(f) **Clothing.** Individual patients shall have their own appropriate amounts and types of clothing for the particular activities, climate, etc. There shall be an appropriate storage place for their clothing.

(g) **Grievances.** The patients shall have the opportunity to present opinions, recommendations and grievances to appropriate staff members. The facility shall have written policies and carry out appropriate procedures for receiving and responding to such

patient communications in a way that will preserve and foster the therapeutic aspects of conflict-resolution and problem solving; e.g., patient-staff government meetings.

(12) **Records**. The form and detail of the clinical records may vary in accordance with these rules.

(a) **Content.** All clinical records shall contain all pertinent clinical information and each record shall contain at least:

1. Identification data, consent forms, acknowledgment of patient, parent(s), and/or legal guardian's receipt and explanation of facility's emergency safety intervention procedures and a copy of patients' rights; when these are not obtainable, reason shall be noted;

2. Source of referral;

3. Reason for referral, e.g. chief complaint, presenting problem;

4. Record of the complete assessment;

5. Initial formulation and diagnosis based upon the assessment;

6. Written treatment plan;

7. Medication history and record of all medications prescribed;

8. Record of all medication administered by facility staff, including type of medication, dosages, frequency of administration, and persons who administered each dose;

9. Documentation of course of treatment and all evaluations and examinations, including those from other facilities, example, emergency room or general hospital;

10. Documentation of the use and monitoring of emergency safety interventions;

11. Documentation of the use of patient safety observations/interventions;

12. Periodic progress report;

13. All consultation reports;

14. All other appropriate information contained from outside sources pertaining to the patient;

15. Discharge or termination summary report; and

16. Plans for follow-up and documentation of its implementation.

17. Identification data and consent form shall include the patient's name, address, home telephone number, date of birth, sex, next of kin, school name, grade, date of initial contact and/or admission to the service, legal status and legal document, and other identifying data as indicated.

18. **Progress Notes**. Progress notes shall include regular notations at least weekly by staff members, consultation reports and signed entries by authorized identified staff. Progress notes by the clinical staff shall:

(a) Document a chronological picture of the patient's clinical course;

(b) Document all treatment rendered to the patient;

(c) Document the implementation of the treatment plan;

(d) Describe each change in each of the patient's conditions;

(e) Describe responses to and outcome of treatment including the use of any emergency safety interventions and medications; and

(f) Describe the responses of the patient and the family or significant others to significant events.

19. **Discharge Summary.** The discharge summary shall include the initial formulation and diagnosis, clinical resume, final formulation, and final primary and secondary diagnoses, the psychiatric and physical categories. The final formulation shall reflect the general observations and understanding of the patient's condition initially, during appraisal of the fundamental needs of the patients. All relevant discharge diagnoses should be recorded and coded in the standard nomenclature of the current “Diagnostic and Statistical Manual of Mental Disorders,” published by the American Psychiatric Association, and the latest edition of the “International Classification of Diseases,” regardless of the use of other additional classification systems. Records of discharged patients shall be completed following discharge within a reasonable length of time, and not to exceed fifteen (15) days. In the event of death, a summation statement shall be added to the record either as a final progress note or as a separate resume. This final note shall take the form of a discharge summary and shall include circumstances leading to death. All discharge summaries must be signed by a physician.

20. **Recording.** Entries in the clinical records shall be made by all staff having pertinent information regarding the patient, consistent with the facility policies, and authors shall fully sign and date each entry. When mental health trainees are involved in, patient care, documented evidence shall be in the clinical records to substantiate the active participation of supervisory clinical staff. Symbols and abbreviations shall be used only when they have been approved by the clinical staff and when there is an explanatory legend. Final

diagnosis, both psychiatric and physical, shall be recorded in full, and without the use of either symbols or abbreviations.

(b) **Clinical Records Policies and Procedures**. The facility shall have written policies and procedures regarding clinical records which are enforced and provide that:

1. Clinical records shall be confidential, current and accurate;

2. The facility shall protect the confidentiality of clinical information and communication between staff members and patients;

3. All staff shall have training, as part of new staff orientation and with periodic updates, regarding the effective maintenance of confidentiality of clinical records. It shall be emphasized that confidentiality also refers to discussions regarding patients inside and outside the facility. Verbal confidentiality shall be discussed as part of all employee training.

4. Clinical records are the property of the facility and shall be maintained for the benefit of the patient, the staff and the facility;

5. The facility is responsible for safeguarding the information in the clinical record against loss, defacement, tampering or use by unauthorized persons;

6. Except as required by law, the written consent of the patient, or if the patient is a minor, the parent(s), and/or legal guardian, is required for the release of clinical record information;

7. Records may be removed from the facility's jurisdiction and safekeeping only according to the policies of the facility or as required by law; and

(c) **Maintenance of Records**. Each facility shall provide for a master filing system which shall include a comprehensive record of each patient's involvement in every program aspect.

1. Appropriate records shall be kept on the unit where the patient is being treated or be directly and readily accessible to the clinical staff caring for the patient;

2. The facility shall maintain a system of identification and filing to facilitate the prompt location of the patient's clinical records;

3. The facility shall retain patients' records at least until the fifth anniversary of the patients' discharge. If the patient is a minor, the records must be retained for at least five (5) years past the age of majority. Records may be preserved in the facility's format of choice, including but not limited to paper or electronic format, so long as the records are readable, capable of being reproduced in paper format upon request, and stored and disposed of in a manner that protects the confidentiality of the record;

4. The clinical record services required by the facility shall be directed, staffed and equipped to facilitate the accurate processing, checking, indexing, filing, retrieval and review of all clinical records. The clinical records service shall be the responsibility of an individual who has demonstrated competence and training or experience in clinical record administrative work. Other personnel shall be employed as needed, in order to effect the functions assigned to the clinical record services; and

5. There shall be adequate space, equipment and supplies, compatible with the needs of the clinical record service, to enable the personnel to function effectively and to maintain clinical records so that they are readily accessible.

(13) **Program and Patient Evaluation**. The staff shall work towards enhancing the quality of patient care through specified,

documented, implemented and ongoing processes of clinical care evaluation studies and utilization review mechanisms.

(a) **Individual Case Review.**

1. There shall be regular staff meetings and/or unit meetings to review and monitor the progress of the individual child or adolescent patient. Each patient's case shall be reviewed within a month after admission and at least monthly during residential treatment. Review of the use of emergency safety interventions shall be in accordance with Rule 111-8-68-.08(2)(l). The reviews shall be documented and the meeting may also be used for review and revision of treatment plans.

2. The facility shall provide for a follow-up review on each discharged patient to determine effectiveness of treatment and disposition.

(b) **Program Evaluation.**

1. **Clinical Care Evaluation Studies**. There shall be evidence of ongoing studies to define standards of care consistent with the goals of the facility, effectiveness of the program, the facility's progress in reducing the use of emergency safety interventions, and to identify gaps and inefficiencies in service. Evaluation shall include, but is not limited to, follow-up studies. Studies shall consist of the following elements:

(i) Selection of an appropriate design;

(ii) Specification of information to be included;

(iii) Collection of data;

(iv) Analysis of data with conclusions and recommendations;

(v) Transmissions of findings; and

(vi) Follow-up on recommendations.

2. **Utilization Review**. Each facility shall have a plan for and carry out utilization review. The review shall cover the appropriateness of admission to services, the provision of certain patterns of services, and duration of services. There shall be documentation of utilization review meetings either in minutes or in individual clinical records.

Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Services" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.08 Behavior Management and Emergency Safety Interventions.

(1) **Behavior Management.**

(a) The facility shall develop and implement policies and procedures on behavior management. Such policies and procedures shall set forth the types of patients served in accordance with its program purpose, the anticipated behavioral problems of the patients, and acceptable methods of managing such problems.

(b) Such behavior management policies and procedures shall incorporate the following minimum requirements:

1. Behavior management principles and techniques shall be used in accordance with the individual treatment plan, written policies and procedures, treatment goals, safety, security, and these rules and regulations.

2. Behavior management shall be limited to the least restrictive appropriate method, as described in the patient's treatment plan, and in accordance with the prohibitions as specified in these rules and regulations.

3. Behavior management principles and techniques shall be administered by facility staff members and shall be appropriate to the severity of the patient's behavior, chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history (including any history of physical or sexual abuse).

(c) The following forms of behavior management shall not be used by staff members with patients receiving services from the facility:

1. assignment of excessive or unreasonable work tasks;

2. denial of meals and hydration;

3. denial of sleep;

4. denial of shelter, clothing, or essential personal needs;

5. denial of essential program services;

6. verbal abuse, ridicule, or humiliation;

7. restraint, manual holds, and seclusion used as a means of coercion, discipline, convenience, or retaliation;

8. denial of communication and visits unless restricted in accordance with Rule 111-8-68- .06(i)(2); and

9. corporal punishment.

(d) Patients shall not be permitted to participate in the behavior management of other patients or to discipline other patients, except as part of an organized therapeutic self governing program in accordance with accepted standards of clinical practice that is conducted in accordance with written policy and is supervised directly by designated staff.

(2) **Emergency Safety Interventions**.

(a) Emergency safety interventions shall only be used when a patient exhibits a dangerous behavior reasonably expected to lead to immediate physical harm to the patient or others and less restrictive means of dealing with the injurious behavior have not proven successful or may subject the patient or others to greater risk of injury.

(b) Any emergency safety intervention involving use of mechanical restraints, manual holds, or seclusion must be ordered by a physician or other licensed professional trained in emergency safety interventions and authorized by State law to order such use.

1. The order may not be a standing order or on an as-needed basis.

2. If the order is a verbal order, it must be received by a licensed nurse or otherwise qualified staff as determined by the medical staff in accordance with State law, prior to initiation of the emergency safety intervention, while the intervention is being initiated by staff, or immediately thereafter. The individual issuing the order must verify the verbal order in a signed written form in the patient's record within the timeframe designated by facility policy and procedure which ensures that it is done as soon as possible. The individual ordering the use of the intervention must be available to staff for consultation, at least by a two-way communication device, throughout the course of the emergency safety intervention.

3. Each order for use of restraint or seclusion must be limited to no longer than the duration of the emergency safety situation.

4. Each order for the use of mechanical restraint, manual hold, or seclusion, must include the name of the physician or other licensed professional, the date and time the order was obtained, the type of intervention ordered, and the length of time for which the use of the intervention was authorized. Restraint and seclusion orders shall not exceed:

(i) four (4) hours for patients ages 18 to 21;

(ii) two (2) hours for patients ages 9 to 17;

(iii) one (1) hour for patients under age 9; and

(iv) fifteen (15) minutes for manual holds with one order renewal for an additional fifteen (15) minutes for a total of thirty (30) minutes.

5. If the emergency safety situation continues beyond the time limit authorized in the order, a registered nurse or other licensed professional must immediately contact the ordering physician or the ordering licensed professional to receive further instructions.

(c) Emergency safety interventions shall not include the use of any restraint or manual hold that would potentially impair the patient's ability to breathe or has been determined to be inappropriate for use on a particular patient due to a documented medical or psychological condition.

(d) The facility shall have written policies and procedures for the use of emergency safety interventions, a copy of which shall be provided to and discussed with each patient (as appropriate taking into account the patient's age and intellectual development) and the patient's parents and/or legal guardians prior to or at the time of admission. Emergency safety interventions policies and procedures shall include:

1. requirements for the documentation of an assessment at admission and at each annual exam by the patient's physician, a physician's assistant, or a registered nurse with advanced training working under the direction of a physician, which reflects that there are no medical issues that would be incompatible with the appropriate use of emergency safety interventions on that patient. Such assessment and documentation must be reevaluated following any significant change in the patient's medical condition;

2. requirements for prohibiting the use of mechanical restraints, manual holds, or seclusion use by any employee not trained in prevention and use of emergency safety interventions, as required by these rules; and

3. requirements that all actions taken that involve utilizing an emergency safety intervention shall be recorded in the patient's record, including at a minimum the following:

(i) date and description of the precipitating incident;

(ii) the order for use of any mechanical restraints, manual hold, or seclusion;

(iii) description of the de-escalation techniques used prior to the emergency safety intervention, if applicable;

(iv) environmental considerations;

(v) names of staff participating in the emergency safety intervention;

(vi) any witnesses to the precipitating incident and subsequent intervention;

(vii) exact emergency safety intervention used;

(viii) evidence of the continuous visual monitoring of a patient in mechanical restraint, manual hold, or seclusion, documented minimally at fifteen (15) minute intervals;

(ix) the provision of fluids every hour, food at regular intervals, and bathroom breaks every two (2) hours;

(x) beginning and ending time of the intervention;

(xi) outcome of the intervention;

(xii) detailed description of any injury arising from the incident or intervention; and

(xiii) summary of any medical care provided.

(e) Emergency safety interventions may be used to prevent runaways only when the patient presents an imminent threat of physical harm to self or others, or as specified in the individual treatment plan.

(f) Facility staff shall be aware of each patient's known or apparent medical and psychological conditions (e.g. obvious health issues, list of

medications, history of physical abuse, etc.), as evidenced by written acknowledgement of such awareness, to ensure that the emergency safety intervention that is utilized does not pose any undue danger to the physical or mental health of the patient.

(g) Patients shall not be allowed to participate in the emergency safety intervention of another patient.

(h) Within one (1) hour of the initiation of an emergency safety intervention and immediately following the conclusion of the emergency safety intervention, a physician or other licensed independent practitioner; or a registered nurse or physician assistant; trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well-being of patients must conduct a face-to-face assessment of the patient. The assessment at a minimum must include:

1. the patient's physical and psychological status;

2. the patient's behavior;

3. the appropriateness of the intervention measures; and

4. any complications and treatments resulting from the intervention.

(i) **Manual Holds.**

1. Emergency safety interventions utilizing manual holds require at least one (1) trained staff member to carry out the hold. Emergency safety interventions utilizing prone restraints require at least two trained staff members to carry out the hold.

2. When a manual hold is used upon any patient whose primary mode of communication is sign language, the patient shall be permitted to have his or her hands free from restraint for brief periods during the intervention, except when such freedom may result in physical harm to the patient or others.

3. A manual hold requires physician authorization at fifteen (15) minute intervals and may not be used for more than thirty (30) minutes at any one time without the consultation of the ordering physician or other licensed professional authorized to order the use of manual holds. The ordering physician or other licensed professional authorized to order the use of the hold shall be contacted by a two-way communications device or in person to determine that the continuation of the manual hold is appropriate under the circumstances.

4. If the use of a manual hold on a patient reaches a total of one hour within a twenty-four (24) hour period, the staff shall reconsider alternative treatment strategies, and document same.

5. The patient's breathing, verbal responsiveness, and motor control shall be continuously monitored during any manual hold. Documentation of the monitoring by a trained staff member shall be recorded every fifteen (15) minutes during the duration of the restraint.

(j) **Seclusion**.

1. A room used for the purposes of seclusion must meet the following criteria:

(i) The room shall be constructed and used in such ways that the risk of harm to the patient is minimized;

(ii) The room shall be equipped with a viewing window so that staff can monitor the patient;

(iii) The room shall be lighted and well-ventilated;

(iv) The room shall be a minimum fifty (50) square feet in area; and

(v) The room must be free of any item that may be used by the patient to cause physical harm to himself/herself or others.

2. No more than one (1) patient shall be placed in the seclusion room at a time.

3. A seclusion room monitoring log shall be maintained and used to record the following information:

(i) name of the secluded patient;

(ii) reason for the patient's seclusion;

(iii) time of patient's placement in the seclusion room;

(iv) name and signature of the staff member that conducted visual monitoring;

(v) signed observation notes; and

(vi) time of the patient's removal from the seclusion room.

(k) **Training, Evaluation, and Reporting.**

1. All facility staff members who may be involved in the use of emergency safety interventions, shall have evidence of having satisfactorily completed a nationally recognized training program for emergency safety interventions to protect patients and others from injury, which has been taught by an appropriately certified trainer in such program. Emergency safety interventions may only be used by those staff members who have received such training and successfully demonstrated the techniques learned for managing emergency safety situations.

2. At a minimum, the emergency safety intervention program that is utilized shall include the following:

(i) techniques for de-escalating problem behavior including patient and staff debriefings;

(ii) appropriate use of emergency safety interventions;

(iii) recognizing aggressive behavior that may be related to a medical condition;

(iv) awareness of physiological impact of a restraint on the patient;

(v) recognizing signs and symptoms of positional and compression asphyxia and restraint associated cardiac arrest;

(vi) instructions as to how to monitor the breathing, verbal responsiveness, and motor control of a patient who is the subject of an emergency safety intervention;

(vii) appropriate self-protection techniques;

(viii) policies and procedures relating to using manual holds, including the prohibition of any technique that would potentially impair a patient's ability to breathe;

(ix) facility policies and reporting requirements;

(x) alternatives to restraint;

(xi) avoiding power struggles;

(xii) escape and evasion techniques;

(xiii) time limits for the use of restraint and seclusion;

(xiv) process for obtaining approval for continual restraints and seclusion;

(xv) procedures to address problematic restraints;

(xvi) documentation;

(xvii) investigation of injuries and complaints;

(xviii) monitoring physical signs of distress and obtaining medical assistance; and

(xix) legal issues.

3. Emergency safety intervention training shall be in addition to the training required in Rule 111-8-68-.05(5)(d) and shall be documented in the staff member's personnel record.

4. The facility shall take and document appropriate corrective action when it becomes aware of or observes the inappropriate use of an emergency safety intervention technique as outlined in these rules and regulations and shall notify each patient's parents and/or legal guardians. Documentation of the incident and the corrective action taken by the facility shall be maintained.

(l) At least monthly, the facility, utilizing a master restraint/seclusion log and the patients' records, shall review the use of all emergency safety interventions for each patient and staff member, including the type of intervention used and the length of time of each use, to determine whether there was a clinical basis for the intervention, whether the use of the emergency safety intervention was warranted, whether any alternatives were considered or employed, the effectiveness of the intervention or alternative, and the need for additional training. Written documentation of all such reviews shall be maintained. Where the facility identifies opportunities for improvement as a result of such reviews or otherwise, the facility shall implement these changes through an effective quality improvement plan designed to reduce the use of emergency safety devices.

(m) Facilities shall submit to the department electronically or by facsimile a report, within twenty-four (24) hours, whenever the facility becomes aware of an incident which results in any injury of a patient requiring medical treatment beyond first aid that is received by a patient as a result of or in connection with any emergency safety intervention. In addition facilities must report the following:

1. For any thirty (30) day period, where three (3) or more incidents for the same patient occur where the facility has used mechanical restraint or seclusion lasting four (4) or more hours for patients ages 18-21; two (2) or more hours for patients ages 9 to 17; or one (1) or more hours for patients under nine (9) years of age and/or when three (3) or more incidents for the same patient occur where the facility has used manual holds lasting thirty (30) or more minutes. The reports shall include the

type of emergency safety intervention, total amount of time in the intervention, and any actions taken to prevent further use of emergency safety interventions.

2. On a monthly basis, the total number of emergency safety interventions shall be reported by patient unit, including the total amount of time each intervention was used, and the monthly average daily census for each unit. The report shall include a summary of the facility's monthly evaluation of their use of emergency safety interventions, including actions taken.

Authority O.C.G.A. Secs. 31-2-9, 31-7-2.1. **History.** Original Rule entitled "Behavior Management and Emergency Safety Interventions" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.09 Waivers and Variances.

(1) The department may, in its discretion, grant waivers and variances of specific rules upon application or petition being filed by a facility. The department may establish conditions which must be met by the facility in order to operate under the waiver or variance granted. Waivers and variances may be granted in accordance with the following considerations:

(a) Variance. A variance may be granted by the department upon a showing by the applicant or petitioner that the particular rule or regulation that is the subject of the variance request should not be applied as written because strict application of the rule would cause undue hardship. The applicant or petitioner must also show that adequate standards affording protection for the health, safety and care of the patients exist and will be met in lieu of the exact requirements of the rule or regulations in question.

(b) Waiver. The department may dispense entirely with the enforcement of a rule or regulation upon a showing by the applicant or petitioner that the purpose of the rule or regulation is met through equivalent standards affording equivalent protection for the health, safety and care of patients.

(c) Experimental Variance or Waiver. The department may grant waivers and variances to allow experimentation and demonstration of new and innovative approaches to delivery of services upon a showing by the applicant or petitioner that the intended protections afforded by the rule or regulation which is the subject of the request are met and that the innovative approach has the potential to improve service delivery.

Authority O.C.G.A. Sec. 31-2-9. **History.** Original Rule entitled "Waivers and Variances" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.10 Enforcement and Penalties.

(1) Enforcement of these rules and regulations shall be done in accordance with the Rules and Regulations for Enforcement of Licensing Requirements, Chapter 111-8-25.

(2) The facility shall notify each patient's parents and/or legal guardians of the department's actions to revoke the license or seek an emergency suspension of the facility's license to operate.

(3) The official notice of the revocation or emergency suspension action and any final resolution, together with the department's complaint intake phone number and website address, shall be provided by the facility to each current and prospective patient's parents and/or legal guardians.

(4) The facility shall ensure the posting of the official notice at the facility in an area that is visible to each patient's parents and/or legal guardians.

(5) The facility shall ensure that the official notice continues to be visible to each patient's parents and/or legal guardians throughout the pendency of the revocation and emergency suspension actions, including any appeals.

(6) The facility shall have posted in an area that is readily visible to each patient's parents and/or legal guardians any inspection reports that are prepared by the Department during the pendency of any revocation or emergency suspension action.

(7) It shall be a violation of these rules for the facility to permit the removal or obliteration of any posted notices of revocation, emergency suspension action, resolution, or inspection survey during the pendency of any revocation or emergency suspension action.

(8) The department may post an official notice of the revocation or emergency suspension action on its website or share the notice of the revocation or emergency suspension action and any information pertaining thereto with any other agencies that may have an interest in the welfare of the patients in care at the facility.

(9) The department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared a state of emergency.

(10) Inspections. The facility shall be available at reasonable hours for observation and examination by properly identified representatives of the department.

(a) At least annually, a report providing statistical data and brief program narrative shall be provided to the department, as requested.

(b) The governing body shall notify the department of the anticipated opening date of a newly constructed facility in order that a pre-opening licensure inspection of the treatment facility may be conducted to determine compliance with these rules and regulations.

(c) The administrator or his representative shall accompany the department representative on tours of inspection and shall sign the completed check-list.

(11) Plans of Correction. If violations of these licensing rules are identified, the facility will be given a written report of the violation that identifies the rules violated. The facility shall submit to the department a written plan of correction in response to the report of violation, which states what the facility will do, and when, to correct each of the violations identified. The facility may offer an explanation or dispute the findings or violations in the written plan of correction, so long as an acceptable plan of correction is submitted within ten (10) days of the facility's receipt of the written report of inspection. If the initial plan of correction is unacceptable to the department, the facility will be provided with at least one (1) opportunity to revise the unacceptable plan of correction. Failure to submit an acceptable plan of correction may result in the department commencing enforcement procedures. The facility shall comply with its plan of correction.

Authority O.C.G.A. Sec. 31-2-11. **History.** Original Rule entitled "Enforcement and Penalties" adopted. F. July 14, 2010; eff. Aug. 3, 2010.

111-8-68-.11 Severability.

In the event that any rule, sentence, clause, or phrase of any of these rules and regulations may be construed by any court of competent jurisdiction to be invalid, illegal, unconstitutional, or otherwise unenforceable, such determination or adjudication shall in no manner affect the remaining rules or portion thereof. The remaining rules or portions of rules shall remain in full force and effect, as if such rule or portions thereof so determined, declared, or adjudged invalid or unconstitutional were not originally a part of these rules.

Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Severability" adopted. F. July 14, 2010; eff. Aug. 3, 2010.