

## Chapter H 24

## GENERAL AND SPECIAL HOSPITALS

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History: Chapter H 24 as it existed on May 31, 1968 was repealed and a new chapter H 24 was created, Register, May, 1968, No. 149, eff. June 1, 1968.

**H 24.01 Compliance with state and local laws.** (1) (a) No hospital may operate in Wisconsin unless it is approved by the department. To be approved by the department, a hospital shall comply with this chapter and with all other applicable state laws and local ordinances. An application for approval shall be submitted to the department on forms provided by the department. Within 90 days after receiving a completed application for approval, the department shall either approve or deny the application. If the application for approval is denied, the department shall give the applicant reasons, in writing, for the denial.

(b) The staff of the hospital shall be licensed or registered in accordance with applicable laws.

(c) The hospital shall be in conformity with laws relating to fire and safety, to communicable and reportable diseases, to post-mortem examinations, and to other relevant matters.

(2) The hospital shall be in conformity with the requirements of reporting communicable disease and infection.

(a) Communicable disease and infection:

1. Reportable communicable disease shall be promptly reported to the local health officer in compliance with ch. HSS 145.

2. Diarrhea of the newborn shall be immediately reported:

a. To the local health office in communities which employ a full-time health officer.

b. To the division of health in communities which do not have a full-time health officer.

3. Known infectious diseases of epidemiological importance shall be reported to the local full-time health officer and the state health officer.

(3) The hospital shall be in conformity with the requirements of reporting illegitimate pregnancies.

(a) *Reporting.* 1. The hospital shall report illegitimate pregnancies of mothers to the division for children and youth, state department of

health and social services, within 24 hours after admission to the hospital or an associated maternity residence.

2. For reporting purposes, illegitimate pregnancy is defined as a pregnancy of one who is unmarried; one who reports the husband is not the father of the infant; one who refuses to give the name of the father of the child or one who has been separated from her husband longer than the normal gestation period.

(b) *Forms.* 1. The hospital shall use forms which are furnished by the division for children and youth, state department of health and social services, for reporting illegitimate pregnancies.

2. All forms, records and certificates with information pertaining to the reporting of unmarried mothers or their infants shall be maintained in confidence and shall be available to the division for children and youth, state department of health and social services, or its designated representative.

Note: Unwed mother report form is obtainable from department of health and social services.

(c) *Protection of unwed mother and infant.* 1. Care shall be taken to keep the presence of an unwed mother and her infant in confidence.

2. The division for children and youth, state department of health and social services, or its designated representative shall have access to unwed mothers.

(4) *Definitions and classifications of hospitals.* (a) *Statutory definitions.*

1. Hospital. "Hospital" means any building, structure, institution or place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment of and medical or surgical care for 3 or more nonrelated individuals hereinafter designated patients, suffering from illness, disease, injury or deformity, whether physical or mental, and including pregnancy and regularly making available at least clinical laboratory services, and diagnostic x-ray services and treatment facilities for surgery, or obstetrical care, or other definitive medical treatment.

(b) *Administrative definitions.* 1. General hospital. A "general hospital" is a hospital providing community service for inpatient medical and surgical care of acute illness or injury and/or for obstetrics.

2. Specialized hospital. A "specialized hospital" is a hospital providing primarily for one type of care, such as a psychiatric hospital, a chronic disease hospital, a children's hospital, a maternity hospital. The specialized hospital shall meet the applicable regulations for a general hospital of corresponding size and all regulations pertaining to such specialized services as are provided by the hospital.

a. A "psychiatric hospital" is a type of mental hospital where patients receive diagnosis and intensive treatment and where usually, only a minimum of continuous long-term treatment facilities are afforded.

b. A "chronic disease hospital" is a hospital, the primary purpose of which is to provide the services and facilities for the diagnosis, treatment and rehabilitation of patients with chronic illness. "Chronic disease" refers to illness or disability which is either permanent or recurrent, which may require long periods of medical supervision or care as well as special

rehabilitative services, as distinguished from acute illness which is usually of short duration.

c. Nursing homes and boarding care homes as classified and defined in s. 146.30, Stats., and hospitals devoted exclusively to the care of patients with tuberculosis or with mental illness are not "chronic disease hospitals."

d. A "maternity hospital" is a hospital, the primary purpose of which is to provide services and facilities for obstetrical care.

3. Specialized unit of a general hospital. When a general hospital provides beds in a segregated unit for a specialized type of care, such as psychiatric, tuberculosis, chronic disease, or nursing home, such a unit is a specialized unit of the general hospital. The services provided in a nursing home unit are separately licensed.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68; r. and recr. (1) (intro.) and (a), Register, October, 1985, No. 358, eff. 11-1-85; correction in (2) (a) 1. Made under s. 13.93 (2m) (b) 7, Stats., Register, October, 1985, No. 358.

**H 24.02 Governing body.** (1) The hospital shall have an effective governing body legally responsible for the conduct of the hospital as an institution.

Note: If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital carry out the functions herein pertaining to the governing body.

(a) The governing body shall have adopted bylaws in accordance with legal requirements.

1. The bylaws shall be in writing and available to all members of the governing body.

2. The bylaws shall:

a. Stipulate the basis upon which members are selected, their term of office, and their duties and requirements.

b. Specify to whom responsibilities for operation and maintenance of the hospital, including evaluation of hospital practices, may be delegated; and the methods established by the governing body for holding such individuals responsible.

c. Provide for the designation of necessary officers, their terms of office and their duties, and for the organization of the governing body into essential committees.

d. Specify the frequency with which meetings shall be held.

e. Provide for the appointment of members of the medical staff.

f. Provide mechanisms for the formal approval of the organization, bylaws, rules and regulations of the medical staff and its departments in the hospital.

Note: The term "medical staff" includes dentists on the staff as well as physicians. Where hospital dental services are minimal or confined largely to oral surgery they are usually conducted as a section of the department of surgery coequal with the other surgical specialties. Where dental services are more extensive and organized into a department of dentistry, coequal with the other major departments "medical and dental staff" would be preferred. See s. H 24.12 (1) (c).

(b) The governing body shall meet at regular, stated intervals.

1. Meetings shall be held frequently enough for the governing body to carry on necessary planning for growth and development and to evaluate the conduct of the hospital, including the care and treatment of patients, the control, conservation and utilization of physical and financial assets, and the procurement and direction of personnel.

2. Minutes of meetings shall reflect pertinent business conducted, and shall be regularly distributed to members of the governing body.

(c) The governing body shall appoint committees. There shall be an executive committee and others as indicted for special purposes.

1. The number and types of committees appointed shall be consistent with the size and scope of activities of the hospital.

2. An executive committee, or the governing body as a whole, shall establish policies for the activities and general policies of the various hospital departments and special committees established by the governing body.

3. Written minutes or reports, which reflect business conducted by the executive committee, shall be maintained for review and analysis by the governing body.

4. Other committees, including finance, joint conference, and building and maintenance shall function in a manner consistent with their duties as assigned by the governing body and maintain written minutes or reports which reflect the enactment of such duties. If such other committees are not appointed, a member or members of the governing body shall assume those duties normally assigned to such committees.

(d) The governing body shall establish a formal means of liaison with the medical staff by a joint conference committee or other appropriate mechanism.

1. A direct effective method of communication with the medical staff shall be established on a formal, regular basis, and shall be documented in written minutes or reports which are distributed to designated members of the governing body and active medical staff.

2. Such effective liaison shall be a responsibility of the joint conference committee, the executive committee, or designated members of the governing body.

(e) The governing body shall appoint members of the medical staff.

1. A formal procedure shall be established, governed by written rules and regulations, covering the application for medical staff membership and the method of processing applications.

2. The procedure related to the submission and processing of applications shall involve the administrator, credentials committee of the medical staff or its counterpart, and the governing body, all functioning on a regular basis.

3. Selection of physicians and definition of their medical privileges, both for new appointments and reappointments, shall be based on written, defined criteria.

4. Action taken on applications for medical staff appointments by the governing body shall be in writing and retained.

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5. Written notification of applicants shall be made by either the governing body or its designated representative.

6. Applicants selected for medical staff appointment shall sign an agreement to abide by the rules, regulations, and bylaws of the hospital.

7. There shall be procedure for appeal and hearing by the governing body or other designated committee if the applicant or medical staff feels the decision is unfair or wrong.

(f) The governing body shall appoint a qualified hospital administrator.

1. The administrator shall have had actual experience of a suitable kind, nature and duration in hospital administration.

2. Preferably, the administrator will have had formal training in a graduate program in hospital administration approved by the association of university programs in hospital administration.

(g) The administrator shall act as the executive officer of the governing body, shall be responsible for the management of the hospital, and shall provide liaison among the governing body, medical staff, nursing department, and other departments of the hospital.

1. In discharging his duties, the administrator shall keep the governing body fully informed of the conduct of the hospital through annual, monthly, or other written reports and by attendance at meetings of the governing body.

2. The administrator shall organize the day-to-day functions of the hospital through appropriate departmentalization and delegation of duties.

3. The administrator shall establish formal means of accountability on the part of subordinates to whom he has assigned duties.

4. To maintain sufficient liaison between the governing body, medical staff, nursing department and other departments, the administrator shall hold interdepartmental and departmental meetings, where appropriate, shall attend or be represented at such meetings on a regular basis, and shall report to such departments as well as the governing body the pertinent activities of the hospital.

5. The administrator shall have sufficient freedom from other responsibilities to permit adequate attention to the management and administration of the hospital.

(h) The governing body shall be responsible for establishing a policy which requires that every patient shall be under the care of a physician.

1. Patients shall be admitted to the hospital only on the recommendation of a physician.

2. A member of the house staff or other physician shall be on duty or on call at all times.

(i) The governing body shall be responsible for providing a physician plant equipped and staffed to maintain the needed facilities and services for patients.

1. The governing body shall receive periodic written reports from appropriate intramural and extramural sources about the adequacy of the physical plant, equipment and personnel, thereof, as well as any deficiencies.

2. A member, members, or committee of the governing body shall be assigned primary responsibility for this aspect in the conduct of the hospital.

3. In order to provide a suitable physical plant which is well-equipped and staffed, the governing body shall be responsible for raising funds or otherwise arranging for the availability of funds, adopting a budget for the institution, and approving schedules of charges.

(2) The hospital shall have an effective program of employe health, under the direction of a physician.

(a) *Physical examination.* 1. A complete history and preplacement physical examination including chest x-ray shall be required of all prospective employes.

2. All employes shall have a periodic examination including a chest x-ray on a regular basis, the extent and interval to be determined by:

a. Age.

b. Health status at last examination.

c. Exposure to occupational disease hazards.

d. Return to work following illness or injury or job transfer.

3. An annual physical examination including chest x-ray shall be required of all staff in the obstetric and newborn units and all food handlers and laundry workers.

4. Cultures or other specific procedures shall be required as indicated.

5. A dated record of latest examination, on an acceptable form, shall be kept on file.

6. The publication "*A General Guide for an Occupational Health Program for Hospital Employees*", published by the division of health, is recommended in establishing and conducting an employe health program.

(b) *Exclusion from duty.* 1. Employes and volunteers with gastrointestinal, upper respiratory or other infectious or contagious disease, who have close contact with patients, shall be relieved from duty until there is evidence that they are free from infection.

2. Carriers of infectious organisms who have close contact with patients shall be relieved from duty until shown to be recovered from the carrier state by appropriate laboratory tests.

(3) The hospital shall have policies for the control of visitors.

(a) *Posting of regulations.* 1. The hospital's regulations regarding visitors shall be prominently posted.

(b) *Visitors to obstetric unit.* 1. When mother and infant share the room, 2 persons named by the mother shall be the only visitors admitted during the hospital stay.

2. Individuals visiting non-obstetric patients in the obstetric unit shall observe the hospital regulations established for visitors to obstetric patients.

(4) Qualifications of hospital administrator hired after the effective date of these rules.

(a) *Education and experience.* 1. The administrator shall have as the minimum a high school diploma and 2 years' experience as administrator, assistant administrator, or administrative assistant in a hospital; or be a college or university graduate from a field associated with administration, business administration or a health or social care related field.

(5) *Volunteers.* (a) Volunteers may assist with patient care only under direct supervision of a registered nurse and after appropriate in-service training. Volunteers may not assist with patient care if this involves functions that require performance by licensed nursing practitioners.

Note: See s. H 24.05 (2) (c) 3.

(b) Volunteers under 16 years of age shall not give direct patient care.

(c) Direct patient care includes, for example, assisting the patient with dressing, bathing, eating, and ambulation.

(6) The hospital shall have policies for the identification of its employees.

(7) The hospital shall have policies for the identification of patients.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.03 Physical environment.** (1) The buildings of the hospital shall be constructed, arranged, and maintained to insure the safety of the patient, and provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

Note: This section applies to all hospitals including existing hospitals and to newly constructed buildings as well.

(a) The buildings of the hospital shall be solidly constructed with adequate space and safeguards for each patient.

1. The physical facility shall have current approvals following inspection by appropriate state and/or local authorities.

2. The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured.

3. The physical plant shall provide:

a. Facilities for the physical separation of all isolation patients, particularly those with communicable diseases, and facilities for handwashing and for carrying out good medical and nursing isolation techniques.

b. Proper facilities for handling contaminated linens.

c. Adequate floor space per bed; at least 100 square feet of floor area per bed in a private room and 80 square feet per bed in multiple patient rooms.

d. Facilities for emergency power and lighting in at least the operating and delivery, nursery, recovery, intensive care, and emergency rooms and stairwells; battery lamps and flashlights in all other areas not serviced by the emergency supply source.

e. Facilities for emergency fuel and water supply.

4. There shall be regular inspection and cleaning of air intake sources, screens, and filters, with special attention given to "high risk" areas.

5. Proper facilities shall be maintained and techniques used for incineration of infectious wastes, as well as sanitary disposal of all other wastes.

6. Kitchens and dishwashing facilities located outside the dietary department shall comply with the standards specified for the dietary department.

7. Corridors and passageways shall be free of obstacles.

8. A person shall be designated responsible for services and for the establishment of practices and procedures in each of the following areas: plant maintenance, laundry operations, and the supervision and training of general housekeeping personnel.

(b) The hospital shall provide fire protection by the elimination of fire hazards; the installation of necessary safeguards such as extinguishers, sprinkling devices and fire barriers to insure rapid and effective fire control; and shall adopt a written fire control plan rehearsed at least 3 times a year.

1. The hospital shall have:

a. Written evidence of regular inspection and approval by state or local fire control agencies.

b. Fire-resistant buildings, and equipment as close to fire-proof as possible.

Note: See sub. (2) (h) 1. Automatic sprinkler protection.

c. Stairwells kept closed by fire doors or equipped with unimpaired automatic closing devices.

d. Annual check of fire extinguishers for type, replacement, and renewal dates.

e. Sprinkler systems at least for trash and laundry chutes, paint and carpenter shops, and most storage areas, and fire detection equipment for bulk storage areas.

f. Conductive floors with the required equipment and ungrounded electrical circuits in areas subject to explosion hazards; a policy for testing conductive flooring and maintaining records of tests.

g. Proper routine storage and prompt disposal of trash.

h. "No Smoking" signs prominently displayed, where appropriate, with rules governing the ban on smoking in designated areas of the hospital enforced and obeyed by all personnel.

i. Fire regulations prominently posted and all fire codes rigidly observed and carried out.

2. Written fire control plans shall contain provisions for prompt notification of all fires; extinguishing fires; protection of patients, personnel, and guests; evacuation; and cooperation with fire fighting authorities.

3. There shall be rigidly enforced written rules and regulations governing proper routine methods of handling and storing explosive agents, particularly in operating rooms and laboratories, and governing the provision of oxygen therapy.

(c) The hospital shall provide a sanitary environment to avoid sources and transmission of infections.

1. An infection committee, composed of members of the medical and nursing staffs and administration, shall establish and be responsible for investigating, controlling, and preventing infections in the hospital. Its responsibilities shall include:

a. The establishment of written infection control measures.

b. The establishment of techniques and systems for discovering and reporting infections in the hospital.

2. Written procedures shall govern the use of aseptic techniques and procedures in all areas of the hospital.

3. To keep infections at a minimum, such procedures and techniques shall be regularly reviewed by the infection committee, particularly those concerning food handling, laundry practices, disposal of environmental and patient wastes, traffic control and visiting rules in high risk areas, sources of air pollution, and routine culturing of autoclaves, sterilizers and incubators.

4. There shall be a method of control used in relation to the sterilization of supplies and water, and a written policy requiring sterile supplies to be reprocessed at specified time periods.

5. Formal provisions shall be made to educate and orient all appropriate personnel in the practice of aseptic techniques such as handwashing and scrubbing practices, proper grooming, masking and dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of patient care equipment and supplies.

6. There shall be measures which control the indiscriminate use of preventive antibiotics in the absence of infection.

7. Education shall be provided to all hospital personnel on the cause, effect, transmission, prevention, and elimination of infections.

8. A continuous process shall be enforced for inspection and reporting of any hospital employe with an infection who may be in contact with patients, their food or laundry.

(d) The hospital shall provide adequate diagnostic and therapeutic facilities.

1. Facilities shall be located for the convenience and safety of patients.
2. Facilities shall be available which allow all routine pre-admission, admission and discharge procedures to be done as prescribed by the medical staff in bylaws, rules and regulations of the hospital.
3. Diagnostic and therapeutic facilities, supplies, and equipment shall permit an acceptable level of patient care to be provided by the medical and nursing staffs.
4. The extent and complexity of such facilities shall be determined by the services that the hospital attempts to offer.

(2) The hospital shall meet the following additional physical environment requirements.

(a) *Walls.* 1. Patient rooms, nurseries, intensive care units, surgery, delivery and recovery rooms shall have walls of smooth, washable surfaces and shall be kept in good repair.

2. Kitchens, utility rooms, baths, janitor's closets, sterilizing rooms and spaces with plumbing fixtures shall have smooth washable wall surfaces up to the splash or spray levels and shall be kept in good repair.

(b) *Floors and carpeting.* 1. Patient room floors shall be of such material as to be easily cleaned.

2. All service rooms including kitchens and utility rooms shall have smooth, waterproof, wear-resistant surfaces, such as terrazzo, tile or equivalent. Kitchen floors shall be greaseproof.

3. Where carpeting, including padding, is used it shall be properly maintained and each run of installed carpeting shall have a flame spread rating of 75 or less when tested in accordance with ASTM E-84 or equal tests. Where carpeting becomes permanently soiled or grossly contaminated, it shall be removed.

(c) *Ceilings and acoustical tile.* 1. Washable ceilings shall be provided in surgeries, delivery rooms, nursery, intensive care units, recovery rooms, kitchens, dishwashing rooms, janitor closets and utility rooms.

2. Where acoustical materials are used, they shall be of the noncombustible type.

(d) *Heating and ventilating.* 1. An auxiliary source of heating for the nursery shall be provided.

2. In rooms where explosive gases are used or stored electrical appliances, such as heaters, air conditioners, fans, etc., shall be placed at least 5 feet above the floor.

(e) *Power and lighting.* 1. Electrical cords shall be maintained in good repair.

2. The emergency lighting system or equipment shall be tested at least monthly.

(f) *Water supply.* 1. Where a public water supply is available it shall be used.

2. If there is a well for any purpose it shall comply with the Wisconsin well construction and pump installation code, ch. RD 12, [NR 112] including an annual test of a well water sample.

3. The water supply system shall conform to the Wisconsin state plumbing code, ch. H 62 [ILHR 82].

(g) *Handwashing facilities.* 1. Approved handwashing facilities shall be provided in patient care areas for the use of hospital personnel as a minimum at or near each nurses' station, preferably in each patient unit and at the following locations:

- a. Scrub sink adjacent to surgery and delivery
- b. Labor room
- c. Recovery room
- d. Nurseries
- e. Nursery work room
- f. Examining rooms
- g. Formula preparation room
- h. Isolation and segregation facilities
- i. Kitchen
- j. Pediatric unit
- k. Emergency room
- l. Intensive care unit
- m. Laundries

2. Handwashing facilities, lavatories and sinks in patient care areas used by doctors and nurses shall be equipped with special valves that do not require direct hand contact; provision of wrist-actuated spade-type handles shall be considered minimal.

(h) *Automatic sprinkler protection.* 1. Automatic sprinkler protection shall be provided except for those hospitals of fire-resistive construction of at least 1-hour protected noncombustible construction. Nonfire-resistant areas in these facilities shall be sprinklered.

(i) *Labor-delivery suite.* Facilities within the labor-delivery suite shall include the following:

1. At least one room equipped as a delivery room and used exclusively for clean obstetrics.
2. Labor room adjacent or near the delivery room.
3. Scrub-up room in area adjacent to delivery room.
4. Clean-up or utility room.

5. Storage space for sterile supplies.
6. The labor delivery suite shall be located in a separate wing, projecting alcove, or corridor dead-end.
7. Means for calling assistance in an emergency shall be provided.
8. Janitor's closet.

(j) *Surgical suite.* Facilities within the surgical suite shall include the following:

1. At least one room equipped as a surgery and used exclusively for that purpose.
2. "Scrub" room or area adjacent to surgery.
3. Clean-up or utility room.
4. Storage space for sterile supplies.
5. The surgery suite shall be located in a separate wing, projecting alcove, or corridor dead-end.
6. Means for calling for assistance in an emergency shall be provided.
7. Janitor's closet.

(k) *Sterilizing service.* 1. Sterilizing service shall be available at all times.

2. Sterilizers shall be checked at least every 3 months for pressure, temperature and proper functioning.

(1) *Surgery and delivery room and hazardous area equipment.* 1. Surgery and delivery tables, stands, stretchers, anesthesia machine and all similar equipment shall be provided with appropriate grounding devices in rooms where explosive gases are used.

2. The pad on the delivery and surgery table and the mouthpiece, hose and bellows of the anesthesia machine shall be of conductive material.

3. All electrical apparatus shall be of a type approved for hazardous areas.

4. Oxygen and suction apparatus shall be provided.

5. Compressed gas tanks shall be adequately secured.

(m) *Nursing unit.* At least the following facilities shall be provided for each nursing unit of the hospital:

1. Patient rooms and toilet facilities. The minimum facilities of one toilet and lavatory for every 8 male and one toilet and lavatory for every 8 female patients shall be provided.

2. Nurses' station with locked drug cabinet.

3. Utility room.

4. Dietary facilities if 24-hour kitchen service is not available.

5. Patient's shower room or bathroom. A shower shall be provided for every 10 maternity patients and a bath or shower for every 15 patients other than maternity.

6. Storage for drugs, linen, supplies, stretcher and wheelchairs.

7. Janitor's closet.

8. The lounge and/or dining room when provided for maternity patients shall be separate from other patients.

9. Telephones.

(n) *Patient rooms.* 1. The following minimum floor area per bed shall be provided: 80 square feet for multiple-patient rooms, 100 square feet for single patient rooms.

2. The distance between patient beds shall be at least 3 feet.

3. Means of signaling hospital personnel shall be provided at the bedside of patients.

4. A hospital type bed with suitable mattress, pillow and necessary coverings shall be provided for each patient.

5. There shall be a bedside table or stand and chair for each patient.

6. There shall be sufficient and satisfactory storage space for clothing, toilet articles and other personal belongings of patients.

(o) *Segregated facilities.* 1. Segregated facilities within the maternity department shall be provided.

2. A single room within the maternity department with toilet and handwashing facilities shall be considered minimal for segregation of a patient for observation.

(p) *Nursery facilities.* 1. A separate nursery or nurseries for newborn infants shall be provided unless total "rooming-in" is employed.

2. A minimum floor area for each bassinet shall be as follows:

a. Full-term nursery, 24 square feet per bassinet.

b. Premature nursery, 30 square feet per bassinet.

c. Suspect nursery, 40 square feet per bassinet.

d. There shall be a minimum of 2 feet between bassinets.

3. The following equipment shall be provided in the nursery:

a. Each infant shall be provided with an individual bassinet.

b. Oxygen shall be readily available in the nursery at all times.

c. Where oxygen and compressed gas tanks are used, they shall be adequately secured.

d. A clock with a second hand shall be provided in every nursery.

e. Each nursery shall have at least one approved incubator.

f. A closet or cabinet space shall be provided for exclusive use of nursery cleaning equipment.

4. Examination area and work space;

a. An adequate examination area and work space shall be provided for each nursery.

b. Each examining area and work area shall be provided with a scrub-up sink having foot-, knee-, or elbow-action control; counter with counter sink having a gooseneck spout and wrist-action controls shall be provided in the work area.

5. Suspect nursery. A suspect nursery, or private patient room used for that purpose, with approved handwashing facilities shall be provided.

(q) *Formula room, preparation and storage.* 1. A separate room or safe area shall be provided for the preparation of infant formulas or for the storage of ready to use formulas.

2. Bottle cleaning, sterilization and refrigeration. Equipment for proper cleaning of bottles, terminal sterilization and refrigeration of formula shall be provided where infant formulas are prepared by the hospital.

(r) *Isolation rooms.* 1. Isolation facilities outside the maternity department shall be provided.

2. A single room with toilet and handwashing facilities shall be considered minimal in each nursing unit.

(s) *Sewage disposal.* Liquid wastes shall be discharged into a sewer system connected with the public sewer system, if available, or into a treatment system approved by the state.

(t) *Radiation protection.* ch. H 57, [HSS 157] Radiation Protection, shall be adhered to.

(u) *Housekeeping in special areas.* 1. Housekeeping and maintenance personnel shall wear appropriate head covering, mask and gown while working in nursery, surgery, and delivery room.

2. The nursery, surgery, and delivery rooms shall each have separate cleaning equipment.

3. The nursery floor shall be wet mopped with a clean mop and dusting shall be done with a clean damp cloth daily.

4. The delivery and surgery rooms shall be wet mopped with a clean mop and the rooms cleaned with a clean damp cloth daily and after each use.

(v) *Handling soiled linen.* 1. Soiled linen shall not be sorted in any section of the nursing unit or common hallway.

2. Soiled bed linen shall be placed immediately in a bag available for this purpose and sent to the laundry promptly.

(3) The hospital shall submit plans and specifications for new construction or remodeling.

(a) *Preliminary or schematic plans.* One copy of preliminary or schematic plans shall be submitted to the department of health and social services, division of health, for review and approval.

(b) *Final plans.* One copy of final plans and specifications shall be submitted to the department of health and social services, division of health, for review and approval before construction is started.

(4) The hospital shall conform to the following standards in new construction and new additions and major remodeling projects when practical.

(a) *General.* 1. Doors. a. Doorways for all bedrooms, treatment rooms, delivery rooms, labor rooms and solaria shall be at least 3 feet 8 inches.

b. Doors of private toilet rooms adjoining patient rooms shall open into the patient rooms or two-way hardware be provided.

c. Labor room toilet doors shall be at least 30 inches wide.

2. Corridors. a. Corridors shall be at least 7 feet in width in patient areas and in other areas where patients may be transported by beds or vehicles.

(b) *Electrical.* 1. Motor generator emergency power for lighting and outlets for operation of equipment shall be provided for the delivery room, surgery, nursery, exits, stairs and patient corridors.

2. There shall be an automatic transfer switch or equivalent which will throw the circuits to the emergency service in case of power failure.

3. Switches, outlets, fixtures. a. Switches, fixtures and receptacles in rooms where explosive gases are used or stored shall be at least 5 feet from the floor; those located below 5 feet shall be approved explosion-proof devices.

b. The standard electrical nurses' call system, consisting of bedside switch, corridor signal light and nurses' station panel, shall be extended to include patient, toilet, nursery, labor, delivery, recovery, and surgery rooms.

c. Switches for general illumination and night lights in patient rooms shall be of an approved mercury or quiet operating type.

(c) *Plumbing.* 1. Approved type handwashing facilities shall be provided for each patient room.

(d) *Accommodations and equipment for patients.* 1. Labor-delivery suite.

a. Janitor's closet.

2. Labor room. a. A patient's toilet shall be located adjacent to or near the labor room.

3. Surgical suite. a. Janitor's closet.

**H 24.04 Medical staff.** (1) The hospital shall have a medical staff organized under bylaws approved by the governing body, and responsible to the governing body of the hospital for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members.

Note: The term "medical staff" includes dentists on the staff as well as physicians. Where hospital dental services are minimal or confined largely to oral surgery they are usually conducted as a section of the department of surgery coequal with the other surgical specialties. Where dental services are more extensive and organized into a department of dentistry, coequal with the other major departments "medical and dental staff" would be preferred. See s. H 24.12 (1) (c).

(a) The medical staff shall be responsible for support of medical staff and hospital policies.

1. Medical staff members shall participate on various staff committees. Committee records shall verify that committee meetings shall be attended by the majority of committee members.

2. There shall be prescribed enforced disciplinary procedures for infraction of hospital and medical policies.

(b) The medical staff shall attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. It is recommended that a minimum of 20% of all hospital deaths be autopsied.

1. The hospital shall have an autopsy rate consistent with the needs of its ongoing staff education program.

2. Autopsy reports shall be distributed to the attending physician and become a part of the patient's record. Whenever possible, they shall be utilized in conference.

3. The autopsy shall be performed by a pathologist or physician versed in autopsy procedure and protocol.

(c) The medical staff shall have established policies concerning the holding of consultations.

1. The status of consultant shall be determined by the medical staff on the basis of an individual's training, experience, and competence. A person selected as a consultant shall be well qualified to give an opinion in the field in which his opinion is sought.

2. Except in an emergency, consultations with another qualified physician shall be held in all cases in which, according to the judgment of the attending physician:

a. The patient is not a good medical or surgical risk.

b. The diagnosis is obscure.

c. There is doubt as to the best therapeutic measures to be utilized.

d. There is a question of criminal action.

3. A satisfactory consultation shall include examination of the patient and the record. A written opinion signed by the consultant shall be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency shall be recorded prior to operation.

4. The patient's physician shall be responsible for requesting consultations when indicated. It shall be the duty of the medical staff, through its chiefs of service and executive committee, to make certain that members of the staff do not fail in the matter of calling consultants as needed.

5. Routine procedures such as an x-ray examination, electrocardiogram determination, tissue examination, and protoscopic and cystoscopic procedures are not normally considered to be consultations.

Note: See s. H 24.12 (2) Maternity (f) Patient Care I. Consultation for obstetrical cases.

### MEMBERSHIP

(d) Staff appointments shall be made by the governing body, taking into account recommendations made by the active staff.

1. The governing body shall have the legal right to appoint the medical staff and the moral obligation to appoint only those physicians who are judged by their fellows to be of good character and qualified and competent in their respective fields.

Note: The term "medical staff" includes dentists on the staff as well as physicians.

2. Reappointments shall be made periodically, and recorded in the minutes of the governing body. Reappointment policies provide for a periodic appraisal of each member of the staff, including consideration of his physical and mental capabilities. Recommendations for such reappointments are noted either in the credential committee or medical staff meetings' minutes.

3. Temporary staff privileges (for example, locum tenens) shall be granted for a limited period if the physician is otherwise properly qualified for such.

(e) Members of the staff shall be qualified legally, professionally, and ethically for the positions to which they are appointed.

1. To select its members and delineate privileges, the hospital medical staff shall have a system, based on definite workable standards, to evaluate each applicant by its credentials committee (or in small hospitals, committee-of-the-whole) which makes recommendations to the medical staff and to the governing body.

2. Privileges shall be extended to duly licensed qualified physicians to practice in the appropriate fields of general practice, internal medicine, surgery, pediatrics, obstetrics, gynecology, and other recognized and accepted fields according to individual qualifications.

3. Criteria for selection shall be individual character, competence, training, experience, and judgment.

4. Under no circumstances shall the accordance of staff membership or professional privileges in the hospital be dependent solely upon certification, fellowship, or membership in a specialty body or society. All qualified candidates shall be considered by the credentials committee.

5. The scope of privileges to be accorded the physician shall be indicated. The privileges of each staff member shall be specifically stated or the medical staff shall define a classification system. If a system involving classification is used, the scope of the divisions shall be well defined, and

the standards which must be met by the applicant shall be clearly stated for each category.

(f) Regardless of any other categories having privileges in the hospital, there shall be an active staff, properly organized, which performs all the organizational duties pertaining to the medical staff. These include:

1. Maintenance of the proper quality of all medical care and treatment in the hospital.
2. Organization of the medical staff, including adoption of rules and regulations for its government (which require the approval of the governing body), election of its officers or recommendations to the governing body for appointment of the officers, and recommendations to the governing body upon all appointments to the staff and grants of hospital privileges.
3. Other recommendations to the governing body upon matters within the purview of the medical staff.

(g) In larger hospitals, and in some smaller hospitals, the medical staff may include one or more of the following categories in addition to the active staff, but this in no way modifies the duties and responsibilities of the active staff.

1. Honorary staff. The honorary staff may be composed of former active staff, retired or emeritus, and other physicians of reputation whom it is desired to honor.
2. Consulting staff. The consulting staff may be composed of recognized specialists willing to serve in such capacity. A member of the consulting staff may also be a member of the active staff, but only if the 2 appointments are made.
3. Associate staff. The associate staff may be composed of those members who use the hospital infrequently or those less experienced members undergoing a period of probation before being considered for appointment to the active staff.
4. Courtesy staff. The courtesy staff may be composed of those who desire to attend patients in the hospital but who, for some reason not disqualifying, are ineligible for appointment in another category of the staff.

## ORGANIZATION

(h) There shall be such officers as may be necessary for the government of the staff. These officers shall be members of the active staff and be elected by the active staff, unless this is precluded by hospital policy.

1. The officers shall be elected from and by the active staff or appointed in accordance with hospital policy on the basis of ability and willingness to assume responsibility and devote time to the office.
2. Where officers are elected, all election rules shall be carefully spelled out in the bylaws. The election shall be an open one and preferably by secret ballot.
3. The chief of staff:

a. Shall have direct responsibility for the organization and administration of the medical staff, in accordance with the terms of the medical staff constitution, bylaws, rules, and regulations.

b. In all medico-administrative matters, shall act in coordination and cooperation with the hospital administrator in giving effect to the policies adopted by the governing body.

c. Shall be responsible for the functioning of the clinical organization of the hospital and keep or cause to be kept careful supervision over the clinical work in all departments.

(i) Bylaws shall be adopted to govern and enable the medical staff to carry out its responsibilities.

1. The bylaws of the medical staff shall be a precise and clear statement of the policies under which the medical staff regulates itself.

2. Medical staff bylaws, rules and regulations shall include the following:

a. A descriptive outline of medical staff organization.

b. A statement of the necessary qualifications which physicians must possess to be privileged to work in the hospital, and of the duties and privileges of each category of medical staff.

c. A procedure for granting and withdrawing privileges to physicians.

d. A mechanism for appeal of decisions regarding medical staff membership and privileges.

e. A definite and specific statement forbidding the practice of the division of fees under any guise whatsoever.

f. Provision for regular meetings of the medical staff.

g. Provision for keeping accurate and complete clinical records.

h. A statement to the effect that the physician in charge of the patient shall be responsible for seeing that all tissue exclusive of liveborn infants removed at operation is delivered to the hospital pathologist, and that an examination and report is made of such tissue.

i. Provision for routine examination of all patients upon admission and recording of preoperative diagnosis prior to surgery.

Note: See s. H 24.12 (2). See Maternity for additional policies and admission (2) (b) and (2) (c) on routine examinations.

j. A ruling permitting a surgical operation only on consent of the patient or his legal representative, except in emergencies.

k. A statement providing that, except in emergency, consultation shall be required as outlined above.

l. A regulation requiring that physician's orders be recorded and signed.

m. If dentists and oral surgeons and other professional disciplines are to be admitted to staff membership, the necessary qualifications, status, privileges and rights of this group shall be stated in the bylaws.

## COMMITTEES

(j) The executive committee (or its equivalent) shall coordinate the activities and general policies of the various departments, act for the staff as a whole under such limitations as may be imposed by the staff, and receive and act upon the reports of the medical records, tissue, and such other committees as the medical staff may designate.

1. The committee shall meet at least once a month, and maintain a permanent record of its proceedings and actions.

2. Committee membership shall be made up of the officers of the medical staff, chiefs of major departments or services, and one or more members elected at large from the active medical staff provided a hospital may vary the composition of its committee structure consistent with the size of its medical staff.

3. Its functions and responsibilities include:

a. Considering and recommending action to the administrator on all matters which are of a medical administrative nature.

b. Investigating any reports of breach of ethics by members of the medical staff, as referred to this committee by the credentials committee.

c. Acting as the program committee for staff meetings, unless this responsibility shall be delegated to a specific committee.

Note: The structure of committee organization shall be a decision to be made by the medical staff as long as the required committee functions are carried out. A small staff may wish to function as a committee-of-the-whole. Others may wish to combine committee functions in 2 or 3 committees.

(k) The credentials committee (or its equivalent) shall review applications for appointment and reappointment to all categories of the staff. They shall delineate the privileges to be extended to the applicant and make appropriate recommendations to the governing body according to the procedure outlined in the hospital's medical staff bylaws.

1. The committee shall make recommendations for initial appointment, hospital privileges, promotions, and demotions.

2. The committee shall be advisory and investigative and make recommendations only. It is not given disciplinary or punitive powers.

(1) The joint conference committee (or its equivalent) shall be a medico-administrative advisory committee and shall be the official means of liaison among the medical staff, the governing body, and the administrator. In the absence of a joint conference committee, a formal means of liaison between the governing body and medical staff shall be established.

1. A formal means of liaison shall be provided even where there is medical staff representation on the governing body.

2. The committee shall meet at least 4 times per year and maintain a permanent record of its minutes.

3. Purposes of the committee shall include:

a. Communications to keep the governing body, medical staff, and administration cognizant of pertinent actions taken or contemplated by one or the other.

b. Consideration of plans for growth.

c. Consideration of issues affecting medical care which shall arise in the operation and affairs of the hospital.

(m) The medical records committee (or its equivalent) shall supervise the maintenance of medical records at the required standard of completeness. On the basis of documented evidence, the committee also shall review and evaluate the quality of medical care given the patient.

1. The committee shall meet at least once a month exclusive of the summer months, and submit a written report to the executive committee.

2. The committee's members shall represent a cross section of the clinical services. In large hospitals, each major clinical department may have its own committee.

3. Membership shall be staggered so that experienced committee physicians are always included. Senior residents may serve on this committee.

4. Review of the record for completeness can be performed for the most part by the medical record librarian. In addition, on-the-spot scanning of current inpatient records for completeness shall be done on the floors.

5. The quality of patient care shall be evaluated from the documentation on the chart. In some hospitals, this function may be given to an "audit" or "evaluation" committee.

6. The committee:

a. Shall make recommendations to the medical staff for the approval of, use of, and any changes in form or format of the medical record.

b. Shall advise and recommend policies for medical record maintenance and supervise the medical records to insure that details are recorded in the proper manner and that sufficient data are present to evaluate the care of the patient.

c. Shall insure that there is proper filing, indexing, storage, and availability of all patient records.

d. With the aid of legal counsel, shall advise and develop policies to guide the medical record librarian, medical staff, and administration so far as matters of privileged communication and legal release of information are concerned.

(n) The tissue committee (or its equivalent) shall review and evaluate all surgery performed in the hospital on the basis of agreement or disagreement among the preoperative, postoperative, and pathological diagnoses, and on the acceptability of the procedure undertaken.

1. The committee shall meet at least once a month, exclusive of the summer months, and submit a written report to the executive committee.

2. This committee's work shall include continuing education through such mechanisms as utilization of its findings in the form of hypothetical cases and/or review of cases by category at staff meetings and/or publishing in coded form physicians' standings in the hospital regarding percentage of cases in which normal tissue is removed.

(o) Meetings of the medical staff shall be held to review, analyze, and evaluate the clinical work of its members. The number and frequency of medical staff meetings shall be determined by the active staff and clearly stated in the bylaws of the staff. Attendance requirements for each individual member of the staff and for the total attendance at each meeting shall be clearly stated in the bylaws of the staff. Attendance records shall be kept. Adequate minutes of all meetings shall be kept. The method adopted to insure adequate evaluation of clinical practice in the hospital shall be determined by the medical staff and clearly stated in the bylaws. Any one of the following 3 methods will fulfill this requirement: monthly meetings of the active staff; monthly departmental conferences in those hospitals where the clinical services shall be well organized and each department is large enough to meet as a unit; and, monthly meetings of the medical records and tissue committees at which the quality of medical work shall be adequately appraised, action taken by the executive committee, and reports made to the active staff.

1. Absence of a staff member from more than the specified percentage of regular meetings for the year, unless excused by the executive committee for just cause such as absence from the community or sickness, shall be considered as resignation from the active medical staff.

2. Staff and departmental meetings shall be held for the purpose of reviewing the medical care of patients within the hospital and those recently discharged.

3. Minutes of such meetings shall give evidence of the following:

a. A review of the clinical work done by the staff on at least a monthly basis; this shall include consideration of selected deaths, unimproved cases, infections, complications, errors in diagnosis, results of treatment, and review of transfusions.

b. Consideration of the hospital statistical report on admissions, discharge, clinical classifications of patients, autopsy rates, hospital infections, and other pertinent hospital statistics.

c. Short synopsis of each case discussed.

d. Names of discussants.

e. Duration of meeting.

#### DEPARTMENTALIZATION

(p) Division of the staff into services or departments to fulfill medical staff responsibilities promotes efficiency and is recommended in general hospitals with 75 or more beds. Each autonomous service or department shall be organized and function as a unit. Medical staff members of each service or department shall be qualified by training and demonstrated competence and granted privileges commensurate with their individual abilities. The chief of service or department shall be a member of the

service or department qualified by training, experience, and administrative ability for the position. He shall be responsible for the administration of the department, for the general character of the professional care of patients, and for making recommendations as to the qualifications of its members. He also shall make recommendations to the administration as to the planning of hospital facilities, equipment, routine procedures, and any other matters concerning patient care. In those hospitals where the review and evaluation of clinical practice are done by committees of the medical staff or by monthly meetings of the entire staff, departmental meetings shall be optional. In those hospitals where the clinical review is done by the departments, each service or department shall meet at least once a month. Records of these meetings shall be kept and become part of the medical staff.

1. Selection of each chief of service by the governing body shall never be made without first obtaining reliable medical advice.

2. Duties and responsibilities of the chief shall include, in addition to those cited above:

a. Responsibility for arranging and expediting inpatient and outpatient departmental programs embracing organization, educational activities, supervision, and evaluation of the clinical work.

b. Responsibility for enforcement of the hospital medical staff bylaws, rules, and regulations, with special attention to those pertaining to his department.

c. Cooperation with the hospital administration with respect to the purchase of supplies and equipment and in formulating special regulations and policies applicable to his department, such as standing orders and techniques.

d. Maintaining the quality of the medical records in his department.

e. Representing his department, in a medical advisory capacity, to the administration and governing body.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.05 Nursing department.** (1) The hospital shall have an organized nursing department. A registered professional nurse shall be on duty at all times and professional nursing service shall be available for all patients at all times.

Note: Wherever the words "professional nurse" appear, this means a nurse who is currently registered in Wisconsin as a professional nurse.

(a) There shall be a well organized departmental plan of administrative authority with delineation of responsibilities and duties of each category of nursing personnel.

1. The delineation of responsibilities and duties for each category of the nursing staff shall be in the form of a written job description for each category.

(b) There shall be an adequate number of registered professional nurses to meet the following minimum staff requirements: director of the nursing department; assistants to the director for evening and night services; supervisory and staff personnel for each department or nursing

unit to insure the immediate availability of a registered professional nurse for bedside care of any patient when needed; and, registered professional nurse on duty at all times and available for all patients on a 24-hour basis.

1. The staffing pattern shall insure the availability of registered professional nursing care for all patients on a 24-hour basis every day.

2. If a licensed practical nurse or nursing assistant is on duty during the evening and night hours in a ward with patients who do not need skilled nursing care, there shall be a registered professional nurse supervisor who shall make frequent rounds and shall be immediately available to give skilled nursing care when needed. She shall be free to render bedside care, and shall not be occupied in the operating room, delivery room, or emergency room.

Note: A licensed practical nurse means a person currently licensed in Wisconsin.

3. The ratio of registered professional nurses to patients together with the ratio of registered professional nurses to other nursing personnel shall be adequate to provide proper patient care and supervision of staff performance.

4. A registered professional nurse shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of the nursing staff available.

(c) There shall be other nursing personnel in sufficient numbers to provide nursing care not requiring the service of a registered professional nurse.

1. The training and supervision of these personnel shall be continually planned and carried out to enable them to perform effectively the duties which are assigned to them.

(d) There shall be adequate nursing personnel for all patient services of the hospital in keeping with their size and degree of activity.

1. A registered professional nurse shall be in charge of the operating rooms and delivery suites.

2. Nursing assistants, surgical technicians, and licensed practical nurses may be permitted to "scrub" under the direct supervision of a registered professional nurse; they shall not be permitted to function as circulating nurses in the operating rooms and the delivery room.

(e) Individuals selected for the nursing staff shall be qualified by education, experience, and demonstrated ability for the positions to which they are appointed.

1. The director of nursing shall make decisions relative to the selection and promotion of nursing personnel based on their qualifications and capabilities and recommend the termination of employment when this is necessary.

2. The educational and experiential qualifications of the director of nursing, her assistants, and supervisors shall be commensurate with the size and complexity of the hospital.

3. The functions and qualifications of nursing personnel shall be clearly defined in relation to the duties and responsibilities delegated to them.

4. There shall be a procedure to insure that hospital nursing personnel for whom licensure is required to have valid and current licensure.

5. Personnel records including application forms and verification of credentials shall be on file.

6. New employes shall be oriented to the hospital, nursing service, and their jobs.

(f) There shall be well-established working relationships with other services of the hospital, both administrative and professional.

1. Registered professional nurses shall confer with the physicians relative to patient care.

2. Interdepartmental policies affecting nursing service and nursing care to patients shall be made jointly with the director of nursing.

3. There shall be established procedures for scheduling laboratory and x-ray examinations, for ordering, securing and maintaining supplies and equipment needed for patient care, for ordering diets, etc.

(g) There shall be constant review and evaluation of the nursing care provided for patients. There shall be written nursing care procedures and written nursing care plans for patients.

1. Nursing care policies and procedures shall be written and consistent with generally accepted practice and reviewed and revised as necessary to keep pace with best practice and new knowledge. Written nursing care policies shall be available on each nursing unit.

2. A registered professional nurse shall plan, supervise, and evaluate the nursing care for each patient.

3. Nursing care plans shall be kept current daily. Plans shall indicate nursing care needed, how it shall be accomplished, and methods, approaches and modifications necessary to insure best results for the patient.

4. Nursing notes shall be informative and descriptive of the nursing care given and include information and observations of significance so that they contribute to the continuity of patient care.

5. Only a) a licensed physician or a registered professional nurse or b) under the direct supervision of a registered professional nurse, a licensed practical nurse, or a student nurse in an approved school of nursing shall be permitted to administer medications, and in all instances, in accordance with the nurse practice act, ch. 149, [441] Stats.

6. All medical orders shall be in writing and signed by the physician. Telephone orders shall be used sparingly, given only to registered professional nurse, and signed or initiated by the physician.

Note: See sub. (2) (o) 2.

7. Blood transfusions and intravenous medications shall be administered in accordance with the nurse practice act, ch. 149, [441] Stats. If

administered by registered professional nurses, they shall be administered only by those who have been specially trained for this procedure.

8. There shall be an effective hospital procedure for reporting transfusion reactions and adverse drug reactions, accidents, medication errors, etc.

(h) Meetings of the registered professional nursing staff shall be held at least monthly to discuss patient care, nursing service problems, and administrative policies. The pattern for meetings may be by clinical departments, by categories of the staff, or by the staff as a whole. Minutes of all meetings shall be kept.

1. Minutes shall reflect the purpose of the staff meetings; e.g., review and evaluation of nursing care, ways of improving nursing service, discussion of nursing care plans for individual patients, consideration of specific nursing techniques and procedures, establishment and/or interpretation of nursing department policies, interpretation of administrative and medical staff policies, reports of meetings, etc.

2. Minutes shall be available to staff members either individually or maintained in a central place.

(2) The hospital shall meet the following additional patient care requirements:

(a) *Medications, stop orders and signatures.* 1. Medications shall not be poured by nursing personnel on one shift for administration during succeeding shifts. This is not to be construed to prohibit the unit dose system under the direction of the pharmacist.

2. Telephone orders shall be signed or initialed by the physician within 24 hours.

Note: See sub. (1) (g) 6.

3. Nurses' notes shall be signed, not initialed.

(b) *Nursing personnel.* 1. Nursing personnel assigned to care for obstetrical patients shall not have other duties which may create danger of infection being carried to these services.

2. Private duty nurses shall be under the supervision of the professional nurse in charge of the unit to which their patient is assigned and under the general direction of the director of nurses.

3. There shall be a continuing inservice education program in effect for all nursing personnel and volunteers giving direct patient care in addition to a thorough job orientation for new personnel and volunteers. Skill training for nonprofessional nursing personnel shall begin during the orientation period.

Note: See sub. (5) (a).

4. Each nurse employe shall wear a badge, tag or uniform which identifies his status.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

Register, April, 1984, No. 340  
Health

**H 24.06 Dietary department.** (1) The hospital shall have an organized dietary department directed by qualified personnel.

**Note:** A hospital which has a contract with an outside food management company or has a food service manager may be found to meet these rules if the company has a therapeutic dietitian who serves, as required by scope and complexity of the service, on a full-time, part-time, or consultant basis to the hospital and provided the company maintains the minimum standards as noted herein and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

(a) There shall be an organized department directed by qualified personnel and integrated with other departments of the hospital. There shall be a qualified dietitian, full-time or on a consultation basis, and, in addition, administrative and technical personnel competent in their respective duties.

1. There shall be written policies and procedures for food storage, preparation, and service developed by a qualified dietitian (preferably meeting the American dietetic association's standards for qualification).

2. The department shall be under the supervision of a qualified dietitian who shall be responsible for quality food production, service and staff education. The dietitian shall serve on a full-time basis if possible or, in smaller hospitals, on a regular part-time supervising or consulting basis.

3. In the absence of a full-time dietitian, there shall be a qualified person serving as full-time director or the department who shall be responsible for the daily management aspects of the department and the dietitian shall visit the hospital at intervals to supervise and instruct personnel.

4. The number of professional dietitians shall be adequate considering the size of the facility and the scope and complexity of dietary functions.

5. Supervisors, other than dietitians, shall be assigned in numbers and with ability to provide a satisfactory span of control to meet the needs of the physical facilities and the organization as well as coverage for all hours of departmental operation.

6. The number of personnel, such as cooks, bakers, dishwashers, and clerks, shall be adequate to perform effectively all defined functions.

7. Written job descriptions of all dietary employes shall be available.

8. There shall be an inservice training program for dietary employes which shall include the proper handling of food and personal grooming.

(b) Facilities shall be provided for the general dietary needs of the hospital. These include facilities for the preparation of special diets. Sanitary conditions shall be maintained in the storage, preparation, and distribution of food.

1. All dietary areas shall be appropriately located, adequate in size, well lighted, ventilated and maintained.

2. The type, size, and layout of equipment shall provide for ease of cleaning, optimal work-flow and adequate food production to meet the scope and complexity of the regular and therapeutic diet requirements of the patients.

3. Equipment and work areas shall be clean and orderly. Effective procedures for cleaning all equipment and work areas shall be followed consistently to safeguard the health of the patient.

4. Lavatories specifically for handwashing, including hot and cold running water, soap and approved disposable towels, shall be conveniently located throughout the department for use by food handlers.

5. There shall be procedures to control dietary employees with infectious and open lesions.

6. The dietary department when routinely inspected and approved by state or local health agencies as a food handling establishment shall have written reports of the inspection on file at the hospital with notation made by the hospital of action taken to comply with recommendations.

7. Dry or staple food items shall be stored at least 12 inches off the floor in a ventilated room which is not subject to sewage or waste water back-flow or contamination by condensation, leakage, rodents or vermin.

8. All perishable foods shall be refrigerated at the appropriate temperature and in an orderly and sanitary manner.

9. Foods being displayed or transported shall be protected from contamination and held at proper temperatures in clean containers, cabinets or serving carts.

10. Dishwashing procedures and techniques shall be well developed, understood, and carried out in compliance with the state and local health codes and with periodic check on:

- a. Detergent dispenser operation.
- b. Washing, rinsing, and sanitizing temperatures and cleanliness of machine and jets.
- c. Routine bacterial counts on dishes, flatware, glasses, utensils and equipment.
- d. Thermostatic controls.

11. All garbage and kitchen refuse which is not disposed of through a disposal shall be kept in leakproof nonabsorbent containers with close fitting covers and disposed of daily in a manner that will not permit transmission of disease, a nuisance, or a breeding place for flies. All garbage containers shall be thoroughly cleaned inside and out each time emptied.

(c) There shall be a systematic record of diets, correlated, when appropriate, with the medical records.

1. Therapeutic diets shall be prescribed in written orders on the chart by the physician and shall be as instructive, accurate, and complete as possible; for example, bland low residual diet or, if a diabetic diet is ordered, the exact amounts of carbohydrate, protein, and fat allowed shall be noted.

2. Nutrition needs shall be met in accordance with those recommended dietary allowances, incorporated herein by reference, which are set forth in Publication 1146, National Academy of Sciences—National Research

Council, entitled "Recommended Dietary Allowances, Sixth Revised Edition", being "A Report of the Food and Nutrition Board, National Academy of Sciences—National Research Council."

Note: A copy of this is on file at the offices of the division of health, the secretary of state, and the revisor of statutes, and such copy may be obtained at the Printing and Publishing Office, National Academy of Sciences, 2101 Constitution Avenue, N.W., Washington, D.C. 20418.

3. The dietitian shall have available an up-to-date manual of regimens for all therapeutic diets, approved jointly by the dietitian and medical staff, which shall be available to dietary supervisory personnel. Diets served to patients shall be in compliance with these established diet principles.

4. The dietitian shall correlate and integrate the dietary aspects of patient care with the patient and patient's chart through such methods as patient instruction and recording diet histories and participate appropriately in ward rounds and conferences, sharing specialized knowledge with others of the medical team.

(d) Departmental and interdepartmental conferences shall be held periodically.

1. The director of dietetics shall attend and participate in meetings of heads of departments and functions as a key member of the hospital staff.

2. The director of dietetics shall have regulary scheduled conferences with the administrator or his designee to keep him informed, seek his counsel, and present program plans for mutual consideration and solution.

3. Conferences shall be held regularly within the department at all levels of responsibility to disseminate information, interpret policy, solve problems, and develop procedures and program plans.

(2) The hospital shall meet the following additional kitchen sanitation and dishwashing, general sanitation and dietary requirements.

(a) *Kitchen sanitation.* 1. Surfaces with which food or beverages come in contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning.

2. Utensils shall be stored in a clean, dry place protected from flies, splash, dust, overhead leakage and condensation and other contamination. Wherever practicable, utensils shall be covered or inverted.

3. Walls, ceilings, and floors of all rooms in which food or drink are stored, prepared, or served shall be kept clean and in good repair.

4. Dustless methods of cleaning shall be used. All except emergency cleaning shall be done during those periods when the least amounts of food and drink are exposed.

5. Tin cans shall be rinsed and flattened before disposal if not otherwise disposed of in a sanitary manner.

(b) *Washing and sanitization of kitchen utensils.* 1. Utensils shall include any dishes, kitchenware, tableware, glassware, cutlery, containers,

covers, or other equipment with which food and drink come in contact during storage, preparation or serving.

2. Facilities for either manual or mechanical prewashing shall be provided.

### MANUAL DISHWASHING

3. A 2-compartment sink shall be provided as a minimum.

4. The utensils shall be washed in hot water at a temperature of 110°-120° F., containing an adequate amount of an effective soap or detergent. Water shall be kept clean by changing it frequently.

5. Following handwashing, all utensils shall be sanitized by either of the following 2 methods:

a. First method. Submerge all utensils for 30 seconds in clean water maintained at a temperature of 170° F. or more.

b. Second method. All utensils shall be submerged or rinsed following the washing operation in hot water at a minimum temperature of 110° F. to remove soap or detergent, and then be submerged for at least 2 minutes in a hypochlorite solution. The solution shall be made up with chlorine concentration of at least 100 parts per million and shall be discarded when the chlorine concentration goes below 50 parts per million. All hypochlorite solutions shall be prepared fresh at least 3 times each day prior to its use in sanitizing the dishes used at each main meal period, and at least twice each day if only glassware is sanitized. Soaps, water softeners, washing compounds and detergents shall not be added to hypochlorite solutions. Utensils shall be racked in baskets so that all surfaces will be reached by the chemical solution while submerged. Other chemical sanitizing solutions may be approved for use by the state health officer in which case the concentration will be specified.

6. A suitable thermometer shall be provided for frequent determination of the temperature of the water used for sanitizing, washing and rinsing utensils.

### MECHANICAL DISHWASHING

7. Utensils shall be stacked in racks or trays so as to avoid overcrowding and in such manner as to assure complete washing contact with all surfaces of each article.

8. The wash water temperature of the utensil washing machine shall be held at from 130° F. - 150° F. The utensils shall be in the washing section for at least 20 seconds.

9. A detergent shall be used in all utensil washing machines.

10. For sanitizing in a spray type machine, dishes shall be subjected to a rinse period of 10 seconds or more at a temperature in the line of at least 180° F. For sanitizing in an immersion tank type machine, dishes shall be submerged for 30 seconds or more with water at a temperature of 170° F. or more. There shall be a constant change of water through the inlet and overflow.

11. Thermometers shall be located in both the wash compartment and rinse water lines at the machine so as to be readily visible.

12. Drying cloths, if used, shall be clean and shall be used for no other purpose.

13. Brushes, dish mops, dishcloths, drying cloths and other hand aids used in dishwashing operation shall be sanitized after each period of use.

(c) *General sanitation.* 1. Necessary means for the elimination of rodents, flies, roaches, bedbugs, fleas and lice shall be used.

2. Poisonous compounds shall be stored in original containers separate from food and kitchenware and properly protected.

3. No common drinking vessels shall be permitted.

4. No common towels shall be permitted at handwashing sinks.

(d) *Canned or preserved foods.* 1. Food canned or otherwise preserved in the institution shall be processed under controlled conditions using methods currently recommended by the bureau of home economics, U.S. department of agriculture.

2. Nonacid vegetables, meat and poultry shall be canned by pressure cooker methods.

3. Donations of home-canned foods shall not be accepted by the institution for reasons of sanitation and safety.

(e) *Milk and milk products.* 1. Milk and milk products shall be grade A pasteurized and procured from sources conforming to joint standards established by the state department of agriculture and the division of health, which standards are incorporated herein by reference, and are set forth in the Wisconsin Administrative Code, state department of agriculture, ch. Ag 80.

Note: A copy of this is on file at the offices of the division of health, the secretary of state, and the revisor of statutes, and such copy may be obtained at the Department of Agriculture, Trade and Consumer Protection, 801 W. Badger Road, Madison, Wisconsin.

2. Milk and fluid milk products shall be served from the original containers in which they are received from the distributor.

(f) *Cooks and food handlers.* 1. Cooks and food handlers shall wear clean outer garments, hair nets or caps and shall keep their hands clean at all times while engaged in handling food, drink, utensils or equipment.

(g) *Garbage can washing facilities shall be provided.*

(h) *Refrigeration.* All refrigerators shall have and be capable of maintaining temperatures of 40° F. or below.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.07 Medical record department.** (1) The hospital shall have a medical record department with administrative responsibility for medical records. A medical record shall be maintained, in accordance with accepted professional principles, for every patient admitted for care in the hospital.

**ADMINISTRATIVE RESPONSIBILITIES**

(a) A medical record shall be maintained for every patient admitted for care in the hospital. Such records shall be kept confidential.

1. Only authorized personnel shall have access to the record.
2. Written consent of the patient shall be presented as authority for release of medical information.
3. Medical records generally shall not be removed from the hospital environment except upon subpoena.

(b) There shall be a written policy for the preservation of medical records, either in the original or by microfilm, for a period of time determined by each hospital based on historical research, legal, teaching and patient care needs.

*Note:* The American hospital association recommends retaining medical records for medical research and legal reasons for a period of 25 years after discharge or patient's death. Where there is little reason to refer to medical records in a given institution, the AHA recommends that a summary card be made and that the records be destroyed after 10 years except in the case of minors, whose records should be kept until they reach their majority.

(c) Qualified personnel adequate to supervise and conduct the department shall be provided.

1. Preferably a registered medical record librarian shall head the department. If such a professionally qualified person is not in charge of medical records, a qualified consultant or trained part-time medical record librarian shall organize the department, train the regular personnel, and make periodic visits to the hospital to evaluate the records and the operation of the department.

2. A sufficient number of regular full-time and part-time employees shall be available so that medical record services may be provided as needed.

(d) A system of identification and filing to insure the prompt location of a patient's medical record shall be maintained.

1. Index cards shall bear at least the full name of the patient, the sex, the address, the birthdate, the medical record number, and the social security number.

2. Filing equipment and space shall be adequate to house the records and facilitate retrieval.

3. A unit record shall be maintained so that both in- and outpatient treatments are in one folder.

(e) All clinical information pertaining to a patient's stay shall be centralized in the patient's record.

1. The original of all reports shall be filed in the medical record.

2. All reports or records shall be completed and filed within a period consistent with good medical practice and not longer than 15 days following discharge.

(f) Records shall be indexed according to disease, operation, and physician and shall be kept up-to-date. For indexing, any recognized system may be used.

1. As additional indices become appropriate due to advances in medicine, their use shall be adopted.

2. The index shall list on a card (or other systematic record) for a specific disease or operation, according to a recognized nomenclature, all essential data on each patient having that particular condition. "Essential data" shall include at least the medical record number of the patient so that the record may be located. All conditions for which the patient is treated during the hospitalization shall be so indexed.

3. In hospitals using automatic data processing, indexes may be kept on punch cards or reproduced on sheets kept in books.

4. Diagnoses and operations shall be expressed in terminology which describes the morbid condition both as to site and ethiological factors or the method of procedure.

5. Indexing shall be current within 6 months following discharge of the patient.

### MEDICAL STAFF RESPONSIBILITIES

(g) The medical records shall contain sufficient information to justify the diagnosis and warrant the treatment and end results. The medical records shall contain the following information; identification data, chief complaint, present illness, past history, family history, physical examination, provisional diagnosis, clinical laboratory reports, x-ray reports, consultations, treatment—obstetrical, medical and surgical, tissue report, progress notes, final diagnosis, discharge summary, and, autopsy findings.

1. The chief complaint shall include a concise statement of complaints which led the patient to consult his physician and the date of onset and duration of each.

2. The physical examination statement shall include all positive and negative findings resulting from an inventory of systems.

3. The provisional diagnosis shall be a diagnostic impression reflecting the examining physician's evaluation of the patient's condition.

4. A consultation report shall be a written medical opinion signed by the consultant, including his findings on physical examination of the patient.

5. All diagnostic treatment procedures shall be recorded in the medical record.

6. Tissue reports shall include a report of microscopic findings if hospital regulations require that microscopic examination be done. If only gross examination is warranted a statement that the tissue has been received and a gross description shall be made by the laboratory and filed in the medical record.

7. Progress notes shall give a chronological picture of the patient's progress and shall be sufficient to delineate the course and the results of treatment. The condition of the patient shall determine the frequency with which they are made.

8. A definitive final diagnosis shall be expressed in terminology of a recognized system of disease nomenclature.

9. The discharge summary shall be a recapitulation of the significant findings and events of the patient's hospitalization and his condition on discharge.

10. Autopsy findings in a complete protocol shall be filed in the record when an autopsy is performed.

11. A chronological listing of the patient's previous records shall be maintained in the front of the chart.

(h) Only members of the medical staff and the medical house staff shall be competent to write or dictate medical histories and physical examinations or other professional personnel authorized by the medical staff.

(i) Records shall be authenticated and signed by a licensed physician.

1. Every physician shall sign the entries which he himself makes.

2. A single signature on the fact sheet of the record shall not suffice to authenticate the entire record.

3. In hospitals with medical house staff, the attending physician shall countersign at least the history and physical examination and summary written by a member of the house staff.

(j) Current records and those on discharged patients shall be completed promptly.

1. Current records shall be completed within 24-48 hours following admission.

2. Records of patients discharged shall be complete within 15 days following discharge.

3. If a patient is readmitted within a month's time for the same condition, reference to the previous history with an interval note and physical examination shall suffice.

(2) The hospital shall meet the following additional medical record requirements.

(a) *Maternity patient and newborn records.* 1. Except in an emergency the attending physician shall, prior to admission of a maternity patient, submit a written prenatal history stressing complications, Rh determination and other pertinent information essential to adequate care.

2. A record of each delivery shall be kept in the delivery suite record book.

3. Each obstetric patient shall have a complete hospital record including the following:

a. Prenatal history and findings.

- b. Labor and delivery record including anesthesia.
- c. Doctor's progress record.
- d. Doctor's order sheet.
- e. Medicine and treatment sheet including nurses' notes.
- f. Laboratory and x-ray reports.
- g. Medical consultant's notes.
- h. Estimate of blood loss.

4. Each newborn infant shall have a complete hospital record including the following:

- a. Record of pertinent maternal data, type of labor and delivery, and condition of infant at birth.
- b. Physical examinations.
- c. Progress sheet (medicine, treatments, weights, feedings and temperatures).
- d. Medical consultant's notes.

5. Pertinent data from the records of the maternity patient and the newborn shall, upon presentation of a signed consent form by the patient, natural mother or guardian be provided to state, county or licensed child welfare agencies.

6. In the case of a fetal death the weight and length of the fetus shall be recorded on the delivery record.

7. Hospitals admitting non-obstetric patients to the obstetric unit shall maintain a log book listing name, hospital number, date of admission, diagnosis, date of discharge or transfer (state reason for transfer), which shall be available for review at all times.

(b) *Birth and death records.* 1. Physicians shall file birth and death certificates including fetal death certificates in compliance with Wisconsin statutes.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.08 Pharmacy or drug room.** (1) The hospital shall have a pharmacy directed by a registered pharmacist or a drug room under competent supervision. The pharmacy or drug room shall be administered in accordance with accepted professional principles.

(a) There shall be a pharmacy directed by a registered pharmacist of a drug room under competent supervision.

1. The pharmacist shall be trained in the specialized functions of hospital pharmacy.

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

3. If there is a drug room with no pharmacist, prescription medications shall be dispensed by a qualified pharmacist elsewhere, and only storing and distributing shall be done in the hospital. A consulting pharmacist shall assist in drawing up the correct procedures, rules, and regulations for the distribution of drugs, and shall visit the hospital on a regularly scheduled basis in the course of his duties. Wherever possible the pharmacist, in dispensing drugs, shall work from the prescriber's original order or a direct copy.

Note: Registered, qualified, or consulting pharmacist means a pharmacist registered in Wisconsin.

(b) Facilities shall be provided for the storage, safeguarding, preparation, and dispensing of drugs.

1. Drugs shall be issued to floor units in accordance with approved policies and procedures.

2. Drug cabinets on the nursing units shall be routinely checked by the pharmacist. All floor stocks shall be properly controlled.

3. There shall be adequate space for all pharmacy operations and the storage of drugs at a satisfactory location provided with proper lighting, ventilation, and temperature controls.

4. If there is a pharmacy, equipment shall be provided for the compounding and dispensing of drugs.

5. Special locked storage space shall be provided to meet the legal requirements for storage of narcotics, alcohol, and other prescribed drugs.

(c) Personnel competent in their respective duties shall be provided in keeping with the size and activity of the department.

1. The pharmacist shall be assisted by an adequate number of additional registered pharmacists and such other personnel as the activities of the pharmacy may require to insure quality pharmaceutical services.

2. The pharmacy, depending upon the size and scope of its operations, shall be staffed by the following categories of personnel:

- a. Chief pharmacist.
- b. One or more assistant chief pharmacists.
- c. Staff pharmacists.
- d. Pharmacy trainees (where a program has been activated).

3. Provision shall be made for emergency pharmaceutical services.

4. If the hospital does not have a staff pharmacist, a consulting pharmacist shall have overall responsibility for control and distribution of drugs and a designated individual(s) shall have responsibility for day-to-day operation of the pharmacy.

Note: To be specified by the pharmacy and therapeutic committee.

(d) Records shall be kept of the transactions of the pharmacy (or drug room) and correlated with other hospital records where indicated. Such special records shall be kept as required by law.

1. The pharmacy shall establish and maintain in cooperation with the accounting department, a satisfactory system of records and bookkeeping in accordance with the policies of the hospital for:

a. Maintaining adequate control over the requisitioning and dispensing of all drugs and pharmaceutical supplies.

b. Charging patient for drugs and pharmaceutical supplies.

2. A record of the stock on hand and of the dispensing of all narcotic drugs shall be maintained in such a manner that the disposition of any particular item may be readily traced.

(e) Policies shall be established to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and the dosage.

1. The medical staff shall have established a written policy that all toxic or dangerous medications, not specifically prescribed as to time or number of doses, shall be automatically stopped after a reasonable time limit set by the staff. The classifications ordinarily thought of as toxic or dangerous drugs are narcotics, sedatives, anticoagulants, antibiotics, ox-tyocics, and cortisone products.

Note: See s. 151.07, Stats.

(f) There shall be a committee of the medical staff to confer with the pharmacist in the formulation of policies.

1. A pharmacy and therapeutic committee (or equivalent committee), composed of physicians and pharmacists, shall be established in the hospital. It represents the organizational line of communication and the liaison between the medical staff and the pharmacist.

2. The committee assists in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, and safety procedures and all other matters relating to drugs in hospitals.

3. The committee shall perform the following specific functions:

a. Serve as an advisory group to the hospital medical staff and the pharmacist on matters pertaining to the choice of drugs.

b. Develop and review periodically a formulary or drug list for use in the hospital.

c. Establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs.

d. Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.

e. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

f. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

4. The committee shall meet at least quarterly and shall report to the medical staff.

(g) Therapeutic ingredients of medications dispensed shall be included (or approved for inclusion) in the United States pharmacopoeia, national formulary, United States homeopathic pharmacopoeia, new drugs, or accepted dental remedies (except for any drugs unfavorably evaluated therein), or shall be approved for use by the pharmacy and drug therapeutics committee (or equivalent committee) of the hospital staff.

1. The pharmacist, with the advice and guidance of the pharmacy and therapeutic committee, shall be responsible for specifications as to quality, quantity, and source of supply of all drugs.

2. There shall be available a formulary or list of drugs accepted for use in the hospital which shall be developed and amended at regular intervals by the pharmacy and therapeutic committee (or equivalent committee) with the cooperation of the pharmacist (consulting or otherwise) and the administration.

3. The pharmacy or drug room shall be adequately supplied with preparations so approved.

(2) Additional requirements. (a) The pharmacy and therapeutic committee shall establish a procedure for reporting adverse medication reactions to the medical staff.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.09 Laboratories.** (1) The hospital shall have a well organized, adequately supervised clinical laboratory with the necessary space, facilities, and equipment to perform those services commensurate with the hospital's needs for its patients. Anatomical pathology services and blood bank services shall be available either in the hospital or by arrangement with other facilities.

### CLINICAL LABORATORIES

(a) Clinical laboratory services adequate for the individual hospital shall be maintained in the hospital.

1. The extent and complexity of service shall be commensurate with the size, scope, and nature of the hospital, and the demands of the medical staff upon the laboratory.

2. Basic laboratory services necessary for routine examinations shall be available regardless of the size, scope, and nature of the hospital.

3. Necessary space, facilities and equipment to perform both the basic minimum and all other services shall be provided by the hospital.

4. All equipment shall be in good working order, routinely checked, and precise in terms of calibration.

(b) Provision shall be made to carry out adequate clinical laboratory examination including chemistry, microbiology, hematology, serology, and clinical microscopy.

1. Some or all of these services may be provided under arrangements by the hospital with a laboratory which shall be certified by the division of health to provide these services.

2. In the case of work performed by an outside laboratory, the original report from this laboratory shall be contained in the medical record.

(c) Facilities and services shall be available at all times.

1. Adequate provision shall be made for assuring the availability of emergency laboratory services, either in the hospital or under arrangements with a laboratory which is certified by the division of health. Such services shall be available 24 hours a day, 7 days a week, including holidays.

2. Where services are provided by an outside laboratory, the conditions, procedures, and availability of work done shall be in writing and available in the hospital.

(d) Personnel adequate to supervise and conduct the services shall be provided.

1. Services shall be under the supervision of a pathologist, or a physician with training and experience in clinical laboratory services or a laboratory specialist qualified by a doctoral degree.

2. The laboratory shall not perform procedures and tests which are outside the scope of training of the laboratory personnel.

3. There shall be a sufficient number of clinical laboratory technologists to promptly and proficiently perform the tests requested of the laboratory.

(e) Routine examinations required on all admissions shall be determined by the medical staff. These shall include at least a urinalysis and a hemoglobin or hematocrit.

1. Required tests upon admission, as approved by the medical staff, shall be consistent with the scope and nature of the hospital.

2. The required list of tests shall be in written form and available to all members of the medical staff.

(f) Signed reports shall be filed with the patient's medical record and duplicate copies kept in the department.

1. The laboratory director shall be responsible for the laboratory report.

2. A copy of the clinical laboratory report shall be signed by the technologist.

3. There shall be a procedure for assuring that all requests for tests are ordered and signed by a physician.

#### ANATOMICAL PATHOLOGY

(g) Services of a pathologist shall be provided as indicated by the needs of the hospital.

1. Services shall be under the direct supervision of a pathologist on a full-time, regular part-time or regular consultative basis. If the latter pertains, the hospital provides for, at a minimum, monthly consultative visits by a pathologist.

2. The pathologist shall participate in staff, departmental and clinicopathologic conferences.

3. The pathologist shall be responsible for the qualifications of his staff and their inservice training.

(h) All tissues removed at operation (except newborn) shall be sent for examination. The extent of examination shall be determined by the pathology department.

1. All tissues removed from patients at surgery shall be macroscopically, and if necessary, microscopically examined by the pathologist.

2. The pathologist or designated physician, in his absence, shall be responsible for verifying the receipt of tissues for examinations.

3. A list of tissues which routinely require microscopic examination shall be developed in writing by the pathologist or designated physician with the approval of the medical staff.

4. A tissue file shall be maintained in the hospital.

5. In the absence of a pathologist or suitable physician substitute, there shall be an established plan for sending to a pathologist outside the hospital all tissues requiring examination.

6. Arrangements for tissue examinations done outside the hospital shall be made with a laboratory which is certified to provide this service by the division of health.

(i) Signed reports of tissue examinations shall be filed with the patient's medical record and duplicate copies kept in the department.

1. All reports of macro and microscopic examinations performed shall be signed by the pathologist or designated physician.

2. Provisions shall be made for the prompt filing of examination results in the patient's medical record and notification of the physician requesting the examination.

3. Duplicate copies of the examination reports shall be filed in the laboratory in a manner which permits ready identification and accessibility.

### BLOOD BANK SERVICES

(j) Facilities for procurement, safekeeping, and transfusion of blood and blood products shall be provided or readily available.

1. The hospital shall maintain, as a minimum, proper blood storage facilities under adequate control and supervision of the pathologist or other authorized physician.

2. For emergency situations the hospital shall maintain at least a minimum blood supply in the hospital at all times, can obtain blood quickly from community blood banks or institutions, or shall have an up-to-date list of donors and equipment necessary to bleed them.

3. Where the hospital depends on outside blood banks, there shall be an agreement governing the procurement, transfer and availability of

blood which is reviewed and approved by the medical staff, administration and governing body.

4. There shall be provision for prompt blood typing and cross matching, either through the hospital or by arrangements with others on a continuous basis, under the supervision of a physician.

5. Blood storage facilities in the hospital shall have an adequate alarm system, which shall be regularly inspected and otherwise safe and adequate.

6. Records shall be kept on file indicating the receipt and disposition of all blood provided to patients in the hospital.

7. Blood which has exceeded its expiration date shall be disposed of promptly.

8. A committee of the medical staff or its equivalent shall review all transfusions of blood or blood derivatives and make recommendations concerning policies governing such practices.

9. The review committee shall investigate all transfusion reactions occurring in the hospital and make recommendations to the medical staff regarding improvements in transfusion procedures.

(2) Laboratory evaluation. The hospital laboratory shall participate in laboratory evaluation programs that are offered by the division of health, in those specialties for which the laboratory offers services.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.10 Radiology department.** (1) The hospital shall have diagnostic X-ray facilities available. If therapeutic x-ray services are also provided, they, as well as the diagnostic services, shall meet professionally approved standards for safety and personnel qualifications.

Note: See s. H 24.03 (2) Physical environment, for reference to ch. H 57 [HSS 157] radiation protection code.

(a) The hospital shall maintain or shall have available radiological services according to needs of the hospital.

1. The hospital shall maintain or shall have diagnostic x-ray facilities available in the hospital building proper or in an adjacent clinic or medical facility that is readily accessible to the hospital patients, physicians, and personnel.

(b) The radiology department shall be free of hazards for patients and personnel.

1. Proper safety precautions shall be maintained against fire and explosion hazards, electrical hazards, and radiation hazards.

2. Periodic inspection shall be made by local or state health authorities or a radiation physicist, and hazards so identified shall be promptly corrected.

3. Radiation workers shall be checked periodically for amount of radiation exposure by the use of exposure meters or badge tests.

4. With fluoroscopes, attention shall be paid to modern safety design and good operating procedures; records shall be maintained of output of all fluoroscopes.

5. Regulations based on medical staff recommendations shall be established as to the administration of the application and removal of radium element, its disintegration products, and other radioactive isotopes.

(c) Personnel adequate to supervise and conduct the services shall be provided, and the interpretation of radiological examinations shall be made by physicians competent in the field.

1. The hospital shall have a qualified radiologist, either full-time or part-time on a consulting basis, both to supervise the department and to interpret films that require specialized knowledge for accurate reading. If the hospital is small, and a radiologist cannot come to the hospital regularly, selected x-ray films shall be sent to a radiologist for interpretation.

2. If the activities of the radiology department extend to radiotherapy, the physician in charge shall be appropriately qualified.

3. The amount of qualified radiologist and technologist time shall be sufficient to meet the hospital's requirements. A technologist shall be on duty or on call at all times.

4. The use of all x-ray apparatus shall be limited to personnel designated as qualified by the radiologist or by an appropriately constituted committee of the medical staff. The same limitation shall apply to personnel applying and removing radium element, its disintegration products, and radioactive isotopes. The use of fluoroscopes shall be limited to physicians.

(d) Signed reports shall be filed with the patient's record and duplicate copies kept in the department.

1. Requests by the attending physician for x-ray examination shall contain a concise statement of reason for the examination.

2. Reports of interpretations shall be written or dictated and signed by the radiologist.

3. X-ray reports and roentgenographs shall be preserved or micro-filmed in accordance with the statute of limitations.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.11 Medical library.** (1) The hospital shall have modern textbooks and current periodicals relative to the clinical services offered.

(a) The hospital shall maintain a medical library according to the needs of the hospital.

1. The medical library shall be located in the hospital building and its contents shall be organized, easily accessible, and available at all times to the medical and nursing staffs.

2. The library shall contain modern textbooks in basic sciences and other current textbooks, journals, and magazines pertinent to the clinical services maintained in the hospital.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.12 Complementary departments.** (1) In hospitals which have surgery, anesthesiology, dental, rehabilitation or maternity departments or services, there shall be effective policies and procedures, in addition to those set forth under "Medical Staff Departmentalization," relating to the staff and the functions of the service(s) in order to assure the health and safety of the patients.

(a) The department of surgery shall have effective policies and procedures regarding surgical privileges, maintenance of the operating rooms, and evaluation of the surgical patient.

1. Surgical privileges shall be delineated for all physicians doing surgery in accordance with the competencies of each physician. A roster of physicians specifying the surgical privileges of each shall be kept in the confidential files of the operating room supervisor and in the files of the hospital administrator.

2. In any procedure with unusual hazard to life, there shall be present and scrubbed as first assistant a physician designated by the credentials committee as being qualified to assist in major surgery.

3. Second and third assistants at major operations may be nurses, nursing assistants, or technicians if designated by the hospital authorities as having sufficient training to properly and adequately assist at such procedures.

4. The operating room register shall be complete and up-to-date.

5. Except in an emergency there shall be a complete history and physical work-up recorded in the chart of every patient prior to surgery (whether the surgery is major or minor). If such has been dictated or transcribed, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note by the physician in the chart.

6. A properly executed consent form for operation shall be in the patient's chart prior to surgery.

7. There shall be adequate provisions for immediate postoperative care.

8. An operative report describing techniques and findings shall be written or dictated immediately following surgery and signed by the surgeon.

9. All infections of clean surgical cases shall be recorded and reported to the administration and the infection committee. There shall be a procedure for the investigation of such cases.

10. The operating rooms shall be supervised by an experienced registered professional nurse.

11. The following equipment shall be available in the operating suites: call-in system, resuscitator, defibrillator, aspirator, thoracotomy set, and tracheotomy set.

12. The operating room suite and accessory services shall be so located that traffic in and out can be and is controlled and there is no through traffic.

13. Precautions shall be taken to eliminate hazards of explosions including use of shoes with conductive soles and prohibition of uniforms, blankets or other items of silk, wool or synthetic fibers which accumulate static electricity where explosive gases are used or stored.

14. Rules and regulations and/or policies related to the operating rooms shall be available and posted.

b. The department of anesthesia shall have effective policies and procedures regarding staff privileges, the administration of anesthetics, and the maintenance of strict safety controls. There shall be required for every patient: Preanesthetic physical examination by a physician with findings recorded within 48 hours of surgery; anesthetic record on special form; post-anesthetic follow-up, with findings recorded, by an anesthesiologist or nurse anesthetist.

1. The chairman of the department of anesthesia shall be responsible for the enforcement of the policies and procedures of the department.

2. In hospitals where there is no department of anesthesia, the department of surgery, shall assume the responsibility for establishing general policies and supervising the administration of anesthetics.

3. The director of the department of anesthesia preferably shall be also the director in charge of inhalation therapy. In any event, the inhalation therapy service shall be under the supervision of a qualified physician or physicians.

4. If anesthetics are not administered by a physician certified by the American board of anesthesiology, they shall be administered by a physician anesthetist or a registered nurse anesthetist under the supervision of the operating physician. The hospital staff shall designate those persons qualified to administer anesthetics and delineate what the person is qualified to do.

5. The post-anesthetic follow-up note shall be written 3 to 24 hours after the operation, and shall note any postoperative abnormalities or complications.

6. Where flammable anesthetics are used or stored the safety precautions shall include:

- a. Shockproof and sparkproof equipment.
- b. Humidity control.
- c. Proper grounding.
- d. Safety regulations posted.

e. Storage of flammable anesthetic and oxidizing gases meeting the standards of the National Fire Protection Association Code, which standards are incorporated herein by reference, and are set forth in National Fire Protection Association No. 56, Code for the Use of Flammable Anesthetics 1965.

Note: A copy of this is on file at the offices of the division of health, the secretary of state, and the revisor of statutes, and such copy may be obtained at the National Fire Protection Association, International, 60 Batterymarch Street, Boston, Massachusetts 02110.

- f. Policy for testing conductive flooring.

(c) According to the procedure established for the appointment of the medical staff, one or more dentists shall be appointed to the dental staff. If the dental service is organized, its organization shall be comparable to that of other services or departments. Whether or not the dental service is organized as a department, the following requirements shall be met: members of the dental staff shall be qualified legally, professionally, and ethically for the positions to which they are appointed; patients admitted for dental services shall be admitted by the dentist either to the department of dentistry or, if there is no department, to an organized clinical service; and, there shall be a physician in attendance who is responsible for the medical care of the patient throughout the hospital stay. A medical survey shall be done and recorded by a member of the medical staff before dental surgery is performed.

Note: The term "dental staff" refers to the group of dentists privileged to practice in a particular hospital. This is used as a generic term analogous to the "particular staff" or the "surgical staff." The dentists are members of the dental department or the dental section of the surgery department.

1. There shall be specific bylaws concerning the dental staff written as combined medical-dental staff bylaws or as separate or adjunct dental bylaws.

2. The staff bylaws, rules and regulations shall specifically delineate the rights and privileges of the dentists.

3. Complete records, both medical and dental, shall be required on each dental patient and shall be a part of the hospital records.

(d) The rehabilitation, physical therapy, and occupational therapy departments shall have effective policies and procedures relating to the organization and functions of the service(s) and shall be staffed by qualified therapists.

1. There may be a rehabilitation department, including both physical and occupational therapy and which may also include other rehabilitation services such as speech therapy, vocational counseling, and other appropriate services or there may be separate physical and/or occupational therapy departments.

2. The department head shall have the necessary knowledge, experience, and capabilities to properly supervise and administer the department. A rehabilitation department head shall be a physiatrist or other physician with pertinent experience. If separate physical or occupational therapy departments are maintained, the department head shall be a qualified physical or occupational therapist (as is appropriate) or a physician with pertinent experience.

3. If physical therapy services are offered, the services shall be given by or under the supervision of a qualified therapist. A qualified physical therapist shall be a graduate of a program in physical therapy approved by the council on medical education of the American medical association (in collaboration with the American physical therapy association) or its equivalent. Additional properly trained and supervised personnel shall be sufficient to meet the needs of the department.

Note: See s. 147.185, Stats.

4. If occupational therapy services are offered, the services shall be given by or under the supervision of a professional registered occupa-

tional therapist (OTR). Other properly trained and supervised personnel such as certified occupational therapy assistants (COTA) and aides, shall be sufficient to meet the needs of the department.

5. Facilities and equipment for physical and occupational therapy shall be adequate to meet the needs of the services and shall be in good condition.

6. Physical therapy or occupational therapy shall be given in accordance with a physician's orders, and such orders shall be incorporated in the patient's record.

7. Complete records shall be maintained for each patient provided such services and shall be part of the patient's record.

(2) Whenever maternity patients and newborns are accepted, the hospital shall provide safe and adequate facilities and render proper care.

(a) *Obstetric and newborn units.* 1. The number of beds and bassinets for obstetric patients and newborn infants, term and premature, shall be designated by the licensee and reported to the division of health.

2. Wherever possible, the individual hospitals shall reduce their obstetric unit bed capacity and continue to maintain a strictly segregated obstetric unit rather than admit non-obstetric patients to the obstetric unit.

3. Hospitals taking other than obstetric patients shall segregate newborn infants and labor and delivery suites.

4. Hospitals which admit to the obstetric unit adult female patients (16 years of age or over) other than obstetric patients shall comply with the following:

a. Shall have written policies and procedures incorporating the criteria for admission or exclusion and care of patients (both obstetric and non-obstetric, as well as newborn infants) and the proposed methods of control, supervision, means of implementation and evaluation, and shall submit same to the division of health prior to admitting non-obstetric patients to the obstetric unit.

b. Shall maintain a department or committee of obstetrics under the supervision of a physician who shall be responsible for carrying out the above plan.

c. Shall designate the rooms to which clean non-obstetric patients may be admitted to the obstetric unit.

d. These designated rooms shall be remote from the nurseries and away from traffic areas utilized in taking infants to mothers for feeding and mothers' rooms.

e. Separate bathroom facilities shall be maintained for obstetric patients.

f. Non-obstetric patients shall not be placed in the same room with obstetric patients.

g. Obstetric patients shall always take priority for facilities in the obstetric unit and a sufficient number of unoccupied beds shall always be

available in the unit to accommodate peak obstetric loads and emergency admissions.

5. Surgery on non-obstetric patients shall not be performed in the delivery suite.

6. Persons giving direct care to newborn infants shall not give care to non-obstetric patients.

Note: See s. H 24.05 (2) (b) 1.

(b) *Admissions, obstetrics.* 1. Infectious disease or suspect cases.

a. Segregation in the obstetric unit (private room with handwashing facilities) and use of isolation techniques in care shall be provided for; obstetric patients reported by their physician to have gastrointestinal, respiratory, skin or other communicable disease, or those reported to have had or been in contact with such a disease within one week preceding admission; undiagnosed or questionable cases such as those with elevated oral temperatures (100.4° F. or above) rash, or diarrhea, until the physician has diagnosed the condition as non-contagious.

b. Obstetric patients with acute infectious diseases shall not be admitted to the obstetric unit and patients developing such diseases after admission shall be transferred from the unit.

2. Delivery without preparation. When delivery occurs outside of the hospital, mother and baby shall be segregated (together or separately) for at least 48 hours.

3. Non-admission of sick infants. Sick infants or children admitted to the hospital shall not be placed in any room in the obstetric or newborn infant units.

4. Admission data—obstetric patients. The blood pressure, weight, temperature, pulse, respiration progress in labor, and the fetal heart rate shall be recorded for every obstetric patient on admission.

(c) *Non-obstetric.* When other than obstetric cases are placed in the obstetric unit compliance with the following shall be required:

1. The physician in charge of obstetrics or his designee shall be responsible for the supervision of admissions and any problems concerning admission or transfer of patients shall be cleared with him.

2. All admissions of non-obstetric patients shall be cleared through the physician in charge of obstetrics or the director of nursing service or their designee before admission to the obstetric unit.

3. Records shall be reviewed at least once daily and a plan shall be made by which patients showing evidence of infection can be transferred at any time during the day or night.

4. Types of patients that may be admitted:

a. Adult female patients (16 years of age or over) considered to be free of infection, malignancy (except cancer-in-situ) or debilitating conditions who have been examined by the physician within the last 48 hours prior to admission to the obstetric unit.

5. Type of patients that shall not be admitted or shall be transferred from the unit should any one of these conditions develop:

a. Patients with known or questionable infections.

b. Patients with observed symptoms or laboratory examination findings of infection.

c. Patients with unexpected purulent drainage or malignancy discovered in surgery. (This does not include noninvasive, intraepithelial carcinoma—cancer-in-situ).

d. Patients requiring intraperitoneal drainage.

e. Patients with postoperative wound infections.

f. Patients with other infections unrelated to the diagnosed condition such as skin, upper respiratory, or genito-urinary infections.

(d) *Staff practices.* 1. Exclusion of personnel caring for infected cases. Hospital personnel giving care to infected cases outside the obstetric unit shall not enter the obstetric unit.

2. Wearing apparel. a. Before giving care to infants in the maternity unit individuals entering the obstetric unit shall put on a clean uniform or gown and a head covering. Before giving care to mothers, individuals entering the O.B. unit shall put on a clean uniform or gown.

b. The staff leaving the maternity unit for brief periods shall remove their uniform or protect it with a clean gown.

c. Rings and wrist watches shall not be worn in nursery or delivery room.

3. Handwashing. Hands and forearms shall be washed with detergent or soap and running water before putting on a clean gown, before and after giving care to any patient, and after handling used equipment.

4. Mask technique. When masks are used, good technique shall be required. Masks shall:

a. Be washed and sterilized unless of a disposable type.

b. Be changed at least every hour and placed in a container marked "soiled masks".

c. Cover nose as well as mouth at all times.

d. Not be left hanging around neck or carried in pocket or belt.

e. Be considered contaminated once in use, and hands shall be washed if masks are touched.

(e) *Labor and delivery suite.* 1. Gowns and caps in labor room. Individual gowns and caps shall be worn by husbands or others while in the labor room.

2. Delivery room apparel. a. Street clothes shall not be worn in delivery room.

b. Persons in delivery room during a delivery shall wear clean cotton uniforms or scrub suit, scrub cap, and mask provided by the maternity department.

c. Sterile gowns shall be worn by all persons participating in the delivery.

d. Conductive shoes or adaptations shall be worn by all persons entering delivery rooms where explosive gases are used.

e. Plastic or rubber scrub aprons shall not be worn in the delivery room.

3. Static electricity. Outer garments, blankets or other items of silk, wool or synthetic fabrics which accumulate static electricity shall not be permitted where explosive anesthetics may be used.

4. Supportive supplies. a. Oxygen, 1% silver nitrate ampules, oxytocics, intravenous fluids, suction apparatus and resuscitation equipment shall be available in every delivery suite.

b. Whole blood and fibrinogen shall be available within one hour. Blood plasma shall be available at all times.

5. Sterilization of supplies. a. Supplies shall be sterilized and asepsis maintained by an approved and effective method.

b. Policies and procedures to be followed in carrying this out shall be in writing.

6. Infant procedures in delivery rooms. a. Any person delivering a baby shall be responsible for care of the baby's eyes in compliance with s. 146.01, Stats.

b. Equipment for aspiration and resuscitation of the newborn shall be available in delivery room.

c. An accepted method of infant identification shall be used.

d. Provision shall be made for keeping baby warm in delivery room and during transport to nursery.

(f) *Patient care*. 1. Consultation. There shall be consultation prior to:

a. Cesarean section or other major operative delivery such as high forceps, internal podalic version, decomposition of a breech, a mutilating procedure, or cervical incisions.

b. Contemplated delivery from below of a patient previously delivered by cesarean section.

2. Oxytocics. Nurses or other non-medical personnel shall not administer oxytocics to antepartum patients of over 20 weeks gestation unless a physician is present.

a. This means oxytocics administered by any means—buccal, nasal, oral, intramuscular, or intravenous.

b. Medication shall be discontinued if the physician (or his "adequate medical substitute") is not immediately available (within the unit or hospital).

Note: "Adequate medical substitute" means a physician well enough versed in obstetrics to properly handle medical emergencies commonly resulting from adverse reaction to administered oxytocics.

c. Only nurses who shall have been properly instructed should stay with patients who are being medically induced in labor.

Note: "Properly instructed" indicates a course of instruction, demonstration, and supervision meeting the criteria established jointly by medical and nursing groups covering the administration of drugs or biologicals (intramuscular, intradermal, etc.) untoward reactions contra-indications for use of drugs or biologicals, precautions, and follow-up. The qualification for such instruction would be:

a) Designation of a specific person as instructor who is qualified to teach the above mentioned techniques.

b) Course be written and approved by the executive committee and the medical and nursing staff.

c) A record be made and signed that the individual nurse has been properly instructed.

3. Anesthesia. The hospital shall establish policies for the anesthetizing of obstetric patients.

4. Instruction on delivery. Nurses shall be instructed that to delay the course of normal delivery either by anesthesia or force is a dangerous practice.

5. Observation. a. Post delivery patients shall be closely observed for at least 6 hours.

b. Patients under the effect of an anesthetic or otherwise unconscious shall not be left unattended.

c. Bedrails shall be used whenever indicated.

6. Individualized equipment. a. Individual equipment shall be sterilized before being assigned to maternity patients and the use of common equipment such as towels, shower caps, hair brushes, combs and drinking glasses shall not be permitted.

b. Sitz baths, perineal lights and all other equipment used in common for obstetric patients shall be disinfected between use by each patient.

7. Equipment for treatment of emergencies shall be provided and available.

8. Transportation of patients. Clean stretchers and clean wheel chairs shall be provided for exclusive use of obstetric patients within the maternity department.

(g) *Nursery practices.* 1. Limited access to nursery. e. Only personnel assigned to nursery shall ordinarily be allowed to enter.

b. Facilities for examination of infants shall be provided so that the examiner need not enter the nursery proper.

c. Physicians or others who occasionally need to enter the nursery shall put on a clean gown and mask; housekeeping and maintenance personnel shall also wear clean head covering.

d. Gowns, head coverings or masks shall no longer be considered clean if worn outside the obstetric unit.

2. Handwashing. Strict handwashing techniques shall be maintained by physicians, nurses and all others before putting on a clean gown, before and after handling each infant or his equipment.

3. Cleaning of equipment. a. All instruments such as stethoscopes, calipers and tape measures which have common use shall be cleaned before and after each use.

b. Containers such as oxygen cylinders and drug bottles shall be thoroughly cleaned before being taken into the nursery and between transfers from one infant to another.

4. Soiled linen and diapers. a. Every nursery shall have at least one sanitary container approved for safe handling of soiled diapers.

b. Each nursery shall have a linen hamper with removable bag for soiled linens other than diapers.

5. Window coverings. Only material easily cleaned shall be used.

6. Boric acid. No boric acid powder, crystals or solution shall be kept in the nursery or anywhere in the maternity department except on individual prescription.

7. Oxygen. a. Oxygen shall be readily available to every nursery.

b. Policies and procedures to be followed in giving oxygen shall be in writing.

8. Supervision of housecleaning. The nurse shall arrange for cleaning at a time when the smallest number of infants are in the nursery, and shall supervise this activity.

(h) *Infant care.* 1. Individual care. a. Each infant shall be provided with an individual bassinet thoroughly cleaned, and sterilized individual equipment.

b. Each baby shall receive care in his crib with individual equipment; a common bathing table shall not be used.

c. Clothing needed by infant during hospital stay shall be furnished by the hospital.

2. Feeding. a. Bottles shall not be propped.

b. Bottle-fed infants shall be individually fed by hospital personnel or parents.

3. Weighing. a. Each nursery shall have a scale for weighing infants.

b. A clean individual paper or sterile diaper shall be used for each weighing.

4. Transporting. Transportation of infants shall be carried out in a manner which promotes safety practices and prevents all possibility of cross infection; common carriers shall not be used.

5. Circumcision. a. Shall be performed under aseptic techniques.

b. Shall be done only in doctor's examining room in the nursery area, delivery room, or a separate unit set up outside of the nursery for this procedure.

c. A physician or professional nurse shall be present for ritual circumcision.

6. Isolation. a. The nurse shall place in suspect nursery or private room with handwashing facilities any infant whose mother is isolated or any infant showing evidence of infection.

(i) *Premature care.* 1. Each maternity department shall have adequate facilities for the care of premature infants or a plan for transfer of these infants to a hospital with adequate facilities.

2. Strict aseptic technique shall be carried out when giving care to premature infants.

(j) *Formula and fluids.* 1. Prescription. Feeding shall be prescribed by the physician and shall not be started without his order.

2. Personnel assigned to formula preparation within the hospital.

a. Preparation of formulas shall be supervised by a registered nurse or a qualified dietitian.

b. Persons caring for infected cases shall not be assigned to formula preparation.

c. Persons who prepare formula shall wear a clean head covering and gown.

d. No one shall be allowed in the room or area during preparation of formula except those assigned to this duty.

3. Cleansing bottles and equipment.

a. Bottles, nipples, bottle caps and utensils used in preparing infant formulas shall be thoroughly washed to remove all milk residue and rinsed in clear water according to accepted techniques.

b. Bottles and nipples from sick or suspected cases shall be sterilized before being returned to formula room or area.

4. Terminal sterilization of formula and fluids.

a. Terminal sterilization of all formulas and fluids shall be accomplished by one of the following methods:

i. Minimum steam pressure of 7½ pounds for 10 minutes.

ii. Inflowing steam at atmosphere pressure for 30 minutes.

iii. In a covered container of actively boiling water for 25 minutes.

b. No more than a 24-hour supply shall be prepared at one time.

5. Refrigeration. Formulas shall be removed from sterilizer, allowed to cool at room temperature and stored in a refrigerator at a temperature of 40° until feeding time.

6. Ready-to-use formulas. Terminal sterilization and refrigeration shall not be required for ready-to-use infant formula packaged and sterilized in sealed containers when such formula is approved by the division of health.

7. Cultures. a. At least monthly routine culture shall be made on formulas at the time they are used for feeding.

b. Report of cultures shall be kept on file.

(k) *Nursery linens*. 1. Separate handling of nursery linen. Linen, blankets and garments used for newborn infants and uniforms and gowns worn in the nursery shall be handled separately from the general laundry.

2. Sterilizing nursery linen. Nursery linens shall be sterilized at 250° F. for 10 minutes unless laundered in the hospital according to acceptable nursery laundry routine.

3. Acceptable nursery laundry routine.

a. Washing:

No.	Operation	Water Level	Minimum Temperature	Minimum Time
1.	Flush .....	10 in.	110° F.	5 min.
2.	Heavy suds .....	5 in.	125° F.	10 min.
3.	Heavy suds .....	3 in.	145° F.	10 min.
4.	Bleach (no soap) .....	5 in.	160° F.	10 min.
5.	Rinse .....	10 in.	160° F.	5 min.
6.	Rinse .....	10 in.	160° F.	5 min.
7.	Rinse .....	10 in.	160° F.	5 min.
8.	Rinse .....	10 in.	160° F.	5 min.
9.	Sour .....	3 in.	130° F.	5 min.
10.	Flush .....	10 in.	Cold	1 min.
11.	Softening Agent .....	5 in.	110° F.	5 min.

b. Garments shall be fluff dried in air heated to 165° F. for 20 minutes or ironed by an ironing surface which is 330° F.

c. Staff shall cover hair, wash hands with soap and running water, and put on a clean gown before handling nursery linen.

d. Clean linen shall be wrapped in a freshly washed wrapper or sheet and transported in clean containers.

4. Cultures. a. At least monthly routine cultures for pathogens shall be made on nursery linen when unwrapped at place of use.

b. Report of cultures shall be kept on file.

(1) *Discharge of infants*. 1. Only an infant's parents or a state, county or licensed child welfare agency shall remove a live infant from a hospital.

2. Unless the infant is discharged to a parent if born in wedlock or to his natural mother if the result of an illegitimate pregnancy, the person

receiving the infant shall identify himself and his agency in writing on the hospital record before the infant is released to him.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.13 Outpatient department.** (1) If the hospital has an organized outpatient department, there shall be effective policies and procedures relating to the staff, functions of the service, and outpatient medical records and adequate facilities in order to assure the health and safety of the patients.

(a) The outpatient department shall be organized into sections (clinics) the number of which depends on the size and the degree of departmentalization of the medical staff, available facilities, and the needs of the patients for whom it accepts responsibility.

1. The outpatient department shall have appropriate cooperative arrangements and communications with community agencies such as other outpatient departments, public health nursing agencies, the department of health, and welfare agencies.

2. Clinics shall be integrated with corresponding inpatient services.

3. Clinics shall be maintained for the following purposes:

a. Care of ambulatory patients unrelated to admission or discharge.

b. Study of pre-admission patients.

c. Follow-up of discharged hospital patients.

4. Patients, on their initial visit to the department, shall receive a general medical evaluation and patients under continuous care shall receive an adequate periodic re-evaluation.

5. Established medical screening procedures shall be employed routinely.

(b) There shall be such professional and nonprofessional personnel as are required for efficient operation.

1. There shall be a physician responsible for the professional services of the department. Either this physician or a qualified administrator shall be responsible for administrative services.

2. A registered professional nurse shall be responsible for the nursing services of the department.

3. The number and type of other personnel employed reflect the volume and type of work carried out and the type of patient served in the outpatient department.

(c) Facilities shall be provided to assure the efficient operation of the department.

1. The number of examination and treatment rooms shall be adequate in relation to the volume and nature of work performed.

2. Suitable facilities for necessary laboratory and other diagnostic tests shall be available either through the hospital or some other certified facility.

(d) Medical records shall be maintained, and correlated with other hospital medical records.

1. The outpatient medical record shall be filed in a location which insures ready accessibility to the physicians, nurses, and other personnel of the department.

2. The outpatient medical record shall be integrated with the patient's overall hospital record.

3. Information contained in the medical record shall be complete and sufficiently detailed relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis, and treatment to facilitate continuity of care.

(e) Conferences, both departmental and interdepartmental, shall be conducted to maintain close liaison between the various sections within the department and with other hospital services.

1. Minutes of staff and/or departmental meetings shall indicate that review of selected outpatient cases takes place and that there is integration of hospital inpatient and outpatient services.

2. The outpatient department shall have close working relationships with the medical and social service department.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.14 Emergency service or department.** (1) The hospital shall have at least a procedure for taking care of the occasional emergency case it might be called upon to handle. If the hospital has an organized emergency service or department, there shall be effective policies and procedures relating to the staff, functions of the service, and emergency room medical records and adequate facilities in order to assure the health and safety of the patients.

(a) The department or service shall be well organized, directed by qualified personnel, and integrated with other departments of the hospital.

1. There shall be written policies which are enforced to control emergency room procedures.

2. The policies and procedures governing medical care provided in the emergency service or department shall be established by and are a continuing responsibility of the medical staff.

3. The emergency service shall be supervised by a qualified member of the medical staff and nursing functions shall be the responsibility of a registered professional nurse.

(b) Facilities shall be provided to assure prompt diagnosis and emergency treatment.

1. Facilities shall be separate and independent of the operating room.

2. The location of the emergency service shall be in close proximity to an exterior entrance of the hospital.

3. Diagnostic and treatment equipment, drugs, supplies, and space, including a sufficient number of treatment rooms, shall be adequate in terms of the size and scope of services provided.

(c) There shall be adequate medical and nursing personnel available at all times.

1. The medical staff shall be responsible for insuring adequate medical coverage for emergency services.

2. Qualified physicians shall be regularly available at all times for the emergency service, either on duty or on call.

3. A physician shall be responsible for all patients who arrive for treatment in the emergency service.

4. Qualified nurses shall be available on duty at all times and in sufficient number to deal with the number and extent of emergency services.

(d) Adequate medical records on every patient shall be kept.

1. The emergency room record shall contain:

a. Patient identification.

b. History of disease or injury.

c. Physical findings.

d. Laboratory and x-ray reports, if any.

e. Diagnosis.

f. Record of treatment.

g. Disposition of the case.

h. Signature of a physician.

2. Medical records for patients treated in the emergency service shall be organized by a medical record librarian or her equivalent.

3. Where appropriate, medical records of emergency services shall be integrated with those of the in-patient and out-patient services.

4. A proper method of filing records shall be maintained.

5. At a minimum, emergency service medical records shall be kept for as long a time as required in the statute of limitations.

(2) Additional standards. Emergency room service shall be coordinated with a community disaster plan.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.15 Social service department.** (1) If the hospital has an organized social service department, there shall be effective policies and procedures relating to the staff and the functions of the service.

(a) The department shall be well organized and directed by a qualified social worker.

1. Preferably, social services shall be organized on a departmental level, responsible to the administration of the institution, and social workers in the institution shall be responsible to the department director, regardless of the unit to which they are assigned.

2. The social service staff includes social workers, social work assistants, and clerical personnel. The social workers shall be qualified by a master's degree from an accredited school of social work. The social work assistants shall be qualified by a bachelor's degree preferably with a social welfare sequence, and shall be given training on the job for specific assignments and responsibilities.

3. The number of social workers and social work assistants shall be adequate to meet patient needs for patient care planning.

4. Planning for patient care shall include participation by the social service department as indicated to enable the patient to make full use of inpatient, outpatient, or extended care or home health services in the community.

(b) The department shall be integrated with other departments of the hospital, and departmental and interdepartmental conferences shall be held periodically.

1. Departmental staff shall participate in ward rounds, medical staff seminars, nursing staff conferences, and in conferences with individual physicians and nurses concerned with the care of the patient.

2. The department shall communicate to appropriate administrative and professional personnel information on community programs and developments which may affect the hospital program.

3. The department shall participate in appropriate education, training, and orientation programs for nurses, medical students, interns and residents, and hospital administrative residents, as well as in inservice training programs.

(c) Records of social service activity related to individual patients shall be kept, and available only to the professional personnel concerned.

1. Functions and activities recorded include:

a. Medicosocial study of referred hospitalized and OPD patients.

b. Evaluation of financial status of patient.

c. Follow-up of discharged patients.

d. Social therapy and rehabilitation of patients.

e. Environmental investigations for the attending physicians.

f. Cooperative activities with community agencies.

2. Significant social service summaries shall be entered promptly in the patient's central medical record for the benefit of all staff involved in care of the patient.

3. More detailed records shall be kept by the department to meet the needs of student or staff training, research, and review by supervisors or consultants.

(d) Facilities shall be provided which are adequate for the personnel of the department, easily accessible to patients and to the medical staff, and which assure privacy for interviews.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.16 Utilization review plan.** (1) The hospital shall have in effect a plan for utilization review which applies at least to the services furnished by the hospital to inpatients. An acceptable utilization review plan shall provide for: First, the review, on a sample or other basis, of admissions, duration of stays, and professional services furnished; and Second, review of each case of continuous extended duration.

(a) The operation of the utilization review plan shall be a responsibility of the medical profession. The plan in the hospital shall have the approval of the medical staff as well as that of the governing body.

Note: Where medical profession or medical staff appear.

(b) The hospital shall have a currently applicable, written description of its utilization review plan. Such description includes: the organization and composition of the committee(s) which will be responsible for the utilization review function; frequency of meetings; the type of records to be kept; the method to be used in selecting cases on a sample or other basis; the definition of what constitutes the period or periods of extended duration; the relationship of the utilization review plan to claims administration by a third party; arrangements for committee reports and their dissemination; and, responsibilities of the hospital's administrative staff.

(c) The utilization review function shall be conducted by one or a combination of the following: by a staff committee or committees of the hospital, each of which shall be composed of 2 or more physicians, with or without the inclusion of other professional personnel; or by a committee(s) or group(s) outside the hospital composed as above which shall be established by the local medical society and some or all of the hospitals and extended care facilities in the locality.

1. The medical care appraisal and educational aspects of review on a sample or other basis, and the review of longstay cases need not be done by the same committee or group.

2. Existing staff committees may assume the review responsibility stipulated in the plan. In smaller hospitals, all of these functions may be carried out by a committee of the whole or a medical care appraisal committee.

3. The committee(s) shall be broadly representative of the medical staff and at least one member who does not have a direct financial interest in the hospital.

(d) Reviews shall be made, on a sample or other basis, of admissions, duration of stays, and professional services furnished, with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services. Such reviews shall emphasize identification and analysis of patterns of patient care in

order to maintain consistent high quality. The review shall be accomplished by considering data obtained by any one or any combination of the following: by use of services and facilities of external organizations which compile statistics, design profiles, and produce other comparative data; or by internal studies of medical records.

1. Reviews of cases, based on diagnostic categories, shall include diagnoses of special relevance to the aged group.

2. Some review functions shall be carried out on a continuing basis.

3. Reviews shall include a sample of recertifications of medical necessity.

(e) Reviews shall be made of each case of continuous extended duration. The hospital utilization review plan shall specify the number of continuous days of hospital stay following which a review shall be made to determine whether further inpatient hospital services are medically necessary. The plan may specify a different number of days for different classes of cases. Reviews for such purpose shall be made no later than the seventh day following the last day of the period of extended duration specified in the plan. No physician shall have review responsibility for any extended stay cases in which he was professionally involved. If physician members of the committee decide, after opportunity for consultation is given the attending physician by the committee, and considering the availability and appropriateness of out-of-hospital facilities and services, that further inpatient stay is not medically necessary, there shall be notification in writing within 48 hours to the institution, the attending physician and the patient or his representative.

1. Because there are significant divergences in opinion among individual physicians in respect to evaluation of medical necessity for inpatient hospital services, the judgement of the attending physician in an extended stay case shall be given great weight, and not rejected except under unusual circumstances.

(f) Records shall be kept of the activities of the committee; and reports shall be regularly made by the committee to the executive committee of the medical staff and relevant information and recommendations reported through usual channels to the entire medical staff and the governing body of the hospital.

1. The hospital administration shall study and act upon administrative recommendations made by the committee.

2. A summary of the number and types of cases reviewed, and the findings, shall be part of the records.

3. Minutes of each committee meeting shall be maintained.

4. Committee action in extended stay cases shall be recorded, with cases identified only by hospital case number.

(g) The committee(s) having responsibility for utilization review functions shall have the support and assistance of the hospital's administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, and promoting the most efficient use of available health services and facilities.

1. With respect to each of these activities, an individual or department shall be designated as being responsible for the particular service.

2. In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for post-hospital care shall be initiated as promptly as possible, either by hospital staff, or by arrangement with other agencies. For this purpose, the hospital shall make available to the attending physician current information on resources available for continued out-of-hospital care of patients and arrange for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.

**H 24.17 Exemptions and rule revision procedures.** (1) **EXEMPTIONS.** (a) Any rules heretofore promulgated which are determined to be in conflict with the provisions of ss. 140.23 to 140.29, Stats., shall be interpreted to be recommendations.

(2) **METHODS, TECHNIQUES AND STUDIES FOR RULE REVISIONS.** (a) New methods and new techniques of construction, including facilities and equipment, administration and patient care are encouraged. This would include studies which ultimately could lead to rule change. Hospitals desiring to institute innovations that are not provided for in these rules and regulations shall:

1. Consult with the staff of the division of health, department of health and social services, early in the planning.

2. Present the plan to the division of health, department of health and social services, for written approval before implementation.

3. Submit the conclusions of the study to the division of health, department of health and social services, for consideration in revision of the rule or regulation.

History: Cr. Register, May, 1968, No. 149, eff. 6-1-68.