

**WASHINGTON STATE
DEPT. OF HEALTH**

**REPORT ON PROPOSALS
CHAPTER 246-320 WAC**

MARCH 21, 2006

HOSPITAL LICENSING REGULATIONS

SECTIONS:

WAC 246-320-001 Through

WAC 246-320-405

(INCLUDING WAC 246-320-990)

July 26, 2006

TO: Interested Parties and Stakeholders

FROM: Allen Spaulding, Rules Coordinator

SUBJECT: Hospital Licensing Rules, Chapter 246-320 WAC – Report on Proposals and Public Comment Process

At the March 21, 2006 public meeting, participants completed a review of 98 rule proposals that were submitted during the public proposal period concerning WAC 246-320, Hospital Licensing Regulations. The meeting facilitators asked participants to indicate one of four levels of support in order to assess each proposal. The meeting actions are captured and/or recorded in the Report on Proposals (ROP) as follows:

1. *I support this proposal as submitted* and suggest that Department of Health (DOH) include it in the rule revision (**Supported as Submitted**).
2. *I support this proposal with the following modifications*, and I suggest that DOH include the modified proposal in the rule revision (**Supported with Modifications**).
3. *I support this proposal in principle*, and I recognize that the proposal requires changes. I suggest that DOH solicit additional input during the public comment period and the public meeting in June, before deciding if it should be included in the rule revision (**Supported in Principle**).
4. *I do not support this proposal in principle or with modification*, and would like DOH to exclude it from the rule revision (**Not Supported**).

The purpose of the ROP and the rules development process is to report the participants recommendations, to the department, for changes to the existing chapter 246-320 WAC. The department has not endorsed the proposals contained in the ROP.

Next Steps

Open Comment Period / Report on Comments: Now that the ROP is available, there is a 7 week comment period which anyone may submit a public comment on any of the proposed changes in the ROP. The department will host another public meeting on June 21, 2006 to assess the level of support on all comments. When submitting your comment(s), please make sure to indicate the proposal number on the comment form. The closing date for receiving public comments will be **June 7, 2006**.

The input from the second public meeting will be compiled in a second publication called the Report on Comments (ROC), which is again made available for anyone to review for a 4 week period. Anyone may monitor the progress of a ROP or ROC at:
http://www.doh.wa.gov/hsqa/fsl/ruledevelop/rule_development.htm.

Final Step

Public Rules Hearing: After the ROC review period ends the department will assess the actions and/or recommendations, from the first and second public meetings, for changes to the existing chapter 246-320 WAC. Anyone may attend the public rules hearing and present his/her views on the reports and/or public meeting actions and/or recommendations.

For questions regarding this process, contact Allen Spaulding at (360) 236-2929, or e-mail to: al.spaulding@doh.wa.gov.

Thank you and feel free to contact me with any questions or concerns.

Sincerely,

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Proposal 001**Supported with Modifications**

Submitter: Dept. of Health, Office of Health Care Survey

Section: 246-320-001

Recommendation: Revise text as follows:

(1) (a) "Physical abuse" means ~~damaging or potentially damaging~~ nonaccidental acts or incidents which may result in bodily injury or death.

(b) "Emotional abuse" means verbal behavior, harassment, or other actions which may result in emotional or behavioral ~~stress or injury problems~~, physical manifestations, disordered or delayed development.

2) "Accredited" means approved by the joint commission on accreditation of healthcare organizations (JCAHO or AOA).

(New definition) ADVERSE EVENT a negative consequence of care that results in an unintended injury or illness, which may or may not have been preventable. As used in this chapter, such an event results in death or loss of bodily function lasting more than seven days or is still present at the time of discharge. Events listed in this chapter have been developed by the National Quality Foundation as "serious reportable events".

(6) "Alcoholism" means an illness characterized by lack of control as to the consumption of alcoholic beverages, or the consumption of alcoholic beverages to the extent an individual's health is substantially impaired or endangered, or his or her social or economic functioning is substantially disrupted.

(7)(b) "Major alteration" means any physical change within an existing hospital that changes the occupancy (as defined in state building code) and scope of service within a room or area, results in reconstruction to major portions of a floor or department, or requires significant revisions to building systems or services.

(New definition) AOA means American Osteopathic Association.

(New definition) Bed or bed space means the physical environment and equipment (both movable and stationary) designed and used for the 24 hour or more care of a patient. This does not include stretchers, exam tables, operating tables, well baby bassinets, labor bed, labor-delivery-recovery bed

(New definition) Bed Capacity means the total licensed space available that meets the physical plant and equipment requirements necessary to support care delivery to a patient in a bed. This shall not exceed the number of bed spaces authorized in a Certificate of Need under chapter 70.38 RCW.

(40) (New sub letter) Hospice care centers which come within the scope of chapter 70.127 RCW; nor

(41) "Individualized treatment plan" means a written or electronically recorded statement of care planned for a patient

(42) "Infant" means an individual not more than 12 months old ~~a baby or very young child up to one year of age.~~

(New definition) "Licensed independent practitioner" means a practitioner as defined in this chapter and any other person permitted by Washington State law and hospital policy having the authority to order medications and other therapeutic interventions for patients.

(52) "Long-term care ~~unit~~" means ~~a group of beds for the~~ accommodation of service delivery to patients who, because of chronic illness or physical infirmities, require skilled nursing care and related medical services but are not acutely ill and not in need of the highly technical or specialized services ordinarily a part of hospital care.

(54) "Maintenance" means the work of keeping something in workable or suitable condition.

(55) ~~"Major permanent loss of function" means sensory, motor, physiological, or intellectual impairment not present on~~

~~admission requiring continued treatment or lifestyle change. When this condition cannot be immediately determined, the designation will be made when the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.~~

(69) "Nursing unit" means a separate physical and functional unit of the hospital including ~~a group of patient rooms~~ or areas containing beds or bed spaces, with available support ancillary, administrative, and service facilities necessary for nursing service to the occupants of these patient rooms.

(New definition) Observation bed means a bed not used nor intended for 24 hour or more patient care delivery

(79) "Patient related technology" means equipment used in a patient care environment to support patient treatment and diagnosis, such as but not limited to electrical, battery and pneumatic powered technology as well as support equipment and disposables.

(New definition (85) (c) sub number) Practitioner means Pharmacists as defined in chapter 18.64 RCW; advanced registered nurse practitioners as defined in chapter 18.79 RCW; dentists as defined in chapter 18.32 RCW; naturopaths as defined in chapter 18.36A RCW; optometrists as defined in chapter 18.53 RCW; osteopathic physicians and surgeons as defined in chapter 18.57 RCW; osteopathic physician [physicians'] assistants as defined in chapter 18.57A RCW; physicians as defined in chapter 18.71 RCW; physician assistants as defined in chapter 18.71A RCW; podiatric physicians and surgeons as defined in chapter 18.22 RCW; and psychologists as defined in chapter 18.83 RCW. (Definition taken from 2005 law change in SSB 5492, RCW 70.41.210)

(88) "Protocols" and "standing order" mean written or electronically recorded descriptions of actions and interventions for implementation by designated hospital personnel under defined circumstances and authenticated by a legally authorized person under hospital policy and procedure. Implementation of a protocol requires an order from a licensed independent practitioner and when used must be recorded in the patient record. A standing order is for an emergency situation, including but not limited to cardio-pulmonary resuscitation or anaphylactic shock and does not require an order from a licensed independent practitioner prior to implementation.

(95) "Restraint" means any method used to prevent or limit free body movement including, but not limited to, involuntary confinement, ~~an apparatus~~ a physical or mechanical device, or a drug given not required to treat a patient's medical symptoms. A patient in restraint is continually monitored face-to-face by an assigned staff member or continually monitored by staff using both video and audio equipment.

A physical restraint is any manual method, physical or mechanical device, material or equipment attached or adjacent to a patient's body that the patient cannot easily remove and restricts freedom of movement or access to one's own body.

A drug or chemical restraint is a medication used to control behavior or to restrict a patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

(New definition) Seclusion means the involuntary confinement of a patient in a room or area where the patient is physically prevented from leaving. A patient in seclusion is continually monitored face-to-face by an assigned staff member or continually monitored by staff using both video and audio equipment or technology.

(97) "Seclusion room" means a ~~small~~, secure room specifically designed and organized for temporary placement, care, and observation of one patient and for an environment with minimal sensory stimuli, maximum security and protection, and visual and auditory observation of the patient by authorized personnel and staff. Doors of seclusion rooms are provided with staff-controlled locks.

(New definition) "Vulnerable adult" means, as defined in chapter 74.34 RCW, a person 60 years of age or older who lacks the functional, physical, or mental ability to care for him or herself; an adult with a developmental disability per RCW 71A.10.020; an adult with a legal guardian per chapter 11.88 RCW; an adult living in a long-term care facility (an adult family home, boarding home or nursing home); an adult living in their own or a family's home receiving services from an agency or contracted individual provider; or an adult self-directing their care per 74.39.050 RCW.

For the purposes of requesting background checks pursuant to 43.43.832 RCW, it shall also include adults of any age

who lack the functional, mental, or physical ability to care for themselves.

For the purposes of this chapter, it shall also include hospitalized adults.

Substantiation:

Level of Support: Supported with Modifications

Modified proposal as follows:

1 (b) "Emotional abuse" means verbal behavior, harassment, or other actions which may result in psychological, emotional or behavioral stress or injury...

2 (New Definition) ADVERSE EVENT a negative consequence of care that results in an unintended injury or illness, which may or may not have been preventable. As used in this chapter, such an event results in death or serious loss of bodily function...

(41) "Individualized treatment plan" means a written and/or electronically recorded statement of care planned for a patient...

(42) (New definition) "Licensed independent practitioner" means a practitioner as defined in this chapter and any other person permitted by Washington State law and hospital policy having the authority to order medications or provide other therapeutic interventions for patients.

(52) Include "swing beds" in definition.

(54) "Maintenance" means the work of keeping something in safe, workable or suitable condition...

(79) "Patient related technology Medical equipment" means ~~medical~~ equipment used in a patient care environment to support patient treatment and diagnosis, such as but not limited to electrical, battery and pneumatic powered technology as well as support equipment and disposables.

(95) (third paragraph) A drug or chemical restraint is a medication used to control behavior or to restrict a patient's freedom of movement and is not a standard treatment for the patient's medical or... remove "or psychiatric condition" and replace with mental disorder.

(New definition) Seclusion means the involuntary confinement of a patient in a room or area where the patient is physically prevented from leaving. A patient in ~~seclusion~~...

Meeting discussion: The following modifications were agreed to: For definition (1) (b) add the word "psychological"; for (2) add the word "serious"; for (41) add "and/"; in definition (42) add the words "or provide" and re-work the language for consideration at the next public meeting; for (52) incorporate the term "swing beds" in definition; for (79) add "medical equipment"; for definition (95), third paragraph, add "mental disorder"; in the new definition for seclusion (not numbered) use the word "seclusion" once only and move the second sentence to the seclusion section or rules.

Concerns mentioned:

- In reference to definition (7) (b), the department may not have authority throughout entire building. And, the definition is not clear or easily understandable.
- The restraints definition needs to line up with JCAHO regulations.
- Include all types of bed space in definition (52). And, don't tie bed space capacity to Certificate of Need standards.
- In definition (69) note inconsistent use of the term "patient care."
- Definition (88) "Protocols" and "standing order"... needs more work. This paragraph is confusing and should be brought back for the comment phase and further discussion.
- Add a definition for "emergency department."

- Move new definitions after #79 to section of rules concerning reporting practitioner.

Other comments or questions:

- For definition (42), what qualifies as “other interventions?” Other participants were uncomfortable with the term “having the authority to..”) This definition gives hospitals authority and definition of “licensed independent practitioner.” The term “Practitioner” would include pharmacists.
- The new definition for (85) (c) was carried over from current statute. This definition needs to be narrowed.
- Is long-term care beds included in definition (52) concerning bed space?

Proposal 002

Supported with Modifications

Submitter: Byron Plan
Section: 246-320-010
Recommendation: New definition as follows

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;

Serious impairment to any bodily functions;

Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

That there is inadequate time to effect a safe transfer to another hospital before delivery, or

That the transfer may pose a threat to the health or safety of the woman or the unborn child.

Substantiation: This language makes the state regulations consistent with the Federal Medicare rules and RCW 70.170.060(2)&(3).

Level of Support: Supported with Modifications

Modified proposal as follows:

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, symptoms of mental disorder, and/or symptoms of substance abuse) – Remove term “psychiatric disturbances”

See additional suggested modification under meeting discussion.

Meeting discussion: The following modification was agreed to: Remove “psychiatric disturbances” and replace with “symptoms of mental disorder.”

The group also asked the department to identify or define the term “severe pain.”

Proposal 003

Supported in Principle

Submitter: Gecelyn Betinol for Terry Smith and Dr. Watts
Section: 246-320-001
Recommendation: Clarify if all protocols must be deemed as an emergency before initiating any protocol or standing order without a physician order.

Substantiation: Many of the respiratory therapy protocols established at Overlake Hospital Medical Center are based on evidence based best practice and have been reviewed and approved by the Medical Staff, E.g. Weaning Protocol. This greatly promotes patient safety but is not considered as an ‘emergency situation’. Thus, according to

paragraph 88, a physician order would be needed to initiate this protocol. The practice at Overlake aligns with best practices, which does not require for a physician order to begin implementation of this protocol.

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: The group discussed the need for defining “emergency” or “emergent” in a way that would not require a physician’s order to initiate standard and/or routine protocols. Participants agreed to forward proposed language for consideration during the comment phase. The group also suggested that this proposal (003) and proposal 009 be reviewed concurrently at the next public meeting.

Proposal 004:

Supported in Principle

Submitter: Anne Piazza; Tom Granger
Section: 246-320-010
Recommendation: Adopt new section as follows:

(1) Definitions:

- (a) "Staffing committee" means a committee established by the hospital with at least one-half of its members who are registered nurses currently providing direct patient care. If registered nurses are represented by a collective bargaining representative, the registered nurse representatives must be selected by the collective bargaining representative. Participation in the committee must be considered a part of the employee's regularly scheduled workweek.
- (b) "Patient care unit" means any unit of the hospital that provides patient care.
- (c) "Intensity" means the level of patient needs as determined by a registered nurse providing direct patient care taking into account at least the following factors:
 - (i) Severity and urgency of the patient's admitting condition;
 - (ii) Scheduled procedures;
 - (iii) Patient's ability to meet health care requisites;
 - (iv) Patient's availability of social supports;
 - (v) Age and functional ability of the patient;
 - (vi) Communications skills of the patient; and
 - (vii) Other needs identified by the patient and by the registered nurse.
- (d) "Skill mix" means the number of registered nurses, licensed practical nurses, and unlicensed assistive personnel providing direct patient care.

(2) Each hospital in the state shall develop and implement as staffing plan for nursing services. The plan must be reviewed and updated annually and filed with the department. The written staffing plan must:

- (a) Set the minimum number and skill mix of registered nurses, licensed practical nurses, and unlicensed assistive personnel required in each patient care unit in the hospital;
- (b) Be based on at least the following criteria on each patient care unit:
 - (i) Census, including activity such as patient discharges, admissions, and transfers;
 - (ii) Level of intensity of all patients and nature of the care to be delivered on each shift;
 - (iii) Skill mix, experience, and specialty certification or training of those providing the care;
 - (iv) The need for specialized or intensive equipment;
 - (v) The architecture and geography of the patient care unit; and
 - (vi) The staffing guidelines of national nursing and specialty nursing organizations.
- (c) Include appropriate limits on the use of agency and traveling nurses;
- (d) Be consistent with the scopes of practice for registered nurses and licensed practical nurses and the authorized duties of unlicensed assistive personnel;
- (e) Include adequate staffing to provide for staff time off, illnesses, meal and break time, and educational, health, and other leaves;

- (f) Include a semiannual process for internal review by the staffing committee that ensures compliance with the staffing plan, provides for the review of incidents and staff concerns, and tracks staffing patterns, number of patients, and their acuity.
- (3) The staffing plan must not diminish existing standards in law, rules, or the terms of an applicable collective bargaining agreement.
- (4) Each hospital shall staff each patient care unit in accordance with its staffing plan. Shift-to-shift adjustments in staffing levels required by the plan may be made only if based upon assessment by a registered nurse providing direct patient care on the patient care unit.
- (5) Each hospital shall post the staffing plan for that patient care unit as required by this section on each patient care unit in the facility.
- (6) Each hospital shall collaborate with its staffing committee in the development and implementation of its staffing plan.
- (7) No hospital shall retaliate against or intimidate any employee for performing any duties or responsibilities in connection with participation on the staffing committee.
- (8) No hospital shall retaliate against or intimidate any employee who notifies the staffing committee, the hospital administration, or the department that any schedule fails to meet with the posted staffing plan, or that the hospital has failed to develop or implement a staffing plan consistent with sections 1 through 7 of this section.
- (9) Hospitals shall maintain accurate daily records showing:
- (a) The number of patients present in each patient care unit at the end of each standard shift within the facility;
 - (b) The number of admissions, discharges, transfers, and observation patients in each patient care unit and each shift; and
 - (c) The number of registered nurses, licensed practical nurses, and unlicensed assistive personnel providing direct patient care in each patient care unit and shift within the facility.
 - (d) All records to be kept under this section must be maintained for a period of seven years be available upon request to the department and to the staffing committee.
- (10) Hospitals shall maintain and post a list of qualified, on-call nursing staff and nursing services that may be called to provide replacement staff in the event of sickness, vacations, vacancies, and other absences of nursing staff and that provides a sufficient number of replacement staff for the hospital on a regular basis.
- (11) Semiannually, hospitals shall collect and submit to the department information regarding nurse staffing. In addition to the skill mix of registered nurse, licensed practical nurse, unlicensed assistive personnel and contract employees, and the nursing care hour per patient per day, such information must also include at least three of the following National Voluntary Consensus Standards for Nursing Sensitive Care established by National Quality Forum:
- a) Death among surgical inpatients with treatable serious complications (failure to rescue)
 - b) Pressure ulcer prevalence
 - c) Falls prevalence
 - d) Falls with injury
 - e) Restraint prevalence (vest and limb only)
 - f) Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients
 - g) Central line catheter-associated blood stream infection rate for ICU and high-risk nursery
 - h) (HRN) patients
 - i) Ventilator-associated pneumonia for ICU and HRN patients
 - j) Smoking cessation counseling for acute myocardial infarction
 - k) Smoking cessation counseling for heart failure
 - l) Smoking cessation counseling for pneumonia
 - m) Practice Environment Scale—Nursing Work Index (composite and five subscales)
 - n) Voluntary turnover
- (12) The department shall investigate complaints of violations of this section.

(13) The department shall maintain for public inspection records of any civil penalties, administrative actions, or license suspensions or revocations imposed on hospitals under this section.

(14) The department shall conduct an annual random audit of not less than ten percent of all hospitals in this state solely to verify compliance with the requirements of this section. Surveys made by private accrediting organizations may not be used in lieu of the audit required under this subsection. The department shall compile and maintain for public inspection an annual report of the audit conducted under this subsection.

Substantiation: Registered nurses, as the largest group of the health care providers and the ones who are there 24 hours a day - every day, have the most direct impact on patient care in hospitals.

Nursing is more than just performing a series of medical tasks and giving medications. Nursing care includes continuous patient assessment, critical thinking and expert judgment, advocating on behalf of our patients, and educating patients and their families. Those activities are the essence of nursing care and are frequently the determining factors why patients live or die.

Patient outcomes research over the past decade increasingly support the conclusion that the quantity and quality of nursing care have a direct impact on patient safety, particularly in reducing the incidence of certain adverse events. Here is what the research tells us:

- A January/February 2006, Health Affairs study by Needleman and his colleagues found that if hospitals increased RN staffing and hours of nursing care per patient, more than 6,700 patient deaths and four million days of care in hospitals could be avoided each year.
- In a widely cited study published in the *Journal of the American Medical Association*, Aiken, Clarke, Sloane, Sochalski & Silber (2002) analyzed data from 10,184 staff nurses, 232,342 patient discharges, and administrative data from 168 Pennsylvania hospitals. After adjusting for patient and hospital characteristics, they found that each additional patient beyond four per nurse resulted in a 7% greater likelihood of dying within 30 days of admission and a 7% increase in the likelihood of failure to rescue. Each additional patient per nurse was also associated with a 23% increase in the odds of nurse burnout and a 15% increase in the odds of job dissatisfaction. In a commentary on this study, Clarke & Aiken (2003) describe it as “one of the clearest demonstrations to date of the impact of nursing staffing on outcomes for both patients and nurses in acute care hospitals.”
- In a study published in the *New England Journal of Medicine*, Needleman, Buerhaus, Mattke, Stewart (2002a) examined data from 799 hospitals in 11 states, including 5,075,969 medical discharges and 1,04,659 surgical discharges. Among medical patients, a higher proportion of hours of nursing care per day provided by RNs and a greater total number of hours of nursing care per day provided by RNs were associated with a shorter length of stay, lower rates of urinary tract infections and upper gastrointestinal bleeding. A higher proportion of hours of care provided by RNs was also associated with lower rates of pneumonia, shock or cardiac arrest and failure to rescue. Among surgical patients, a higher proportion of nursing care provided by RNs was associated with lower rates of urinary tract infections, and a greater number of RN hours of care per day was associated with lower rates of failure to rescue. The authors summarize their findings, in part, by noting their estimate that patients treated in hospitals with high RN staffing (in this study, meaning those whose staffing placed them in the upper quarter of hospitals studied) have lengths of stay 3-5% shorter and rates of complication 2-9% lower than hospitals with low RN staffing (those in the lower quarter of hospitals in this study). (Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002b).
- In a study of 1609 hospital reports of sentinel events (unanticipated events that result in death, injury or permanent loss of function), the Joint Commission on Accreditation of Healthcare Organizations found that 24% of such events were attributed to nurse staffing levels (JCAHO, 2002, p.9).
- Examining hospital discharges from states participating in the National Inpatient Sample (NIS), Kovner, Jones, Zhan, Gergen & Basu, (2002) found that higher levels of nurse staffing were associated with lower rates of pneumonia.

- Cho, Ketefian, Barkauskas & Smith (2003) studied the impact of nurse staffing on adverse events, morbidity, mortality and costs. They found that an increase of 1 hour of RN care per patient day was associated with an 8.9% decrease in the odds of pneumonia; a 10% increase in proportion of RNs was associated with a 9.5% decrease in the odds of pneumonia. Each adverse event was associated with a greater length of stay. Pneumonia, wound infection and sepsis were associated with a greater probably of death during hospitalization.
- Using data from 1751 units in hospitals participating in the National Database of Nursing Quality Indicators, Dunton, Gajewski, Taunton & Moore (2004) found that higher rates of patient falls were associated both with fewer nursing hours per patient day and a lower percentage of RNs. The associations were strongest on medical units. This echoed earlier findings by Sovie & Jawad (2001), who studied 28 university hospitals that had undergone restructuring and an increase in the rate of patient falls as patient-to-nurse ratios increased.
- In a study of 19 teaching hospitals in Ontario, Canada, McGillis Hall, Doran & Pink (2004) found that a lower proportion of RNs employed on a hospital nursing unit was associated with higher numbers of medication errors and wound infections. They also found that lower levels of work experience were associated with higher numbers of wound infections. In addition, a lower proportion of RNs was associated with larger numbers of overall nursing hours.

In addition, research demonstrates that increased nurse staffing does not represent significantly increased net costs for hospitals, and can even result in cost savings, since the cost of nurses' wages are offset by the reduction in patient complications and length of stay resulting from increased staffing.

- Lichtig, Knauf & Milholland (1999) suggested that by decreasing adverse outcomes (particularly those that are likely to result in increased length of stay), increased RN staffing could result in modestly decreased hospital costs. Earlier, Flood & Diers (1988) had similarly suggested an association between staffing levels and lower hospital costs resulting from decreased rates of nosocomial infections.
- Most recently, Needleman and his colleagues (2006) found that increasing overall hours of nursing care (irrespective of overall skill mix) would lead to a significant reduction in length of stay, patient deaths and other adverse outcomes, at net increase of hospital costs of 1.5% percent or less. Increasing RN hours as a proportion of nursing hours without increasing overall nursing hours (i.e., increasing skill mix while holding nurse staffing hours steady) was associated with a small net reduction in costs. Specifically, this study found that if hospitals increased RN staffing and hours of nursing care per patient, more than 6,700 patient deaths and four million days of care in hospitals could be avoided each year.

With the growing abundance of research, we know that the care provided by registered nurses has a direct impact on hospital quality of care and patient safety. In order to ensure safe patient care, we must have adequate staffing in our hospitals. WSNA is advocating for the attached proposed roles to required hospitals to develop and implement, with input from registered nurses providing direct patient care, a staffing plan for nursing services that is based on the patient care needs and the skill mix of registered nurses and other nursing personnel.

The proposed regulation would:

- Require each hospital to develop and implement a staffing plan for nursing services based on criteria such as census, intensity of patients, skill mix of nursing personnel.
- Require the involvement of a staffing committee composed of at least one-half registered nurses who provide direct patient care
- Allow for shift-to-shift adjustments in unit-specific staffing levels based on the assessment of registered nurses providing direct patient care on that unit.
- Require the hospital to maintain daily records of patient census and the number and type of nursing personnel per unit per shift.
- Require the hospital to submit to the Department of Health Nursing Sensitive Quality Indicators such as total nursing care hours provided per patient day on each unit and nurse staff satisfaction.

References:

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Level of Support: Supported in Principle

Modify proposal as follows: Participants were encouraged to suggest alternate language during the open comment period

Meeting discussion: Concerns mentioned included:

- The proposed rules are too prescriptive and outside the scope of this rules making project. A legislative initiative may be more appropriate.
- The proposed rules don't contain an indication of staffing plans or data collection.
- The proposed requirements overlap with JCAHO standards. What is the intent?
- Should the proposed requirement be broadened to include all hospital staff?

Rebuttal:

- The proposal is evidence based with the intention of addressing and/or improving patient care and safety.

Other comments or questions:

- The recommendations are evidence-based. They must be outcome-based as well.
- Allow hospitals to make their own determinations regarding nursing/staff ratios.
- What about consideration for a broader delivery care model?

Proposal 005:**Supported with Modifications**

Submitter: Geoffrey W. Glass
Section: 246-320-010
Recommendation: Revise text as follows

(7) “Alteration”:

(a) “Alteration” means any change in use, addition, ~~remodel~~, renovation, or modification to an existing hospital or a portion of an existing hospital.

~~(b) “Major Alteration” means any physical change within an existing hospital that changes the occupancy (as defined in state building code) and scope of service within a room or area, results in reconstruction to major portions of a floor or department, or requires revisions to building systems or services.~~

(c) “Minor Alteration” means an alteration that does not require an increase in capacity to structural, mechanical or electrical systems; which does not affect fire and life safety systems and which does not add beds or facilities in addition to that for which the hospital is currently licensed.

Substantiation: This change differentiates minor alterations from all other alterations as relates to the requirement for drawings being prepared under the direction of a licensed architect or engineer. Further, the change uses the word “renovation” in lieu of “remodel” to bring consistency with the AIA Guidelines.

Level of Support: **Supported with Modifications.**

Modified proposal as follows:

(7) “Alteration”:

~~(a)~~ “Alteration” means ~~any~~ change in use, addition, ~~remodel~~, renovation, or modification...

(c) “Minor Alteration” means ~~an alteration~~ renovation that does not require an increase in capacity to structural, mechanical or electrical systems...

Meeting discussion: The following modifications were agreed to: Delete “(a)”; delete word “any”; and substitute “alteration” for “renovation.”

Proposal 006**Supported as Submitted**

Submitter: Geoffrey W. Glass
Section: 246-320-010
Recommendation: Revise text as follows

(64) “New Construction” means any of the following:

(a) New ~~buildings~~ facilities to be licensed as a hospital;

~~(b) Additions to an existing hospital;~~

~~(c) Conversion of an existing building or portions thereof for use as a hospital;~~

~~(d) (b) Alterations, to an existing hospital~~

Substantiation:

Level of Support: **Supported as Submitted**

Modify proposal as follows:

None

Meeting discussion: Participants agreed this standard should be modified into a single, simple sentence.

Proposal 007

Supported as Submitted

Submitter: Geoffrey W. Glass
Section: 246-320-010
Recommendation: Delete text as follows

(85) “Pressure relationships” of air o adjacent areas means:

- (a) Positive (P) pressure (Should this definition be revised?) is present in a room when the:
 - (i) Room sustains a minimum of 0.001 inches of H2O pressure differential with the adjacent area, the room doors are closed, and air is flowing out of the room; or
 - (ii) Sum of the air flow at the supply air outlets (in CFM) exceeds the sum of the air flow at the exhaust/return air outlets by at least 70 CFM with the room doors and windows closed;
- (b) Negative (N) pressure (Should this definition be revised?) is present in a room when the:
 - (i) Room sustains a minimum of 0.001 inches of H2O pressure differential with the adjacent area, the room doors are closed, and air is flowing into the room; or
 - (ii) Sum of the air flow at the exhaust/return air outlets (in CFM) exceeds the sum of the air flow at the supply air outlets by at least 70 CFM with the room doors and windows closed;
- (c) Equal (E) pressure (Should this definition be revised?) is present in a room when the:
 - (i) Room sustains a pressure differential range of plus or minus 0.0002 inches of H2O with the adjacent area, and the room doors are closed; or
 - (ii) Sum of the air flow at the supply air outlets (in CFM) is within ten percent of the sum of the air flow at the exhaust/return air outlets with the room doors and windows closed.

Substantiation: Delete entire definition (83). The AIA Guidelines have no requirement for pressure relationships (except for airborne infection isolation rooms; instead in Table 7.2 they reference “Air movement relationship to adjacent area”. Given that DOH has committed to referencing the AIA Guidelines as the basis for WAC requirements, all existing WAC 246 reference to “pressure relationships” should be removed in favor of “air movement relationship to adjacent area” (except as relates to airborne infection isolation rooms).

Level of Support: Supported as Submitted

Modify proposal as follows:

None

Meeting discussion:

None

Proposal 008

Supported in Principle

Submitter: Barbara Skyles
Section: 246-320-010
Recommendation: Revise Definitions as follows

(85) Pressure Relationships of air to adjacent areas means:

- (a) Positive (P) Pressure is present in a room when the:
 - (i) Room sustains a minimum of 0.01 ~~not 0.001~~ inches of water gauge (2.5 Pa) pressure differential with the adjacent area, ~~the room doors are closed,~~ and the air is flowing into the room;
- (b) Negative (N) Pressure is present in a room when the:

(i) Room sustains a minimum of 0.01 ~~not 0.001~~ inches of water gauge (2.5 Pa) pressure differential with the adjacent area, ~~the room doors are closed,~~ and the air is flowing into the room;

Substantiation: The above changes correct a misprint from the previous regulations and provide requirements consistent with AIA Guidelines for Design and Construction of Hospital and Health Care Facilities, ASHRAE 62 Standard, and CDC & HICPAC Guidelines for Environmental Infection Control in Health Care Facilities.

Level of Support: Supported in Principle.

Modify proposal as follows:

None

Meeting discussion: Based on the assessed level of support for the previous proposal (007), which effectively deletes definition (85), participants agreed that this type of requirement could be addressed as a construction oriented issue through the adoption of the AIA guidelines for design and construction of hospital and health care facilities.

Other comments or questions:

- The existing standard is too stringent.
- AIA covers this proposal – seems more construction oriented than operational.
- It would be helpful to define “positive” vs. “negative” air flow.
- A measurable standard is needed.
- If a standard is needed, make it operational, not construction.
- Need to make standards the direction of air into or out of a room or area.

Proposal 009

Supported in Principle

Submitter: Scott Alberts
Section: 246-320-010
Recommendation: Revise text as follows

(88) "Protocols" and "standing order" mean written or electronically recorded descriptions of actions and interventions for implementation by designated hospital personnel under defined circumstances and authenticated by a legally authorized person under hospital policy and procedure. Implementation of a protocol requires an order from a licensed independent practitioner and when used must be recorded in the patient record. A standing order is for an emergency situation, including but not limited to cardio-pulmonary resuscitation or anaphylactic shock and does not require an order from a licensed independent practitioner prior to implementation.

Substantiation: The respiratory Care Society of Washington in support with our Medical Director is requesting further clarification in regards to the classification of what is being considered “Protocols and Standing orders”. Current Respiratory Care and Therapist driven protocols have been designed and validated through accepted evidence based medicine techniques to improve patient care and safety in not only a hospital situation but also in alternative areas, i.e. skilled nursing care facilities, home care, etc. Examples of protocols and standing orders of concern would be; mechanical ventilator weaning, emergent ABG collection and analysis, He/O₂ (Heliox) therapy administration, management of patients receiving bronchodilator therapy and oxygen therapy for adults and pediatrics. These are a few that are in use throughout our state which we feel may be in jeopardy due to this current review. We appreciate your consideration of these crucial patient care and safety issues.

Level of Support: Supported in Principle.

Modify proposal as follows:

Meeting discussion: This proposal and subsequent issues are consistent with proposal 003. The participants agreed these two proposals (003 and 009) should be grouped, they require additional information and/or comments, and should be discussed at the next public meeting.

Other comments or questions:

- Need to provide the department with a definition for “emergency.”

Proposal 010**Supported as Submitted**

Submitter: Geoffrey W. Glass
Section: 246-320-010
Recommendation: Revise text as follows

~~(94) “Remodel” means the reshaping or reconstruction of a part or area of the hospital.~~

Substantiation: Delete the definition of remodel as the AIA Guidelines use the term “renovation” and this is defined in WAC 246-320 as a component of “alteration”.

Level of Support: **Supported as Submitted**

Modify proposal as follows:

Meeting discussion: None

Proposal 011**Supported with Modifications**

Submitter: Dept. of Health, Office of Health Care Survey
Section: 246-320-025
Recommendation: Revise text as follows

(1) (a) Conduct at least one on-site licensing survey on average once every eighteen months ~~each calendar year~~ to determine compliance with the provisions in chapter 70.41 RCW and this chapter;

(new language) Notify the hospital at least four weeks before starting an on-site survey;

(New language) Require each hospital to submit a corrective action plan that addresses each deficient practice identified in the written survey findings;

May provide a hospital a corrective action plan that directs the hospital on how to address the written survey findings;

(d) Accept as meeting the 18 month state licensing survey according to subsection 1a above an accreditation survey conducted by JCAHO or AOA. Not conduct the annual on-site licensing survey when requested by a hospital accredited by JCAHO in accordance with
~~subsections (2) and (3) of this section.~~

(New Language) Conduct unannounced complaint investigations concerning allegations of patient care or safety are received that indicate a hospital may be potentially in violation of the requirements in this chapter or chapter 70.41 RCW.

Notify the hospital in writing of the complaint investigation findings;

Require each hospital to submit a corrective action plan that addresses each deficient practice identified in the written complaint investigation findings;

May provide a hospital a corrective action plan that directs the hospital on how to address the written complaint investigation findings.

~~(2) A hospital accredited by the JCAHO may request exclusion from an annual on-site licensing survey during the year of the JCAHO survey. To request exclusion, a hospital must submit to the department:~~

~~(a) A written request asking to be excluded from the annual on-site licensing survey during the calendar year in which the hospital will be surveyed by the JCAHO;~~

~~(b) The written request at least thirty days prior to the beginning of the calendar year for which the exclusion from an annual on-site licensing survey will be made;~~

~~(c) Verification of current JCAHO accreditation; and~~

~~(d) A copy of the decisions and findings of the JCAHO survey within thirty days of receipt of the final JCAHO survey report.~~

~~(3) The department will grant an exclusion from the annual on-site licensing survey when:~~

~~(a) The hospital:~~

~~(i) Meets the requirements in subsection (2) of this section; and~~

~~(ii) Verifies current JCAHO accreditation;~~

~~(b) The department determines the JCAHO survey standards used at the time of the JCAHO survey exceed or are substantially equivalent to chapter 70.41 RCW and this chapter.~~

(4) A hospital excluded from state conducted an eighteen month annual on-site licensing survey in accordance with this section:

(a) Is ~~not~~ subject to a complaint investigation an annual on-site licensing survey at any time during the calendar year the hospital is surveyed by the JCAHO and for twelve months after the date of the JCAHO survey; and

(b) Must notify the department in writing of: their JCAHO or AOA accreditation decision and any changes in JCAHO or AOA accreditation status within ten days of receipt of the accreditation report from the respective accreditation organization JCAHO.

Substantiation:

Level of Support: Supported with Modifications.

Modified proposal as follows:

(4) (b) Must notify the department in writing of: their JCAHO or AOA accreditation decision and any changes in JCAHO or AOA accreditation status within ~~ten~~ thirty calendar days of receipt”...

Meeting discussion: The following modification was agreed to: Delete the word “ten” and replace with term “thirty calendar.”

Other comments or questions:

- Does this proposal represent any substantive changes?
- When would the department give a corrected action plan?
- The proposed changes are consistent with current applicable statute.

Proposal 012

Not Supported

Submitter: Tom Granger, SEIU 1199NW

Section: 246-320-025

Recommendation: New Paragraph as follows

(1) (e) The agency shall make available on the agency website the results of each hospital inspection, as well as the findings of any complaint or other investigation that results in a finding of deficiencies. Such postings shall be made within 15 days of the completion of any inspection or investigation.

Substantiation: Health care consumers are increasingly being encouraged by employers, health plans, and the government to investigate the performance of a health care provider before seeking the assistance of a provider. However, at present there is a dearth of data on which consumers can rely to help inform their choice of providers. Readily available information on the outcomes of DOH inspections and investigations can help assist consumers in their choice of health care providers. Additionally, wide dissemination of the outcomes of DOH inspections and investigations will serve as an incentive for hospitals to eliminate/rectify practices and procedures that result in negative findings as a result of DOH inspections and investigations.

Level of Support: Not Supported

Modify proposal as follows:

Meeting Discussion: Concerns Mentioned:

- The proposal is inconsistent with current statute and the Public Records Act.
- The proposed changes may be beyond the scope of rule making authority.
- Rule making is not the forum for legislative changes.
- The intent of House Bill 1711 has never been to post inspection or investigative outcomes on the Web.
- Beyond the scope of what RCW 70.41 allows the department to do in rule making.
- The Legislature makes these determinations which means it can't be accomplished in rule making.

Other comments or questions:

- All of the above conflicts with the fact that all public records are subject to disclosure. The intent of this proposal is to make public information readily available.

Proposal 013	Not Supported
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Submitter: Geoffrey W. Glass
Section: 246-320-025
Recommendation: Revise text as follows

(d) Conducting an on-site licensing survey in accordance with WAC 246-320-025; ~~and Compliance with the on-site survey conducted by the State Fire Marshall as provided in chapter 70.41.~~

Substantiation: Senate Bill 6485 requires DOH to:

“exploring ways to streamline the frequency and duration of onsite survey activities, improving hospital notification when possible, and fostering greater coordination and less duplication of efforts.
 “The Office of the State Fire Marshal and relevant local agencies are added to the list of entities with whom DOH is to coordinate when conducting hospital inspections.”

DOH Licensing surveys including fire and life safety scope have improved with additional surveyor training over the years and are reflective of the unique fire and life safety environment of hospitals. The current system of DOH conducting the fire and life safety survey associated with their annual licensing survey serves the interest to “reduce duplication of efforts” and should no be changed in favor of a State Fire Marshall duplicative site survey. Instead, the State Fire Marshall’s office should be involved with DOH licensing surveyor training to assure coordination and consistency in conducting hospital inspections.

Level of Support: Not Supported

Modify proposal as follows:

None.

Meeting discussion: The group made the following comments:

- We cannot develop rules that supersede or replace what is already written in the law.
- Consider developing a separate section to address this issue.
- Fire/Life Safety inspections have to be performed by State Fire Marshal for both initial and relicensure purposes. This duty cannot be delegated by the State Fire Marshal.
- This issue needs to be worked through the legislative process, not rule making.
- Not within scope of rule.

Proposal 014:

Supported in Principle

Submitter: Dept. of Health, OHCS
Section: 246-320-045
Recommendation: Revise text as follows

WAC 246-320-045 Application for license -- License expiration dates —~~Notice of decision~~—~~Adjudicative proceeding~~.
 The purpose of this section is to ensure hospitals are licensed in accordance with chapter 70.41 RCW.

(1) An applicant not currently licensed must submit to the department an application for licensure and applicable fee in accordance with RCW 70.41.100 and WAC 246-320-990.

(2) sub letter, new language) Compliance with the on-site survey conducted by the State Fire Marshal as provided in chapter 70.41.

(3) (a) No later than November 30 of each calendar year, an application for licensure or verification of license information and applicable fee in accordance with RCW 70.41.100 and WAC 246-320-990; and

Substantiation:

Level of Support: **Supported in Principle.**

Modify proposal as follows:

None

Meeting discussion: The group agreed this proposal should be considered with proposal 013, rewritten and collect comments during the next phase, and bring back for further discussion at the next public meeting.

Proposal 015:

Supported in Principle

Submitter: Dept. of Health, OHCS
Section: 246-320-
Recommendation: New section as follows

WAC 246-320-NEW SECTION, Department Responsibilities -- Notice of decision -- Adjudicative proceeding. The purpose of this section is to identify the actions and responsibilities of the Department with regards to the licensing, surveying and investigating complaints of hospitals.

(41) The department will issue hospital licenses initially and reissue hospital licenses as often thereafter as necessary each calendar year so as to cause approximately one-third of the total number of hospital licenses to expire on the last day of the calendar year. ~~Licenses issued pursuant to this chapter may be valid for any period not to exceed thirty six months.~~

(52) The department may issue a provisional license to permit the operation of the hospital for a period of time to be determined by the department if there is failure to comply with the provisions of chapter 70.41 RCW or this chapter.

(63) The department may deny, suspend, modify, or revoke a license in any case in which it finds that there has been a failure or refusal to comply with the requirements of chapter 70.41 RCW or this chapter.

(a) The department's notice of a denial, suspension, modification, or revocation of a license will be consistent with RCW 43.70.115. An applicant or license holder has the right to an adjudicative proceeding to contest a license decision.

(b) A license applicant or holder contesting a department license decision will within twenty-eight days of receipt of the decision:

(i) File a written application for an adjudicative proceeding by a method showing proof of receipt with the office of the Adjudicative Clerk, Department of Health, PO Box 47879, Olympia, WA 98504-7879; and

(ii) Include in or with the application:

(A) A specific statement of the issue or issues and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the contested department decision.

(c) The proceeding is governed by the Administrative Procedure Act chapter 34.05 RCW, this chapter, and chapters 246-08 and 246-10 WAC. If a provision in this chapter conflicts with chapter 246-08 or 246-10 WAC, the provision in this chapter governs.

(4) The Department will:

(a) Conduct on-site surveys of each hospital every 18 months or more often to ensure compliance with the health and safety standards in this chapter and chapter 70.41 RCW:

(i) Notify the hospital at least four weeks prior to the scheduled date of the survey;

(ii) Coordinate the survey with other agencies, including local fire jurisdiction, state fire marshal, state pharmacy board, and report the survey findings to those agencies;

(iii) Issue a statement of deficiencies following each on-site survey that identifies non-compliance with the standards in Chapter 70.41 RCW and this chapter; and

(iv) Notify a hospital when the hospital submitted plan of correction adequately addresses the statement of deficiencies.

(b) Deem on-site surveys conducted by the JCAHO or AOA as meeting the 18 month survey requirement in accordance with RCW 70.41.122;

(c) Conduct an investigation of every complaint against a hospital and adverse event reported by a hospital that concerns patient safety and well-being;

(d) In accordance with RCW 70.41.045, post to the agency website a list of the most frequent problems identified during hospital surveys and complaint investigations;

(e) Respond within 15 days to a hospital's request for an exemption or use of an alternative as provided for in section 065 of this chapter; and

(f) Respond within 30 days to a hospital's request for an interpretation as provided for in section 065 of this chapter.

Substantiation:

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: The group agreed that specific language needs to be submitted to department during the comment stage and discussed at the next public meeting.

Other comments or questions:

- This proposal needs to include language addressing or defining “patient safety and well-being.”
- This proposal is consistent with definitions of adverse events.
- This proposed needs to clearly define the structure for an adverse event investigation.
- Can the department give notice on adverse event investigations?
- “(f) Respond within 30 days to a hospital’s request for an interpretation as provided for in section 065 of this chapter.” It would be nice if the department could “respond within 15 days” along with statement of when a decision would come.
- Some would prefer dialogue back and forth rather than a fixed date.
- We need to understand the relationship between adverse event and unanticipated outcome.
- Hospitals would like DOH to announce investigations.
- The vast majority of investigations are Medicare driven. Medicare will not allow for the state to announce in advance. With state owned facilities, it is common practice for the department to speak with the hospital ahead of time.
- (4) (f) Respond within 30 days to a hospital’s request ... needs to be changed to 15 days. (Need to improve the timeliness of response).
- All requests for exemptions are not equal, the proposed change does not provide consideration for scale and volume. Dialogue needs to be open and transparent vs. fixed dates.
- Not in favor of a system that starts clock over with a wrong stamp.
- Much of the proposed language is here as conformance with existing law.

Proposal 016:	Supported in Principle
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Submitter: Dept. of Health, OHCS
Section: 246-320-065
Recommendation: Revise text as follows

(1) A hospital requesting exemption from the provisions of this chapter must submit a written request to the department asking for an exemption. The hospital’s request must:

Specify the section or sections for which the exemption applies;
 Explain the reason for making the exemption request;

Describe how and why the exemption request will not jeopardize patient safety, health and well-being; and

~~when appropriate,~~ Include ~~supporting~~ documentation that supports the reason for the exemption.

(2) A hospital requesting ~~approval for~~ use of alternative materials, design, and methods must submit a written request to the department asking for approval to use an alternative. The hospital’s request must:

(i) Explain the reason(s) for the use of ~~an~~ the alternative including a discussion of how the alternative is equivalent to the methods required in this chapter; and must

(ii) Include ~~be supported by~~ technical documentation that supports the reason for the alternative; and

(iii) Describe how and why the alternative will not jeopardize patient safety, health and well-being.

(4) A hospital requesting an interpretation of a rule or regulation contained in this chapter must submit a written request to the department. The hospital's request must:

Specify the section or sections for which an interpretation is needed;

Include details of the circumstances to which the rule is being applied; and

(iii) Provide any other information the department deems necessary.

~~(5) The department will, in response to a written request, send a written interpretation of a rule or regulation within thirty calendar days after the department has received complete information relevant to the requested interpretation.~~

Substantiation:

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: The group agreed that more information is needed before accepting any modifications.

Other comments or questions

- The addition of “appropriate” was discussed as a possible modification: (iii) Describe how and why the alternative will not jeopardize patient safety, health and well-being... if appropriate.
- All requests for exemption are not created equal. We must recognize the scale.
- This rule section needs to clarify when an exemption would be granted.
- As written, this proposal is consistent with current department practice.

Proposal 017:

Supported in Principle

Submitter: Dept. of Health, OHCS

Section: 246-320-085

Recommendation: Revise text as follows

WAC 246-320-085 Single license to cover two or more buildings—~~When permissible.~~ The purpose of this section is to allow a single hospital license to cover more than one building.

(1) (b) (i) Governance by a single authority or body over all buildings or portions of buildings under the single license; ~~and~~

(ii) A single medical staff for all hospital facilities under the single license; and

(iii) Incorporation and use of all policies and procedures for all facilities and departments under the single license.

(3) Outpatient clinics and services will not be included as part of a hospital's license unless the clinic or service provides care to inpatients.

Substantiation:

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: The group agreed that more information is needed before accepting any modifications.

Other comments or questions:

- Changing “provides care to inpatients” to “provides inpatient care” was discussed as a possible modification to (3).
- Will outpatient services not be included in the license?
- The department agreed to complete additional research with CMS/Medicare.

Proposal 018: **Supported in Principle**

Submitter: Dept. of Health, OHCS
Section: 246-320-125
Recommendation: Revise text as follows

(2) Establish and review governing authority policies to include requirements for reporting practitioners and informing patients of any unanticipated outcomes in accordance with chapter 41.70 RCW, promote performance improvement, and provide for organizational management and planning;

Substantiation:

Level of Support: **Supported in Principle**

Modify proposal as follows:

Meeting discussion: Although the majority consensus was “Support as Submitted”, the notes captured indicate additional work is needed and this proposal should be revisited, based on comments received, at the next public meeting.

Concerns mentioned:

- This is the section to add the definition of practitioner.
- A definition is needed for “practitioner.”
- A definition is needed for “unanticipated outcome.”
- Hospitals need to incorporate unanticipated outcome into their current policies.
- The department does not have authority to define “unanticipated outcome”. The Legislature has not given them authority.
- Additional language needs to be provided during the comment period.
- Does the proposed changes mean that when the department reviews governing policies, it is addressing these issues?

Proposal 019: **Withdrawn**

Submitter: Tom Granger, SEIU 1199NW
Section: 246-320-125
Recommendation: Revise text as follows

(1) Adopt and periodically review bylaws which address legal accountabilities and responsibilities. Bylaws will provide for medical staff communication and conflict resolution with the governing authority. Bylaws shall include the time, date, and place of all governing authority meetings, and each meeting of the governing authority shall allow for public comment. Notices of each of the governing board’s meetings shall be widely disseminated throughout the hospital and the hospital’s catchment area no less than 2 weeks prior to each meeting. The Department of Health shall maintain a current, electronic copy of each hospital’s bylaws; changes to a hospital’s bylaws shall be delivered to the Dept. of Health electronically within 30 days of a change. Copies of a hospital’s bylaws maintained by the Department of Health shall be subject to public disclosure;

Substantiation: Hospitals in Washington have an obligation to the community in which they operate. Not only do most hospitals in the state receive tax exemptions based on their non-profit status, but many also receive tax revenues

and taxpayer funded government grants. Nevertheless, the community in which a hospital operates often has very little understanding of – or voice in – hospital operations. Requiring that hospitals notify the community of governing body meetings, allowing public comment during governing body meetings, and making hospital bylaws readily publicly available will allow community members to become more proactively involved in the manner in which a hospital serves the community.

Level of Support: **Withdrawn**

Modify proposal as follows:

Meeting discussion: The proposal was withdrawn by the submitter.

Proposal 020:

Supported in Principle

Submitter: Dept. of Health, OHCS

Section: 246-320-145

Recommendation: Revise text as follows:

(New language after (3) (a)) Posting the complaint hotline notice in accordance with RCW 70.41.330;

Reporting practitioners in accordance with RCW 70.41.210;

(b) Timely Complaint resolution for patients, families, employees, providers and others; and

(New language after (5)) Ensure the adoption and implementation of policies and procedures concerning abandoned babies and hospitals as a safe haven in accordance with RCW 13.34.360.

(9) Adopt and implement policies and procedures in accordance with chapter 26.44 RCW to ensure suspected abuse to a child, vulnerable adult dependent or developmentally disabled person is reported within one administrative day to:

(b) The department of health; ~~or~~ and

(10) Notify the department whenever any of the following adverse events have been confirmed to have occurred:

~~(a) An unanticipated death or major permanent loss of function, not related to the natural course of a patient's illness or underlying condition;~~

~~(b) A patient suicide while the patient was under care in the hospital;~~

~~(c) An infant abduction or discharge to the wrong family;~~

~~(d) Sexual assault or rape of a patient or staff member while in the hospital;~~

~~(e) A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;~~

~~(f) Surgery performed on the wrong patient or wrong body part;~~

Surgical events:

Surgery performed on the wrong body part;

Surgery performed on the wrong patient;

Wrong surgical procedure performed on a patient;

Retention of a foreign object in a patient after surgery or other procedure;

Intraoperative or immediately post-operative death in an ASA Class 1 patient;

Product or device events:

Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital;

Patient death or serious disability associated with the use or function of a device in patient care which the device is used or functions other than intended;

Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a hospital;

Patient protection events:

Infant discharged to wrong person;

Patient death or serious disability associated with a patient elopement (disappearance) for more than four hours;

Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a hospital;

Care management events:

Patient death or serious disability associated with a medication error such as but not limited too errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, wrong route of administration;

Patient death or serious disability associated with a hemolytic reaction due to administration of ABO-incompatible blood or blood products;

Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a hospital;

Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital;

Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in a neonate;

Stage 3 or 4 pressure ulcers acquired after admission to the hospital;

Patient death or serious disability due to spinal manipulative therapy;

Environmental events:

Patient death or serious disability associated with an electric shock while being cared for in the hospital;

Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains wrong gas or is contaminated by toxic substances;

Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital;

Patient death associated with a fall while being cared for in the hospital;

Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital;

Criminal events:

Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;

Abduction of a patient of any age;

Sexual assault on a patient within or on the grounds of a hospital; and

Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of the hospital.

(11) Provide written notification to the department as required in subsection (10) of this section within two administrative business days of the hospital confirming the adverse event occurred ~~leaders learning of the confirmed event~~. The hospital is encouraged to confirm these events through a review or assessment by the hospital quality improvement or risk management processes. Each notice to the department:

(after (11) (a) (iii)) A summary discussion of:

What lead up to or caused the event to occur;

The steps taken to correct the problem(s) that lead to the event;

The date for implementing the corrections to the problem(s); and

The process used to monitor the effectiveness of the correction.

Substantiation:

Level of Support: **Supported in Principle**

Modify proposal as follows:

See Discussion Below.

Meeting discussion: Although the majority consensus was “Support with Modifications”, the notes captured do not indicate agreed modifications. However, the notes indicate additional work is needed and this proposal should be revisited, based on comments received, at the next public meeting.

Concerns mentioned:

- Must be written consistent with 2SHB 2292.
- This section will require a thorough interpretive guideline.
- Define “timely” as it relates to (3)(b).
- Define “vulnerable” as it relates to (9). Currently, it is assumed that anyone in the hospital qualifies as a “vulnerable adult.”
- Define “immediately post-op death.”
- Consider the use of interpretive guidelines to clarify the various terms throughout this proposal.
- Define “serious disability” as it relates to the proposed new text: Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in a neonate;
- Inconsistent language and/or need to clarify the timelines related to (11).

Proposal 021:

Withdrawn

Submitter: Tom Granger, SEIU 1199NW

Section: 246-320-145
Recommendation: Revise text as follows

(3) (b) Note that the following is intended to be an addendum to proposed language in the current “discussion draft”, paragraph (3) (b), p. 25:

The agency shall collect and make public on its website each instance of a hospital’s notification of a patient or patient’s family of an unanticipated outcome as required by RCW 70.41.380. The posting on the agency’s website shall include the date on which a hospital notified a patient or patient’s family of an unanticipated outcome, as well as a brief description of the unanticipated outcome.

Substantiation: Health care consumers are increasingly being encouraged by employers, health plans, and the government to investigate the performance of a health care provider before seeking the assistance of a provider. However, at present there is a dearth of data on which consumers can rely to help inform their choice of providers. Identification of hospitals having notified patients of unanticipated outcomes – to include the number and nature of such unanticipated outcomes - can help assist consumers in their choice of health care providers. Additionally, identification of hospitals having reported such unanticipated outcomes – possibly on an ongoing basis – will provide an incentive for such hospitals to resolve these problems.

Level of Support: **Withdrawn**

Modify proposal as follows:

Meeting discussion: Concerns mentioned:

- This is outside of the scope of the department’s authority concerning this rules project.
- The department has no authority to enact the proposed change. It’s strongly suggested the department enact legislation.
- The licensed independent practitioner is responsible to notify family, not the hospital, in JCAHO accredited hospitals.

Proposal 022: **Supported in Principle**

Submitter: Anne Piazza; Tom Granger
Section: 246-320-145
Recommendation: Revise text as follows

(11) Provide written notification to the department as required in subsection (10) of this section within two administrative business days of the hospital confirming the adverse event occurred ~~leaders learning of the confirmed event~~. The hospital is encouraged to confirm these events through a review or assessment by the hospital quality improvement or risk management processes. Each notice to the department:

- (a) Must include:
- (i) The hospital's name;
 - (ii) The type of event which is being reported from subsection (10) of this section;
 - (iii) The number of patients, registered nurses, licensed practical nurses, and unlicensed assistive personnel present in the relevant patient care unit at the time that the reported adverse event occurred. Additionally, the notice to the department shall include the number of staff on the patient care unit working overtime at the time of the event, as well as the number of consecutive hours worked by each staff working overtime at the time of the adverse event.
 - ~~(iii)~~ (iv) The date the event occurred; and A summary discussion of:
 - What lead up to or caused the event to occur;
 - The steps taken to correct the problem(s) that lead to the event;
 - The date for implementing the corrections to the problem(s); and
 - The process used to monitor the effectiveness of the correction.

Substantiation: Patient outcomes research over the past decade increasingly support the conclusion that the quantity and quality of nursing care have a direct impact on patient safety, particularly in reducing the incidence of certain adverse events.

- In a study of 1609 hospital reports of sentinel events (unanticipated events that result in death, injury or permanent loss of function), the Joint Commission on Accreditation of Healthcare Organizations found that 24% of such events were attributed to nurse staffing levels (JCAHO, 2002, p.9).
- Most recently, a study published in the January/February 2006 Health Affairs found that if hospitals increased RN staffing and hours of nursing care per patient, more than 6,700 patient deaths and four million days of care in hospitals could be avoided each year.
- Rogers, Hwang, Scott, Aiken & Dinges (2004) found that work duration, overtime and number of hours worked per week had significant effects on errors. The likelihood of making an error was three times greater when nurses worked shifts lasting 12.5 hours or more. Regardless of the length of a nurses' scheduled shift, working overtime increased the likelihood of making at least one error. Overtime following a 12 hour shift significantly increased the risk of error. Working more than forty or fifty hours per week significantly increased the risk of error. Notably, the relationship between errors and overtime were independent of age, hospital size or type of hospital unit.

The proposed changes above to include the recording of "patient and registered nurse staffing census at the time of the event" would allow hospital and the department an opportunity to investigate whether nurse staffing was a contributing factor leading to the adverse event and take corrective measures to prevent such incidences in the future.

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: Concerns mentioned:

- This proposal needs to be consistent with JCAHO guidelines.
- During a survey, nurse staffing issues are not always included and could be addressed as the cause. This proposal would ensure that would happen, and it needs to be considered in the root cause analysis.
- Systems can also be identified as a cause and addressed in a root cause analysis.
- Make consistent with 2SHB 2292. The proposal, as written, exceeds current law.

Other comments or questions:

- Consider deleting "written notification" related to (11).
- The department should investigate response to adverse events.
- 2SHB 2292 gives the department guidance on adverse event.
- The department does not conduct the investigation. Hospitals do. The department determines whether there are adequate systems in place to address the adverse events and whether the action taken was appropriate.
- Language needs to be provided to the department during the comment phase.
- Delete the written notification requirement.
- Consider this outside of an adverse event report.

Proposal 023:

Withdrawn

Submitter: Anne Piazza; Tom Granger

Section: 246-320-145

Recommendation: Revise text as follows

145 (11) (c) ~~will be confidentially maintained by the department in accordance with the protections of the Public Disclosures Act, chapter 42.17 RCW, and other applicable laws and reporting requirements provided in RCW 70.41.150, 70.41.200, and 70.41.210 and~~

shall be subject to public disclosure, and shall be posted by the agency on the agency's website in abbreviated form except where explicitly prohibited by law. In each case where public disclosure of such information is explicitly

prohibited by law, the agency shall endeavor to format and make subject to public disclosure such information in a manner that avoids violation of the law. For example, the agency shall redact patient identifiers, aggregate the number of incidents reported, indicate the period rather than the exact date of an incident, and take other steps necessary to eliminate the possibility of patient identification when such information is made available for public disclosure. However, in no instance shall the name of the hospital associated with an adverse event or number of events be deemed confidential.

Substantiation: Health care consumers are increasingly being encouraged by employers, health plans, and the government to investigate the performance of a health care provider before seeking the assistance of a provider. However, at present there is a dearth of data on which consumers can rely to help inform their choice of providers. Identification of hospitals experiencing and reporting adverse events as delineated under paragraph 10 of section 145 can help assist consumers in their choice of health care providers. Additionally, identification of hospitals having reported such adverse events – possibly on an ongoing basis – will provide an incentive for such hospitals to resolve such problems.

Level of Support: Withdrawn

Modify proposal as follows:

Meeting discussion: Proposal was withdrawn by submitter. 2SHB 2292 makes this proposal obsolete.

Proposal 024 **Supported as Submitted**

Submitter: Linda L. Foss
Section: 246-320-145
Recommendation: Revise text as follows

(9) Adopt and implement policies and procedures in accordance with chapter 26.44.030 to ensure suspected abuse to a child, adult dependent or developmental disable person is reported within in 48 hours to local police or appropriate law enforcement.

Substantiation: This language brings this WAC 246-320-146 current with RCW 26.44. Current WAC gives the hospital 1 administrative day. This will decrease confusion. It omits the language of other state agencies. Law enforcement determines and reports to other agencies as stated in RCW 26.44. Hospital is still required to report sexual assault under the adverse section of the WAC 246-32145 (10)

Level of Support: Supported as Submitted

Modify proposal as follows:

None

Meeting discussion: The group recognized this proposal as a substantive rule change which requires abuse to be reported to law enforcement. It also provides clarity and consistency.

Proposal 025 **Supported as Submitted**

Submitter: Dept. of Health, OHCS
Section: 246-320-165
Recommendation: Revise text as follows

(New language before (1)) Hospitals will adopt and implement policies and procedures to:

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion: The intent is to ensure hospitals not only have a policy, but have adopted practices to implement the policy.

Proposal 026

Supported in Principle

Submitter: Dept. of Health, OHCS
Section: 246-320-185
Recommendation: Revise text as follows

(1) (i) Due process; and

Reporting process for practitioners in accordance with RCW 70.41.210.

(2) Include licensed physicians, licensed independent practitioners and may include other individuals granted privileges by the governing authority to provide patient care services; and

Substantiation:

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: Concerns mentioned:

- We need to define “licensed independent practitioner” related to credentialing.
- We need to determine who on the medical staff need be credentialed under the medical staff by-laws, and more research is needed for the definition.
- We need to consult with JCAHO guidelines.

Other comments or questions:

- The language is consistent with Senate Bill 5492.
- Does this proposed change result in having to apply the standards to medical staff?

Proposal 027

Supported as Submitted

Submitter: Dept. of Health, OHCS
Section: 246-320-205

Recommendation: Revise text as follows

(New language after (5)) Regard materials obtained through procedures employed in diagnosing a patient’s condition or assessing a patient’s clinical course as original clinical evidence excluded from requirements for content of the medical record in subsection (3) of this section. Original clinical evidence includes, but is not limited to:

x-ray films;

digital records;

laboratory slides;

tissue specimens; and

medical photographs.

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion: This may provide clarity regarding medical records retention. This issue was not previously addressed in the rules. New or emerging substantive issues will be rewritten according to “plain talk” guidelines.

Proposal 028**Supported as Submitted**

Submitter: Dept. of Health, OHCS
Section: 246-320-225
Recommendation: Revise text as follows

(New language) Medication management/administration related to wrong medication, wrong dose, wrong time and near misses and any other medication errors and incidents

Negative health outcomes and incidents injurious to patients (RCW 70.41.200e)

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion: Comments or questions:

- This proposal applies to the quality improvement process and comes directly out of the statute.
- Medication “near misses” are not addressed in statute. Tracking “near misses” is a quality improvement initiative.
- This new data collection requirement needs a definition for “near misses.”

Proposal 029**Supported as Submitted**

Submitter: Dept. of Health, OHCS
Section: 246-320-245
Recommendation: Revise text as follows

Hospitals will:

Post the Department of Health complaint hotline number

(after (2)(a)) Protection from abuse and neglect

Use of physical and chemical restraints

Complain about their care and treatment without fear of retribution or denial of care

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion:

Proposal 030**Supported in Principle**

Submitter: Dept. of Health, OHCS
Section: 246-320-265
Recommendation: Revise text as follows

(3) Adopt and implement written policies and procedures consistent with the published guidelines of the centers for disease control and prevention (CDC) and the Association for Professionals in Infection Control & Epidemiology (APIC) regarding infection control in hospitals, to guide the staff. Where appropriate, policies and procedures are specific to the service area and address:

(j) Barrier and transmission precautions including maintaining humidity levels in accordance with APIC guidelines; and

(k) Pharmacy and therapeutics; ~~and~~

Substantiation:

Level of Support: **Supported in Principle.**

Modify proposal as follows:

Meeting discussion: The group agreed to combine this proposal (030) with proposal 031.

Concerns mentioned:

- Should this only be in patient care areas and laboratories? Clarification is needed.
- It is not monitored now. The state has not required humidification equipment for the past ten years.
- Policies are needed to address humidification issues after construction. How would the existing facility comply? If it is taken out of policy, there is no requirement for hospitals to do it.
- What will a hospital do, by policy, when a facility has excessively high or low humidity? This is an operational issue not a construction issue.

Additional comments or questions

- Should hospitals determine if humidification is needed? It seems better addressed in the WAC applying to construction. APIC standards address this.
- CDC Guidelines for environmental control has the bulk.
- What is known about preventing infections?
- Would a hospital license be at risk for this requirement?

Proposal 031**Supported in Principle**

Submitter: Geoffrey W. Glass
Section: 246-320-265
Recommendation: Revise text as follows

(j) Barrier and transmission precautions ~~including maintaining humidity levels in accordance with APIC guidelines~~; and

Substantiation: Delete reference to maintaining humidity levels in accordance with APIC guidelines. Humidity conditions in western Washington State are such that humidity levels are within 30 – 60% the substantial majority of the time. Humidity control equipment is subject to failure at regular intervals at which point HVAC systems can become wet environments and subject to mold and other bacterial growth that can present great risk to patient care. The current WAC 246-320-525 Table 525-3 refers to ASHRAE Guidelines for recommended humidity levels as an interpretive guideline. It is recommended that the WAC rewrite clarify in the AIA Guidelines that relative humidity control as advisory (appendix material) and should be removed as a reference to 246-320-265.

Level of Support: **Supported in Principle.**

Modify proposal as follows:

None.

Meeting discussion: Refer to discussion in Proposal 030.

Proposal 032**Supported as Submitted**

Submitter: Dept. of Health, OHCS
Section: 246-320-285
Recommendation: Revise text as follows

(1) Prepare, dispense, store and administer medications in accordance with current law, regulation, licensure, and professional standards of practice;

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:**Meeting discussion:****Proposal 033****Supported in Principle**

Submitter: Tom Granger, SEIU 1199NW
Section: 246-320-045 (correction from previously listed section)
Recommendation: Revise text as follows

New Section (4) (d)

Note that the following is intended to be an addendum to proposed language in the current “discussion draft” paragraph (4) (d), p.21:

The agency shall identify and post to its website the name of each hospital having experienced one of the frequent problems. The posting shall include a brief description of the frequent problem and the date on which the frequent problem occurred at each hospital.

Substantiation: Health care consumers are increasingly being encouraged by employers, health plans, and the government to investigate the performance of a health care provider before seeking the assistance of a provider. However, at present, there is a dearth of data on which consumers can rely to help inform their choice of providers. Identification of hospitals having experienced frequent hospital problems can help assist consumers in their choice of health care providers. Additionally, identification of hospitals having experienced one or several of the frequent problems – possibly on an ongoing basis – will provide an incentive for such hospitals to resolve these problems.

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: The notes indicate additional work is needed and this proposal should be revisited, based on comments received, at the next public meeting.

Concerns mentioned:

- Inconsistent with statute, and falls outside the statutory authority as written.

- RCW 70.41.045 requires DOH to post frequent problems. Many feel the “frequent problem list” does not result in change. Is there a gauge to determine if hospitals are improving?
- Without identifying the hospital, consumers are not protected and this falls within the realm of public health and safety.

Other comments or questions:

- This section gives the department the ability to choose what to post. Is the department responsible for sharing information as well as licensing?
- Can the department post trends and analysis or frequent problems?
- Disclosure is possible now, this just makes it easier.
- More discussion is needed.

Proposal 034
Supported as Submitted

Submitter: Dept. of Health, OHCS
Section: 246-320-325
Recommendation: Revise text as follows

(1) If providing laboratory services, adopt and implement policies and procedures which require availability of pathology and clinical laboratory services on a timely basis and reflect accepted standards of care for those services to include qualified staff to manage the service in accordance with chapter 70.42 RCW and chapter 246-338 WAC, Medical Test Sites and 42 CFR 493, Clinical Laboratory Improvement Amendment;

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion: This proposal is a technical fix and does not represent a major change. The proposed change simply restates the need to comply with existing law.

Proposal 035
Supported in Principle

Submitter: Dept. of Health, OHCS
Section: 246-320-345
Recommendation: Revise text as follows

(3) (a) Development of an individualized patient plan of care, ~~when appropriate~~ based on an initial assessment of patient condition; and

(b) Periodic review and revision based on reassessment of patient condition; and

(new language) Periodic patient assessment for risk of falls, skin condition, risk for pressure ulcers, pain and medication use, therapeutic effects and side or adverse effects

(5) (g) Use of physical & chemical restraints;

Use of seclusion

(h) (ii) Written or electronic orders authenticated by a legally authorized practitioner for all drugs, intravenous solutions, blood, medical treatments, and nutrition; and

(after (q)) Informed consent; and

Living will

(6) (a) (i) Patient history and physical assessment including but not limited to falls, mental status and skin condition;

(c) Additional on-going specialized assessments when warranted by the patient's condition or needs, including:

Substantiation:

Level of Support: Supported in Principle

Modify proposal as follows:**Meeting discussion: Concerns mentioned:**

- Requirements for restraints are inconsistent.
- Prescriptive language was removed in 1999, but it has since been found that facilities are not being accountable.
- Need to define “chemical restraint” in hospital policy.
- Where do we draw the line? (Examples feel hand-picked)
- Are these technical fixes? Is this something that is done in current practice?
- We need common language for “Living Will.” (Medicare has a different definition)
- Hospitals should not have informed consent obligations. Is this about just having policies?
- Who has to have this? Informed consent could be addressed in guidelines.
- More research is needed. Questions need to be addressed.

Proposal 036**Supported as Submitted**

Submitter: Dept. of Health, OHCS

Section: 246-320-365

Recommendation: Revise text as follows

(after (5) (a) (i)) To anesthesiology services and qualified anesthesiology practitioner; and

(8) If providing an intermediate care or level 2 nursery, have nursing, laboratory, pharmacy, radiology, and respiratory care services appropriate for infants:

(9) If providing a neonatal intensive care or level 3 nursery, have:

(11) (c) Provide staff and services in accordance with WAC 246-324-170~~(3)~~;

(12) (c) Provide staff and services in accordance with WAC 246-322-170~~(3)~~; and

(new language to (13)) Policies and procedures specific to the care and needs of the patients receiving the services;

Staff trained in the care of long term patients; and

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:**Meeting discussion: Concerns mentioned:**

- Define “qualified anesthesiology practitioner” in (5) (a) (i) (Example: MD, DO, ARNP, DDS, etc.)
- This proposed change is important because more procedures are being conducted outside the operating room.
- Should anesthesiology be changed to anesthesia?

Proposal 037**Supported with Modifications**

Submitter: WSCP & AORN
Section: 246-320-365
Recommendation: Revise text as follows

(5) Assure sufficient number of personnel to ensure that a registered nurse qualified by training and experience is present in the operating room and functions as the circulating nurse throughout every surgical or invasive procedure.

Substantiation: The presence of a registered nurse (RN) qualified by training and experience serving in the circulating role is essential for timely delivery of quality surgical care and optimal patient outcomes. Currently, there is no law or regulation in Washington that ensures patient safety in the operating room by requiring a registered nurse to be present to continually assess and manage patient care needs throughout a surgical procedure. The Association of periOperative Registered Nurses (AORN), as the recognized leader in patient safety, asserts that it is the right of the patient to receive the highest quality nursing care. No other person is more knowledgeable or qualified to handle the multiple critical issues surrounding patient safety in the operating room than the registered nurse who is specifically trained in perioperative nursing. The perioperative RN, through professional and patient-centered expertise, is the primary patient advocate in the operating room and is responsible for monitoring all aspects of the patient's condition. During surgery, most patients are anesthetized or sedated and are powerless to make decisions on their own behalf. By employing critical thinking, assessment, diagnosing, outcome identification, planning, and evaluation skills, the RN circulator directs the nursing care and coordinates activities of the surgical team for the benefit of patient whose protective reflexes or self-care abilities are compromised by the procedure. For these reasons, AORN and WSCP strongly recommend that the Washington State Department of Health enact the above rule, in the interest of patient safety, to ensure that there is a perioperative registered nurse in the role of circulator throughout every surgical procedure.

(NOTE: ADDITIONAL INFORMATION PROVIDED AS ATTACHMENT "A" AT THE END OF THIS DOCUMENT)

Level of Support: Supported with Modifications

Modified proposal as follows:

(5) Assure ~~sufficient number of personnel to ensure~~ that a registered nurse qualified by training and experience is ~~present in the operating room and~~ functions as the circulating nurse throughout every surgical or invasive procedure in the operating room.

Meeting discussion: The following modifications were agreed to: Delete "sufficient number of personnel to ensure that" and "is present in the operating room and." Insert "in the operating room". These modifications addressed the issue of separating the need for a nurse circulator in the operating room from requiring a nurse circulator being present during every invasive procedure.

Concerns mentioned:

- This issue may be addressed through individual health professions scope of practice
- This may be a scope of practice issue vs. standard of care issue.
- This is a patient safety issue. If not addressed in hospital rule then where should it be?

Other comments or questions:

- A registered nurse must be in charge of patient care at all times.
- Could a circulator be something other than a registered nurse? How about a physician?
- The proposed change reflects current hospital practices. Reiterating this proposed requirement in the hospital licensing rules would provide consistency and support patient safety practices.

Proposal 038**Supported as Submitted**

Submitter: Susan Kelly
Section: 246-320-365
Recommendation: Revise text as follows

And Section (11) (c): Provide ~~staff~~ (services) in accordance with WAC 246-324-170~~(3)~~.
 And Section (12) c) : Provide ~~staff~~ (services) in accordance with WAC 246-322-170~~(3)~~

Substantiation: The rule as written has been in error. The reference to staff should have been services since the rule was adopted. This is a technical correction so that both the chemical dependency/alcohol rules and the psychiatric rules for units in hospitals will be the same as for the chemical/alcohol & psychiatric hospitals.

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting Discussion:

Proposal 039

Supported as Submitted

Submitter: Byron Plan
Section: 246-320-365
Recommendation: Revise text as follows

(14) For every patient presenting to the emergency department with an emergency medical condition, the hospital will perform a medical screening exam, provide treatment and stabilization within the hospitals capability.

Adopt and implement policies and procedures for the transfer of a patient with an emergency medical condition or who is in active labor based on: patient request, inability to treat the patient due to facility capability, staff availability or bed availability, and the ability of the receiving hospital to accept and care for the patient.

Substantiation: This language makes the state regulations consistent with the Federal Medicare rules and RCW 70.170.060(2)&(3).

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion: This proposal is consistent with EMTALA guidelines. This proposal is only designed for the transfer of patients as described above.

Other questions or comments:

- If this proposal includes EMTALA type standards, what about rules for receiving in a hospital mirroring EMTALA language? Suggest additional language.

Proposal 040

Supported in Principle

Submitter: Dept. of Health, OHCS
Section: 246-320-385
Recommendation: Revise text as follows:

Outpatient care services. The purpose of the outpatient care services section is to guide the development of the plan for patient care for hospitals that care for in patients in out patient sites or clinics. This is accomplished by ensuring availability of materials and resources and through establishing, monitoring, and enforcing policies and procedures that promote the delivery of quality health care.

If providing care to in patients in an out patient setting or clinic, hospitals will:

(after (1)) Assure the integration and use of all hospital policies and procedures

Substantiation:

Level of Support: Supported in Principle

Modify proposal as follows:

Meeting discussion: The group agreed this proposal could be “Supported as Submitted”, if the department can provide evidence that this is just a housekeeping item for clarification.

Other comments or questions:

- How does this proposal fit with proposal number 017?
- The language is based on Medicare’s interpretation of outpatient clinics.
- This is inter-related with following internal housekeeping policies.
- Additional information is needed from the department before determining whether this is an actual “support.”

Proposal 041

Supported with Modification

Submitter: Dept. of Health, OHCS
Section: 246-320-405
Recommendation: Revise text as follows:

(2) (a) (i) Maintain a physical environment free of hazards from electrical, biological and radiological agents, falls, equipment and spills; and

(after (5) (a) (iv)) Regularly tested through practice drills

(6) (a) Establish and implement a plan to maintain a fire-safe environment of care that meets fire protection requirements established by the Washington state patrol, ~~fire protection bureau~~ office of the state fire marshal and local jurisdiction;

(7) (b) As part of the hospital quality improvement process, investigate, report, and evaluate procedures in response to system failures; and

Substantiation:

Level of Support: Supported with Modifications

Modify proposal as follows:

Meeting discussion: Electrical and/or EMS shielding is regularly tested as a Medicare requirement. Does event or table top exercise count? This is consistent with JCAHO requirements. This proposal brings us in line with Medicare regulations.

Proposal 042

Supported in Principle

Submitter: Geoffrey W. Glass
Section: 246-320-405
Recommendation: Revise text follows

(1) The hospital will designate a person or persons responsible

to develop, implement, monitor, and follow up on safety, security, hazardous materials, emergency preparedness, ~~life safety~~ fire prevention, ~~patient-related technology~~-medical equipment, utility systems, and physical plant elements of the management plan.

(6) ~~Life safety~~-Fire Prevention. The Hospital will:

(c) Orient, educate, and drill staff on policies and procedures relating to ~~life safety~~ fire prevention management and emergencies.

(7) ~~Patient-related technologies~~-Medical Equipment. The hospital will:

(a) Establish and implement a plan to:

(i) Complete a technical and as engineering review to ensure that ~~patient-related technology~~-medical equipment will function safely with appropriate building support systems;

(ii) Inventory all ~~patient-related technologies~~-medical equipment that require preventive maintenance;

(c) Educate staff regarding relevant ~~patient-related technology~~-medical equipment.

(9) Physical plant. The hospital will provide:

(a) Storage;

(b) Plumbing with:

(i) A water supply providing hot and cold water under pressure which conforms to the quality standards of the department;

(ii) Hot water supplied for bathing and handwashing purposes no exceeding 120 degrees F;

(iii) The cross connection controls meeting requirements in ~~WAC 246-320-525 (4) (a)~~;

(note: this reference is being removed by reference to the AIA Guidelines and new language will need to be added in this section)

~~And~~

~~(iv) Medical gas piping meeting requirements in WAC 246-320-99902 (6) and (10);~~

(delete this reference to WAC 246-320-99902 as these codes and standards should only apply when related to design and construction and will be referenced in the AIA Guidelines)

(c) Ventilation

i) To prevent objectionable odors and/or excessive condensation; and

ii) ~~with air pressure relationships meeting the requirements in WAC 246-320-525 (Table 525-3);~~

Substitute the following language: “(ii) With air movement relationship to adjacent area meeting the requirements of Table 7-2 of the Guidelines for Design and Construction of Hospital and Health Care Facilities.”

~~d) Interior finishes suitable to the function in accordance with WAC 246-320-525(6);~~

~~(e) Electrical with:~~

~~(i) Patient call systems in accordance with WAC 246-320-525 (Table 525-1); and~~

~~(ii) Tamper resistant receptacles in waiting areas and where noted in Table 525-5 and WAC 246-320-99902(3).~~

(Delete this references (d and e) to WAC 246-320-525 as these codes and standards should only apply when related to design and construction and will be referenced for new construction in the AIA Guidelines)

Substantiation:

- Changes in Environment of Care terminology (Life Safety to Fire Prevention and Patient Related Medical Technology to Medical Equipment) are made to assure consistency with JCAHO terminology.
- Changes to (b) plumbing, (c) ventilation, (d) interior finishes and (e) electrical are made to bring consistency with Guidelines for Design and Construction of Hospital and Health Care Facilities. These requirements should only be addressed during construction review and should no be required as a part of an operational license review (this creates retroactive construction requirements).

Level of Support: Supported in Principle

Modify proposal as follows:

Recommended modification, further discussion needed to assess level of support: (1) The hospital will designate

a person or persons responsible to develop, implement, monitor, and follow up on safety, security, hazardous materials ~~and waste~~, emergency preparedness, ~~life safety~~ fire prevention, ~~patient related technology~~ medical equipment, utility systems, and physical plant elements of the management plan.

Meeting discussion: Concerns mentioned:

- There needs to be consistency in language.
- This should apply to the construction WAC. The operational issues address correct operation of equipment – not whether the right equipment is in place.
- There are concerns about cross connection/cross contamination. The danger of putting the proposal in construction only is that these issues do not always fall under CRS review. There is a concern about how to separate new construction from existing construction.

Other comments or questions:

- The intent is to prevent retroactive application of the construction standard.
- More research/discussion is needed.

Proposal:043

Supported as Submitted

Submitter: Raejean Bales
Section: 246-320-990
Recommendation: New Section

A licensee shall submit an additional late fee in the amount of one hundred dollars per day, not to exceed twelve hundred dollars, from the renewal date (which is November 30 every year) until the date of mailing the fee, as evidenced by the postmark.

Substantiation: There is a substantial amount of cost to DOH every year in collecting the annual fee from late renewals. The late fees are representative of the comparison of cost in time and employee salaries spent every year. A similar late fee was imposed previously for late renewals of In Home Service agency licenses. As a result, the late renewals have decreased to an almost non-existent amount.

Level of Support: **Supported as Submitted**

Modify proposal as follows:

Meeting discussion: Concerns mentioned:

- Are late payments an issue?
- Concerns were expressed about burdening small hospitals.

Other comments or questions:

- Experience indicates it is the large hospitals that are not paying on time.
- The hospital contact list needs to be current and the correct individuals at each hospital need to be notified.
- Would the department collect additional monies by sending the notices out late?

Proposal:044

Supported as Submitted

Submitter: L. Kent Gregory
Section: 246-320-990
Recommendation: Include review of non-hospital based Ambulatory Surgery Centers in services offered; fees collected by DOH CRS.

Substantiation: Compliance with Medicare Certification Requirements for non-hospital based Ambulatory Surgery Centers are subject to interpretation. Without any review process, applicants for certification receive no

comments from DOH until the facility is built and ready to open. Comments for approval come with the on-site survey. Given the capitol outcry, corrections and revision have a significant negative impact.

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion:

Proposal:045

Supported as Submitted

Submitter: Dept. of Health, OHCS

Section: 246-320-145

Recommendation: Consider rules necessary to implement passage of 2SHB 2292. See pertinent sections of bill at end of document listed as attachment “B”.

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:

None

Meeting discussion: This proposal refers to adverse event analysis and determining root cause.

Proposal:046

Supported as Submitted

Submitter: Dept. of Health, OHCS

Section: 246-320-

Recommendation: Consider rule language necessary to implement the requirements of ESHB 1672. See pertinent sections of bill at end of document listed as attachment “C”.

Substantiation:

Level of Support: Supported as Submitted

Modify proposal as follows:

Meeting discussion:

HOSPITAL PHYSICAL ENVIRONMENT & CONSTRUCTION REGULATIONS

FOR SECTIONS:

WAC 246-320-500 Through

WAC 246-320-99902

(EXCLUDING WAC 246-320-990)

Proposal 047**Supported as Submitted**

Submitter: Construction Review Services
Section: WAC 246-320-500
Recommendation: Revise text as follows:

Applicability of WAC 246-320-500 ~~and 246-320-505 through 246-320-99902~~

The purpose of the new construction regulations is to provide minimum standards for a safe and effective patient care environment consistent with other applicable rules and regulations without redundancy and contradictory requirements. Rules allow flexibility in achieving desired outcomes and enable hospitals to respond to changes in technologies and health care innovations.

- 1) These regulations apply to a hospital as defined in RCW 70.41.020 Including:
 - a) New buildings to be licensed as a hospital;
 - b) Conversion of an existing building or portion thereof for use as a hospital;
 - c) Additions to an existing hospital;
 - d) Alterations to an existing hospital; and
 - e) Buildings or portions of buildings licensed as a hospital and used for outpatient care facilities;
 - f) Excluding non-patient care ~~buildings areas~~ used exclusively for administration functions.
- 2) The requirements of chapter ~~246-320~~ WAC in effect at the time the application, fee, and construction documents are submitted to the department for review will apply for the duration of the construction project.

NEW SECTION

- 3) Standards for design and construction
 - a) Facilities constructed and intended for use under this chapter shall comply with:
 - i) The following chapters of the Guidelines for Construction of Healthcare Facilities, 2006 edition, as amended:
 - (a) 1 General
 - (b) 2 Environment of Care
 - (c) 3 Site
 - (d) 4 Equipment
 - (e) 5 Planning, Design and Construction
 - (f) 6 Record Drawings and Manuals
 - (g) 7 General Hospital
 - (h) 9 Outpatient Facilities
 - (i) 10 Rehabilitation Facilities
 - (j) 11 Psychiatric Hospital
 - (k) 12 Mobile, Transportable, and Relocatable Units
 - (l) 13 Hospice Facility
 - (m) XX Small Inpatient Primary Care Hospitals
 - ii) The National Fire Protection Association, Life Safety Code, NFPA 101 as adopted by the Center of Medicare/Medicaid and amended by the Code of Federal Regulations (CFR).

The State Building Code as adopted by the State Building Code Council under the authority of chapter 19.27 RCW

Substantiation: The change in 1(f) is to clarify the intent of the section. An interpretation was provided in December of 2000 to explain that the intent of that section was allow campus buildings that were solely used for administrative purposes to be handled by the local AHJ only and not required to be submitted to CRS. The original intent of the word “AREAS” was so that seemingly attached buildings that are used solely for administrative purposed also would not have to be submitted to CRS. It wasn’t understood at the time that it is more technically correct to use the word “BUILDINGS” which is more understandable to the architectural and design community. A “building” can be attached to another “building”, the building and life safety codes require a physical separation between the two buildings, meeting the intent of the original rule ensuring that the portions of the facility that are providing patient cares are able to stand alone.

The new section 3 has been added to adopt the national standard for design and construction of healthcare facilities. The Guidelines are updated on a four-year cycle by the multidisciplinary Health Guidelines Revision Committee (HGRC). Individuals knowledgeable about health care practices and health care facility design (doctors, nurses, facility managers, architects, and engineers) and those who apply the document in the field (state and federal authorities having jurisdiction, or AHJs) serve on the committee. (AHJs reviewing and approving plans and construction for health facilities are often architects or engineers.)

The revision process involves two opportunities for public comment. During a proposal period, anyone can submit a

proposal to change language in the Guidelines. The HGRC considers these proposals and develops a draft manuscript. This draft is then posted for public comment, and anyone can comment on the proposed changes. From its review of these comments, the HGRC develops the manuscript for the next edition of the Guidelines. We believe that this national level of expertise can provide a much more evidence based research to ensure that the standards are minimum standards. These standards are also referenced by the JCAHO, and have been adopted in over 40 other states. This lends itself to consistence to the national healthcare system. It is important to note that the final draft has been approved and is what has been used for this stakeholdering process. The content in the published edition will be the same however the document organization will change. DOH staff will coordinate the final rule chapter and section references.

The inclusion of lines ii) and iii) are included to make this rule more of a “single source” document and to be more customer friendly by providing all of the other references to other pertinent regulations. In ii), the reference to NFPA 101 is a requirement for participation in the Center for Medicare/Medicaid (CMS) programs which undergoes its own federal stakeholdering process. CMS adopts through the Code of Federal Regulations which edition is mandatory to comply and CRS reviews facilities to ensure that they meet the standard. In iii) the building code is adopted by the State Building Code Council which also uses their own state stakeholdering process to adopt the standards. These codes are enforced at the local level, so it is imperative that DOH reviewed to the same standard. CRS collaborates with local authorities to limit the amount of duplicative review and still provided a level of consistency to healthcare environments across the state. In some smaller jurisdictions CRS is the sole source of plan review, so the reference to the standards that are adopted by the state are necessary to call them to our customers attention.

Level of Support: Supported as Submitted

Meeting discussion: There was a concern that replacing the word “Buildings” with “Areas” would be a huge change because areas in a hospital that are not patient care would be covered by this new rule. The word “Buildings” would also be a problem, in that non-patient areas are in hospitals, but do not necessarily have patient care environments. An interpretation provided December of 2000, clarifies this issue, which does include “area”. The only “areas” exempt from meeting the rules to provide a safe environment are those areas that are “separated” from the remainder of the building and do not share utilities/ services. This “separation” is defined in the Building Codes as a separate “building”.

Proposal 048
Not Supported

Submitter: Construction Review Services

Section: WAC 246-320-505

Recommendation: Revise text as follows:

- 1) Drawings and specifications for new construction, excluding minor alterations, must be prepared by, or under the direction of, an architect registered under chapter 18.08 RCW. The services of a consulting engineer registered under chapter 18.43 RCW must be used for the various branches of the work where appropriate. The services of a registered professional engineer may be used in lieu of the services of an architect if work involves engineering only.
- 2) A hospital must submit construction documents for proposed new construction to the department for review and authorization to begin construction approval prior to commencing occupying the new construction, as specified in this subsection, with the exception of administration areas that do not affect fire and life safety, mechanical and electrical for patient care areas. Compliance with these standards and regulations does not relieve the hospital of the need to comply with applicable state and local building and zoning codes. The construction documents must include:
 - a) A written program containing, at a minimum:
 - i) Information concerning services to be provided and operational methods to be used; and
 - ii) A plan to show how they will ensure the health and safety of occupants during construction and installation of finishes. This includes taking appropriate infection control measures, keeping the surrounding area free of dust and fumes, and assuring rooms or areas are well-ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors;
 - b) Drawings and specifications to include coordinated architectural, mechanical, and electrical work. Each room, area, and item of fixed equipment and major movable equipment must be identified on all drawings to demonstrate that the required facilities for each function are provided; and
 - c) Floor plan of the existing building showing the alterations and additions, and indicating:
 - i) Location of any service or support areas; and
 - ii) Required paths of exit serving the alterations or additions.
- 3) A hospital will:
 - a) Respond in writing when the department requests additional or corrected construction documents;
 - ~~b) Notify the department in writing when construction has commenced;~~

- c) Submit to the department for review any addenda or modifications to the construction documents;
 - d) Assure construction is completed in compliance with the final "department approved" documents; and
 - e) Notify the department in writing when construction is completed and include a copy of the local jurisdiction's approval for occupancy.
- 4) The hospital will not ~~begin construction use any new or remodeled areas until:~~
- a) The Infection Control Risk Assessment (ICRA) has been approved by the department.
 - b) The interim Life Safety Plan has been approved by the department.
 - c) ~~The construction documents are approved.~~ Authorization to begin construction has been granted by the department; and
 - d) The local jurisdictions have issued a building permit. ~~n approval to occupy.~~

Substantiation: Thousands of healthcare dollars are wasted each year as facilities begin construction without prior approval. Examples include healthcare facilities built before documents were submitted and without any meetings with the department. Later to find that the facilities, which were renovations of existing business occupancy, were not sprinklered and would not be allowed to be used as intended. In other instances the life safety of the patients was compromised when construction was completed without prior approval of the department because interim fire or life safety measures were not provided as required. The intent of this rule change is to ensure that the documents are submitted to us timely, and that the responses to our plan review comments are returned timely. It is intended that through our coordination efforts with the local AHJ that we will be able to issue authorization to begin construction at the same time that the local authority has issued their permit.

The following conflicts have been identified:

- i) **Conflict with International Building Code** – “*Section 105.1 Required. Any owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert or replace any electrical, gas, mechanical or plumbing system, the installation of which is regulated by this code, or to cause any such work to be done, shall first make application to the building official and obtain the required permit.*”
- ii) **Coordination with local building and fire officials:** SHB1591 required the Department of Health to “*identify conflicts and eliminate them.*” The department has chosen to partner with the local building and fire officials to ensure that duplicative review is not made and the most reasonable timeframes are met by collaborating on the plan review responsibilities i.e sharing the review responsibilities depending on the workload. When facilities choose not to submit the documents to the department at the same time as their submission to the local it increases the timeframes for plan review because the increased efficiencies can not be obtained by coordinating with the local authorities.
- iii) **Conflict with the Center for Medicare / Medicaid (CMS):** The Code of Federal Regulations (CFR) part 482.41 states: “The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.” The intent of the construction review program is to help ensure healthcare facilities are constructed to standards that provide a safe environment. The CFR also adopts construction standards for participation in Medicaid / Medicare programs which not only include requirements for the completed construction but interim life safety measures as well for additions and remodels. Plan review must occur before construction begins to ensure that these standards are met.
- iv) **Infection Control:** Based on the annual report on nosocomial infection published by the Center for Disease Control - Nationally, over 2.5 million patients acquire an infection during their stays in hospitals. 100,000 patients die from those infections, of that 10,000 people die from infections that are caused by construction related activity. The State of Washington Construction Review Program has been one of the nations fore runners in assisting facilities and encouraging facilities to provide and infection control risk assessment (ICRA). To continue this charge it is imperative to the patient’s safety that the infection control risk assessment be provided and approved before construction begins to ensure that the safety measures and engineering controls are properly provided.

Level of Support: Not Supported

Meeting discussion: Concerns mentioned:

- The current process works extremely well for facilities.
- The potential loss of millions of dollars because of long permit timelines. Construction Review periods take a long time.

DOH Rebuttal:

- DOH needs support from Architectural Community to get Authorization to Begin Construction on 1st submission.
- Long plan review timelines are a problem from the past. We are continuously improving our process and decreasing our timelines.

Questions to DOH:

- Q. Can we exclude issues not typically reviewed by the state? i.e. civil, excavation, etc.
A. DOH does not review civil, excavation, etc.
- Q. Would this proposal “hamstring” the design/ build process?
A. DOH does not see any potential conflict with the design/build process.

Suggestions by Group:

- Would like the proposal in principle if construction could be started after 1st set of comments are given by Construction Review, with promise from facility to commit to satisfying those comments.
- Would like size of the project taken into consideration.
- Would like the actual timing of submitting documents to DOH be concurrent with the local jurisdictions.

Proposal 049
Supported with Modifications

Submitter: Anne Piazza & Tom Granger

Section: 246-320-505 (2) (a)

Recommendation: Revise text as follows:

(a) A written program containing, at a minimum:

(i) Information concerning services to be provided and operational methods to be used; ~~and~~

(ii) A plan to show how they will ensure the health and safety of occupants during construction and installation of finishes. This includes taking appropriate infection control measures, keeping the surrounding area free of dust and fumes, and assuring rooms or areas are well-ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors;

(iii) A plan, with input from direct-care providers, to ensure that the new construction will accommodate patient handling equipment including ceiling mounted patient lifts and includes the physical space and construction design required to incorporate such equipment in all areas of a hospital in which patient handling and movement occurs.

Substantiation: Health care workers are the leader amongst all industries I Washington State for musculoskeletal disorders, with injury rates higher than other dangerous occupations such as construction, agriculture, manufacturing and transportation.

The manual moving, transferring and re-positioning of patients is the primary cause for the high rates of back and musculoskeletal injury in the health care industry. These injuries not only lead to higher worker compensation and insurance costs, but also drive many health care providers out of direct patient care.

The development of assistive patient handling equipment and devices has essentially rendered the ac of strict “manual” patient handling unnecessary as a function of nursing care. Assistive patient handling equipment and devices control the ergonomic hazard associated with patient handling by technologically “engineering out” the energy/force imposed onto the nurse worker during the act of lifting, transferring or repositioning patients.

A growing number of health care facilities have incorporated patient handling technology and have reported positive results. Injuries among nursing staffs have dramatically declined since implementing patient handling equipment and devices along with an institutional commitment to the safest available methods. As a result, the number of lost work days secondary to injury and staff turnover has declined. Cost-benefit analyses have also shown that assistive patient handling technology successfully reduces worker’s compensation costs for musculoskeletal disorders.

Health care lags way behind many other industries as they have mechanized to remove the causes of musculoskeletal, acute and chronic back injuries. The structure and layout of the patient care unit directly impacts the usage and installation of specific lifting equipment. The proposed regulation will ensure that all future construction of hospitals will be able to accommodate the lifting equipment that can alleviate musculoskeletal injuries to both nurses and patients.

Level of Support: Supported with Modifications

Modified proposal as follows:

(a) A written program containing, at a minimum:

(i) Information concerning services to be provided and operational methods to be used; and

~~(ii) A plan to show how they will ensure the health and safety of occupants during construction and installation of finishes. This includes taking appropriate infection control measures, keeping the surrounding area free of dust and fumes, and assuring rooms or areas are well ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors;~~

When developing architectural plans for constructing or remodeling a hospital or a unit of a hospital in which patient handling and movement occurs, consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment at a later date.

Meeting discussion: Remove (ii), this is covered in Section 5.1.A of the Guidelines. The proposal for (iii) was too prescriptive and too restrictive. The law states “to consider” not “shall”. Members of the Nurses Association stated that hospitals already consider but choose not to. The new law passed by legislature provides a B&O tax break incentive of \$1000 a bed. The group decided to incorporate the language found in the RCW.

Proposal 050
Not Supported

Submitter: Construction Review Services
Section: WAC – 246-320-5??
Recommendation: Add a new chapter:

New Chapter – 246-320-5??

- 1) **"Airborne precaution room"** means a room that is designed and equipped to care for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue [five microns or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and can be widely dispersed by air currents within a room or over a long distance).
- 2) **"Alteration"**:
 - a) "Alteration" means any change, addition, remodel or modification in construction, or occupancy to an existing hospital or a portion of an existing hospital.
 - b) "Major alteration" means any physical change within an existing hospital that changes the occupancy (as defined in state building code) and scope of service within a room or area, results in reconstruction to major portions of a floor or department, or requires revisions to building systems or services.
 - c) "Minor alteration" means any physical change to an existing hospital which does not affect the structural integrity of the hospital building, which does not affect fire and life safety, and which does not add beds or facilities over those for which the hospital is licensed.
- 3) **"Ambulatory"** means an individual physically and mentally capable of walking or traversing a normal path to safety, including the ascent and descent of stairs, without the physical assistance of another person.
- 4) **"Area"** means a portion of a room or building that is separated from other functions in the room or portions of the building by a physical barrier or adequate space.
- 5) **"Clean"** when used in reference to a room, area, or facility means space or spaces and/or equipment for storage and handling of supplies and/or equipment which are in a sanitary or sterile condition.
- 6) **"Communication system"** means telephone, intercom, nurse call or wireless devices used by patients and staff to communicate.
- 7) **"Facilities"** means a room or area and equipment serving a specific function.
- 8) **"Maintainable"** means able to preserve or keep in an existing condition.
- 9) **"Maintenance"** means the work of keeping something in suitable condition.
- 10) **"Movable equipment"** means equipment not built-in, fixed, or attached to the building.
- 11) **"New construction"** means any of the following:
 - a) New buildings to be licensed as a hospital;
 - b) Additions to an existing hospital;
 - c) Conversion of an existing building or portions thereof for use as a hospital;
 - d) Alterations to an existing hospital.
- 12) **"Notify"** means to provide notice of required information to the department by the following methods, unless specifically stated otherwise in this chapter:
 - a) Telephone;
 - b) Facsimile;
 - c) Written correspondence; or
 - d) In person.
- 13) **"Patient care areas"** means all nursing service areas of the hospital where direct patient care is rendered and all other areas of the hospital where diagnostic or treatment procedures are performed directly upon a patient.
- 14) **"Pressure relationships"** of air to adjacent areas means:

- a) Positive (P) pressure is present in a room when the:
 - i) Room sustains a minimum of 0.001 inches of H₂O pressure differential with the adjacent area, the room doors are closed, and air is flowing out of the room; or
 - ii) Sum of the air flow at the supply air outlets (in CFM) exceeds the sum of the air flow at the exhaust/return air outlets by at least 70 CFM with the room doors and windows closed;
 - b) Negative (N) pressure is present in a room when the:
 - i) Room sustains a minimum of 0.001 inches of H₂O pressure differential with the adjacent area, the room doors are closed, and air is flowing into the room; or
 - ii) Sum of the air flow at the exhaust/return air outlets (in CFM) exceeds the sum of the air flow at the supply air outlets by at least 70 CFM with the room doors and windows closed;
 - c) Equal (E) pressure is present in a room when the:
 - i) Room sustains a pressure differential range of plus or minus 0.0002 inches of H₂O with the adjacent area, and the room doors are closed; or
 - ii) Sum of the air flow at the supply air outlets (in CFM) is within ten percent of the sum of the air flow at the exhaust/return air outlets with the room doors and windows closed.
- 15) **"Protective precaution room"** means a room designed and equipped for care of patients with a high risk for contracting infections, such as bone marrow and organ transplant patients.
- 16) **"Room"** means a space set apart by floor-to-ceiling partitions on all sides with proper access to a corridor and with all openings provided with doors or windows.
- 17) **"Seclusion room"** means a small, secure room specifically designed and organized for temporary placement, care, and observation of one patient and for an environment with minimal sensory stimuli, maximum security and protection, and visual observation of the patient by authorized personnel and staff. Doors of seclusion rooms are provided with staff-controlled locks.
- 18) **"Sensitive area"** means a room used for surgery, transplant, obstetrical delivery, nursery, post-anesthesia recovery, special procedures where invasive techniques are used, emergency or critical care including, but not limited to, intensive and cardiac care or areas where immunosuppressed inpatients are located and central supply room.
- 19) **"Sinks":**
- a) "Clinic service sink (siphon jet)" means a plumbing fixture of adequate size and proper design for waste disposal with siphon jet or similar action sufficient to flush solid matter of at least two and one-eighth inch diameter.
 - b) "Scrub sink" means a plumbing fixture of adequate size and proper design for thorough washing of hands and arms, equipped with knee, foot, electronic, or equivalent control, and gooseneck spout without aerators including brush and handsfree soap dispenser.
 - c) "Service sink" means a plumbing fixture of adequate size and proper design for filling and emptying mop buckets.
 - d) "Handsfree handwash sink" means a plumbing fixture of adequate size and proper design to minimize splash and splatter and permit hand washing without touching fixtures with hands, with adjacent soap dispenser with foot control or equivalent and single service hand drying device.
 - e) "Handwash sink" means a plumbing fixture of adequate size and proper design for washing hands, with adjacent soap dispenser and single service hand drying device.
- 20) **"Soiled"** (when used in reference to a room, area, or facility) means space and equipment for collection or cleaning of used or contaminated supplies and equipment or collection or disposal of wastes.
- 21) **"Toilet"** means a room containing at least one water closet.
- 22) **"Water closet"** means a plumbing fixture fitted with a seat and device for flushing the bowl of the fixture with water.

Substantiation: Terms used for the construction industry need to be separated out from the clinical terms. These have historically been overlooked in their current location in the rules and often the clinical definition may be slightly different than the construction definition.

Level of Support: Not Supported

Meeting discussion: General consensus was that the definitions should be located in one location, and not separated. Other proposals were made that would cover this proposal and address concerns with this proposal as well.

Proposal 051

Supported as Submitted

Submitter: Beverly Court

Section: WAC 246-320-685

Recommendation: Revise text as follows:

Currently the WAC reads "a separate long-term care unit where ten or more beds are planned..."
 Propose "a separate long-term care unit not to include swing beds where ten or more beds are planned..."

Substantiation: WAC 246-320-685 does not distinguish between a nursing home unit that must be physically distinct and separate for reimbursement purposes for Medicare and Medicaid and those services provided to patients who are in “swing bed status”. According to federal rule, a swing bed hospital is authorized to provide long term care services in any bed in the facility. Every bed must be able to provide both acute and long term care. The concept was that the patient would not have to be moved, rather their status would change from “acute” to “swing bed” status. Requiring swing bed capacity over nine patients to be in a separate and distinct part of the hospital violates federal rule. The patient, in many cases, must be moved. Medicare auditors have raised the issue that since the swing beds are in a distinct section per state WAC, that those costs can be excluded for Medicare reimbursement purposes. Department of Health had to issue a revised letter in September 2005 to the Medicare fiscal intermediary clarifying that a Washington hospital so cited was not in violation of federal rules on this issue. Revising the WAC will eliminate the conflict with federal rules.

Level of Support: Supported as Submitted

Meeting discussion: It was mentioned that the AIA guidelines may need to be amended to include this section as it currently does not exist.

NOTE: The Guidelines used for the stakeholdering process was a draft format. The section numbers were changed in the published version, however the content remained the same. The ROP has been cross referenced from the draft text to the now published version. The section numbers and page location have been added as shown and highlighted.

Proposal 052
Supported as Submitted

Submitter: Michael J. Kelly
Section: Guidelines 2.1.A5 (2.1.3.4, page 18)
Recommendation: Omit text in entirety:

~~The functional program shall address potential future expansion that may be needed to accommodate increased demand.~~

Substantiation: Having the functional program address potential future expansion that may be needed to accommodate increased demand is extremely subjective at best. 10 years ago, we were looking to downsize inpatient space and now we are bulging. Too subjective and unrealistic. This should be addressed in the business plan but not the functional plan.

Level of Support: Supported as Submitted

Meeting discussion:

Proposal 053
Supported as Submitted

Submitter: Michael J. Kelly
Section: Guidelines 3.1.B (2.2, page 21)
Recommendation: Omit text in entirety:

~~Availability of Transportation
A transportation plan shall be established.~~

Substantiation: Transportation plans and standards typically, when required, are required by local jurisdictions; shouldn't be a state issue.

Level of Support: Supported as Submitted

Meeting discussion:**Proposal 054****Supported as Submitted**

Submitter: Tim Heidlebaugh
Section: Guidelines 3.2.C (3.3, page 21)
Recommendation: Revise text as follows:

Parking shall be made available for patients, families, personnel and the public (as required by the local authority having jurisdiction) ~~described in the individual sections for specific facility type.~~ Signage shall be provided to direct people unfamiliar with the facility to appropriate parking areas.

Remove sections 9.1G, 9.3B, 9.4C, 9.5C, 9.6C, 9.7A, 9.9C, 9.11b, 7.1d, 11.1c including all sub-paragraphs.

Substantiation: All hospital parking in WA State is a locally controlled and administered process. All cities and counties have established codes. The Guidelines will conflict with these local and city codes. There also may be maximum requirements established in direct conflict with this code as stated.

Level of Support: Supported as Submitted

Meeting discussion: It was stated that parking is a local requirement. Concerns were that the sections to be removed could be looked over in the comment stage.

Proposal 055**Supported as Submitted**

Submitter: Johnny J. Synder
Section: Guidelines A4.1.B (A1.3.1, page 24)
Recommendation: Revise text as follows:

Design should consider the placement of cables from portable equipment so that personnel circulation and safety are maintained.

Substantiation: Inserting the word personnel will provide a visual description of possible hazards.

Level of Support: Supported as Submitted

Meeting discussion:

Proposal 056**Supported with Modifications**

Submitter: Michael J. Kelly
Section: Guidelines 5.1.A1 (b) (2.1, page 26)
Recommendation: Revise text as follows:

~~The ICRA shall be conducted by a panel with expertise in infection control, direct patient care, risk management, facility design, construction and construction phasing, ventilation, safety, and epidemiology.~~ ICRA shall be conducted by a panel as defined by the institution but at a minimum shall include epidemiology and facility representation.

Substantiation: The current proposal requires a panel that most, if not all, of the required positions are one in the same. A representative from Facilities and Epidemiology is more than sufficient.

Level of Support: Supported with Modifications

Modified proposal as follows:

~~The ICRA shall be conducted by a panel with expertise in infection control, direct patient care, risk management, facility design, construction and construction phasing, ventilation, safety, and epidemiology. ICRA shall be conducted by persons with expertise in the areas affected by the project at a minimum this would include infection control, epidemiology and facility representation.~~

Meeting discussion: It was suggested to also add members of the design team, but then noted that they may not always be available and that smaller projects may not have a design team. The group decided to add infection control expertise to the project team. It was also noted that it wasn't expected that each expertise was a separate individual.

Proposal 057**Not Supported**

Submitter: Arthur D. Kjos
Section: Guidelines 5.1.A1 (c)
Recommendation: Reword as follows:

“c. The panel shall provide updated ICRM documentation of the risk assessment together with updated recommendations for planning, design, commissioning and operation.

A separate ICRM shall be documented for risk management of patient safety during the construction process.”

Substantiation: Essentially these are two discrete documents. The ICRM for design and planning is part of the functional program and should be treated as such. This document has a life beyond the initial project inception and construction, and will be used throughout the life of the facility.

The ICRM for construction is a document intended on protection of patients and staff surrounding the construction area. This document is not intended to live beyond the construction period.

Level of Support: Not Supported

Meeting discussion: The group did not understand what the proposal was after and decided not to support the proposal. They encouraged the proposer to submit a comment, that would clarify the proposal.

Proposal 058**Supported as Submitted**

Submitter: Michael J. Kelly
Section: Guidelines 7.2.A1 (3.1.1.1, page 40)
Recommendation: Revise text as follows:

In new construction, the maximum number of beds per room shall be ~~one~~ two.

Substantiation: Dictating single bed rooms in new construction creates undo economic hardships for healthcare organizations (rural and land locked urban medical centers). Hospitals must be allowed to flex to semi-private environments condition warrant or census dictates. Additionally, this would create an unsafe environment for patient care as evidenced by a condition where the facility would be at reduced capacity (all private rooms) they would not have the infrastructure in place in order to provide safe patient care. Optionally, move this section to the appendix.

Level of Support: Supported as Submitted

Meeting discussion: The new guidelines apply only to new construction. But they will influence a significant proportion of the nation's approximately 6,000 hospitals, which are already launching a building boom to meet demand from an aging population and replace obsolete facilities. Some experts warn that not all hospitals can afford to convert to all-private rooms. In dense urban areas, there may not be enough real estate to expand, and in rural areas that need to

serve a widely spread population, hospitals may not find it feasible to build a facility large enough to give them all private rooms. Hospitals also must have "surge capacity" -- the ability to add beds in an emergency or disease outbreak. Supporting the existing standard, single patient rooms have proven to provide better patient care outcomes. Most new construction is going to private room voluntarily.

Proposal 059
Supported as Submitted

Submitter: Art Kjos
Section: Guidelines 7.2.A4 (3.1.2, page 41)
Recommendation: Omit text in entirety:

~~Patient/family centered rooms.~~

Substantiation: The term "Patient/Family-centered" is not defined. This section relies on common knowledge within the health care design/construction community. The interpretation varies from institution. The appendix reference should remain but be attached to 7.2.A2 State Requirements.

Level of Support: Supported as Submitted

Meeting discussion:

Proposal 060
Supported as Submitted

Submitter: Mike Chitwood
Section: Guidelines 7.2.A5 (a)(b) (3.1.1.5, page 40) & 7.2.B5 (a) (3.1.5.5, page 41)
Recommendation: Revise text as follows:

7.2.A5.a: A hand-washing station shall be ~~located~~ provided in the toilet room.

7.2.A5.b: Or a hand-washing station shall be provided in the patient room in addition to that in the toilet room. This shall be located outside the patient's cubicle curtain and convenient to staff entering and leaving the room.

7.2.B5.a: Hand-washing stations or waterless cleansing stations shall be conveniently accessible to the nurses station, medication station, and nourishment ~~center~~ station. "Convenient" is defined as not requiring staff to access more than two spaces separated by a door.

Substantiation:

* Waterless cleaners shall be permitted in lieu of the requirement for a sink in both the patient room and toilet. The intent is to allow one sink to serve both locations and a waterless cleaner to provide an alternate means of hand sanitation. In a private room the sink will be located in the room and in semi-private room a sink will be required in both the patient room and the toilet.

*The problem involves an old requirement for additional sinks in already confined spaces when an industry-approved alternative has become available. The standard of care has moved to the use of waterless hand sanitizers.

*Remove the duplication of sinks in patient room and toilet.

*Infection control and medical communities have approved and adopted alternate forms of hand cleansing (waterless cleaners)

Level of Support: Supported as Submitted

Meeting discussion:

- Alcohol gels don't completely replace hand washing.
- It makes sense to have 2 sinks in private patient rooms.
- There needs to be a sink accessible for the healthcare worker between the door and the bed.

Proposal 061**Supported with Modifications**

Submitter: Carolyn Johnson
Section: Guidelines 7.2.A6 (d) (2.2.1.3, page 37)
Recommendation: Revise text as follows:

Toilet room doors shall swing outward or be double acting. Where local requirements permit, folding or sliding doors may be used, provided adequate provisions are made for acoustical and visual privacy.

Substantiation: The original wording eliminates the possibility of using surface mounted sliding door. This type of door is a good solution, in some cases, to space limitations and is more durable and easy to use than folding.

Level of Support: Supported with Modifications

Modified proposal as follows:

Toilet room doors shall swing outward or be double acting. Where local requirements permit, ~~folding~~ surface mounted sliding doors may be used, provided adequate provisions are made for acoustical and visual privacy.

Meeting discussion: Concerns were made that the terms “sliding door” could be considered a “pocket door”, and these are difficult to clean and an infection control issue. Folding doors were eliminated based on Proposal #62.

Proposal 062**Supported in Principle**

Submitter: Richard Salogga
Section: Guidelines 7.2.A6 (d) & 7.3.B6 (c) (2.2.1.3, page 37)
Recommendation: Revise text as follows:

Toilet room doors shall swing outward or be double acting. ~~Where local requirements permit, folding doors may be used, provided adequate provisions are made for acoustical and visual privacy.~~

Substantiation: Folding doors on patient toilet rooms are not now approved and have never been approved in the past 25 years since I have been designing hospitals, thus, there could be no local approval for folding doors. Folding doors are lesser in quality, provide minimal acoustic privacy, and may not be fitted with privacy locks that meet accessibility requirements and overriding staff access from the room exterior.

Level of Support: Supported in Principle

Meeting discussion: See proposed new wording suggested by the group in proposal #61.

Proposal 063**Supported as Submitted**

Submitter: Richard Salogga
Section: Guidelines 7.2.B15 (a) (2.3.5.1, page 39)
Recommendation: Revise text as follows:

There shall be a nourishment area with sink, work counter, refrigerator, storage cabinets, and equipment for hot and cold nourishment between scheduled meals. This area shall include space for trays and dishes used for non-scheduled meal service. This function may be combined with a clean utility without duplication of sinks and work counters.

Substantiation: The proposed added text is consistent with current regulations allowing nourishment to be combined with clean utility. Ref: WAC 246-320-535,(6), (b), and (d).

Level of Support: Supported as Submitted

Meeting discussion:

Proposal 064

Not Supported

Submitter: Richard Salogga
Section: Guidelines 7.2.B18
Recommendation: Omit text in entirety:

~~Storage space for stretchers and wheelchairs. Space shall be provided in a strategic location, without restricting normal traffic.~~

Substantiation: Space requirement is redundant. Equipment storage space is already included via 7.2.B17. Also, this redundant requirement is not included in 7.3 Intermediate Care Units, or 7.4 Critical Care Units. In addition, the text is vague and does not quantify the equipment or space required.

Level of Support: Not Supported

Meeting discussion: General consensus was to leave the language in. The requirement for storage is redundant, however the specific type of storage in this section is not listed elsewhere for the state to amend the guidelines. To omit this particular section has no net result.

Proposal 065

Not Supported

Submitter: Ray Tiedemann
Section: Guidelines 7.2.C2 (c)
Recommendation: Revise text as follows:

Airborne infection isolation room(s) shall have self-closing devices on all room exit doors (except in suites where glass sliding partitions are used.)

Substantiation: The negative air room is already monitored (7.2.C.2.E) and will alarm for staff attention in icu/ccu/ed areas where glass partitions are used for visual observations of patients.

Level of Support: Not Supported

Meeting discussion: The concern was with staff having to negotiate a self closing door. The group was reminded that this was for new construction only and not a retro active requirement. In new construction, hold open devices will be installed and that would resolve this issue.

Proposal 066

Supported with Modifications

Submitter: Richard Salogga
Section: Guidelines 7.9.D2 (h) (5.3.3.2 [4][a], page 79)
Recommendation: Revise text as follows:

Hand-washing station(s). At least one hand-washing station with hands-free or wrist blade-operable controls shall be available for every four beds, or major fraction thereof, uniformly distributed to provide equal access from each bed.

Substantiation: Added text clarifies the number of hand-washing stations required without being excessive. Currently, WAC 246-320-645 (PACU),(3),(c), requires “a hand-washing sink is located convenient to every six patient stations or major fraction”. Thus, the proposed added text is consistent with current, clear text.

Level of Support: Supported with Modifications

Modified proposal as follows:

Hand-washing station(s). At least one hand-washing station with hands-free or wrist blade-operable controls shall be available for every ~~four beds~~ six beds, or fraction thereof, uniformly distributed to provide equal access from each bed.

Meeting discussion: General discussion found that “major” was difficult to interpret, although reasonable that more than half of the number was considered “major”. The group could not justify the need for additional sinks to be provided. i.e. With 4 – 6 beds, 1 sink is required as written, and at 7 beds, 2 sinks are required. It was proposed that we provide 1 sink for each 6 beds.

Proposal 067

Supported as Submitted

Submitter: Arthur D. Kjos
Section: Guidelines 7.9.E5 (c) (5.3.5.4 [3], page 80)
Recommendation: Omit text in entirety:

~~In new construction, view windows at scrub stations permitting observation of room interiors shall be provided.~~

Substantiation: View windows typically have blinds installed to prevent views of the work in-progress. These blinds rarely get opened in real practice. Blind mechanisms are difficult to sterilize and pose a risk of contamination of the staff member who operates the blind.

Level of Support: Supported as Submitted

Meeting discussion: This was not seen as a “minimum” requirement, instead it is a surgeon driven issue. The need for a window at the scrub station has diminished as safer, less time sensitive anesthetics have been being used.

Proposal 068

Supported with Modifications

Submitter: Richard Salogga
Section: Guidelines 7.10.A3.d (2) (d) (4.3.1.1[2], page 65)
Recommendation: Revise text as follows:

Labor rooms shall have controlled access with doors ~~that are arranged for observation from a nursing station.~~

Substantiation: For facilities with more than 6-8 beds, it is not feasible to create plans where all patient room doors are visible from a nurse’s station. Security is adequately addressed by 7.10.A3.f (1) (a).

Level of Support: Supported with Modifications

Modified proposal as follows:

Labor rooms shall have controlled access. ~~with doors.~~

Meeting discussion: The text still needs to capture the observation of the doors if in a controlled suite. Concern was that the guidelines should ensure adequate security. The group agreed that it could be nearly impossible to design a suite that all doors will be visible from the nurse station. The group also further agreed that the intended control can be accomplished in many ways, not just by the use of doors. The text was revised to leave it open to the facility to determine if it should be access controlled.

Proposal 069**Supported as Submitted**

Submitter: Mike Chitwood
Section: Guidelines 7.11.D.25.d (5.1.3.7 [5][c][i], page 73)
Recommendation: Revise text as follows:

The room shall be equipped with two hand-held showerheads with temperature controls and dedicated holding tank with floor drains.

Substantiation:

- * Eliminate the reference to the requirement for a holding tank.
- *This item should be under the purview and reviewed by local sewer authority.
- *Authority Having Jurisdiction allows / agrees that dilution is an effective mitigation factor for the contaminants that facilities deal with during a hazmat event.
- *The decontamination process, by design, uses copious amounts of water to dilute and render materials harmless, which is the preferred method defined by the Material Safety Data Sheets.
- *It is impossible to quantify the size of tank required for a hazmat event to ensure that the tank does not overflow during the event.

Level of Support: Supported as Submitted

Meeting discussion:**Proposal 070****Supported as Submitted**

Submitter: Arthur D. Kjos
Section: Guidelines 7.17.B9 (5.9.3, page 94) & 9.12.B9 (2.3.3, page 239)
Recommendation (1): 7.17.B9 - Omit text in entirety

~~Examination room. An examination room with hand-washing stations and writing surface shall be provided with an area of at least 100 square feet (9.29 square meters).~~

Recommendation (2): 9.12.B9 – Revise text as follows:

~~If home training is provided in the unit, a private treatment area of at least 120 square feet (11.15 square meters) shall be provided for patients who are being trained to use dialysis equipment at home. This room shall contain counter, hand-washing stations, and a separate drain for fluid disposal. If the attending physician is resident to the facility, an examination room with hand-washing stations and writing surface shall be provided with at least 100 square feet (9.29 meters). If a home training treatment area is provided per 9.12.B9, the treatment area may be used for the exam room.~~

Substantiation: The examination process is normally completed in the patient room in acute care settings per 7.17.B9 and in outpatient facilities 9.12.B9 the examination process is completed in the attending physician's offices.

Level of Support: Supported as Submitted

Meeting discussion:**Proposal 071****Supported as Submitted**

Submitter: Michael J. Kelly
Section: Guidelines 7.29 (2.3.10, page 39)
Recommendation: Add new section as follows:

7.29.D

-Housekeeping and soiled rooms may be combined.

Substantiation: Current practice by DOH that is not in the proposed code language.

Level of Support: Supported as Submitted

Meeting discussion: Concern of whether this is the best practice depending on who was going in & out of the room and if that needed to be controlled. Control is an issue for the facility and not a minimum requirement.

Proposal 072**Supported as Submitted**

Submitter: Arthur D. Kjos

Section: Guidelines 7.31.B4 (b) (1) (8.2.2.3[2][b][i], page 110)

Recommendation: Revise text as follows:

New construction. The minimum door size for inpatient bedrooms in new work shall be ~~3 feet 8 inches (1.12 meters)~~ 4 feet wide and 7 feet (~~2.13 meters~~) high to provide clearance for movement of beds and other equipment.

Substantiation: Existing WAC guidelines require 3'1" clear. This is a 4 foot door leaf, the new guidelines specify in terms of leaf size not clear opening. A 4 foot leaf is the minimum size needed for safe and efficient transfer of equipment and patient gurneys into patient rooms.

Level of Support: Supported as Submitted

Meeting discussion: Additional substantiation offered by the group was that Bariatric patients require larger beds, wheelchairs, doorways, etc.

Proposal 073**Supported in Principle**

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.D (6.1.1.4 Page 99)

Recommendation: Add new text:

Substantiation: Consider adding requirement for hospital pharmacies to follow applicable requirements of USP 797 (clean room provisions for mixing, etc.).

Level of Support: Supported in Principle

Meeting discussion: The group had questions on whether USP 797 has validity (ASHE is pushing back). They recognized that USP 797 should be included but it should not be a requirement. The group supported the idea of moving this proposal to the Pharmacy guidelines, in the appendix material.

DOH NOTE: Facilities will be required to meet USP 797 by the year 2008, by JCAHO.

Proposal 074**Supported as Submitted**

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.D1 (d) (10.2.1.2[2], page 119)

Recommendation: Revise text as follows:

Air change rates. Air supply and exhaust in rooms for which no minimum total air change rate is noted may vary down to ~~zero~~ the minimum required by the Washington State Ventilation and Indoor Air Quality Code (WAC 51-13) in

response to room load. For rooms listed in Table 7.2 (2.1-2), where VAV systems are used, minimum total air change shall be within limits noted.

Substantiation: Many room types (like offices) are not addressed in Table 7.2 but should have continuous ventilation.

Level of Support: Supported as Submitted

Meeting discussion:

Proposal 075

Supported with Modifications

Submitter: Dick Moeller - WSSHE

Section: Guidelines 7.31.D1 (e) (A2.2.2.1, page 33)

Recommendation: Revise text as follows:

Space temperature ~~and relative humidity~~ shall be as indicated in Guideline table 7.2 If humidity control is not required by the facility, documentation stating an understanding and acceptance that humidity control will not be provided must be signed by the facility and kept as part of the project documentation.

Add to appendix: “A7.34.D1.e It’s recognized that some facilities may not require humidity control within the ranges indicated in table 7.2 and that the final determination of a facilities ability to control humidity will be made by that facility.”

Substantiation: Given the cost of installation, maintenance and operation, not all facilities require/desire the ability to control humidity within the limits contained in Table 7.2. Changing the Guideline limits from a requirement to a controlled option will provide more flexibility to facilities.

Level of Support: Supported with Modifications

Modified proposal as follows:

Space temperature shall be as indicated in Guideline table 7.2. If humidity control is not required by the facility, documentation stating an understanding and acceptance that humidity control will not be provided must be provided in the functional program and kept as part of the project documentation.

Add to appendix: “A7.34.D1.e It’s recognized that some facilities may not require humidity control within the ranges indicated in table 7.2 and that the final determination of a facilities ability to control humidity will be made by that facility.”

Meeting discussion: This change was made because the originally proposed text was unclear as to who is expected to sign what, and where it was to be signed. Requiring a statement in the functional program is the most appropriate solution.

Proposal 076

Supported with Modifications

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.D1 (e) (Table 2.1-2 [note 8], page 132)

Recommendation: Revise text as follows:

See note at end of table 7.2

~~...The humidity is expected to be at the higher end of the range when the temperature is also at the higher end, and vice versa. When humidifying, the system shall be able to increase humidity the lowest percentage indicated when the room~~

is at the highest temperature indicated. When dehumidifying, the system shall be able to reduce humidity to the highest percentage indicated when the room is at the lowest temperature indicated...

(Note...additional rewording may be appropriate in other sentences as well)

Substantiation: Note 8 for Table 7.2 is asking for excessive humidification/dehumidification capacity. Is 60% humidity really required while a newborn nursery is at 78 degrees? If so, the requirement will be extremely expensive to accomplish. The suggested modifications above will make the requirement achievable with the systems typically installed in larger hospitals today.

Level of Support: Supported with Modifications

Modified proposal as follows:

See note at end of table 7.2

~~...The humidity is expected to be at the higher end of the range when the temperature is also at the higher end, and vice versa.~~

Meeting discussion: The group agreed to not provide the substitute language as proposed, but agreed to strike the existing language.

Proposal 077

Supported in Principle

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.D1 (e) (Table 2.1-2)

Recommendation: Revise as follows:

Substantiation: Requirements for individual room temperature control have been eliminated in Table 7.2. Is this intentional? Can multiple patient rooms now be served from one thermostat?

Level of Support: Supported in Principle

Meeting discussion: The groups general consensus was to assign a “taskforce” to recommend what rooms should have individual temperature control, and that the Table 7.2 is adjusted accordingly.

Proposal 078

Not Supported

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.D1.h

Recommendation:

Substantiation: Please verify that the intent is to **not** allow (unducted) “plenum return” in non-sensitive patient care areas. Plenum return is currently allowed by WAC in non-sensitive areas such as patient rooms and exam rooms. Ducted return is beneficial, but significantly more expensive.

Level of Support: Not Supported

Meeting discussion: The group agreed that the guidelines were clear, but that there was a concern about applying this to exam rooms.

Proposal 079

Supported with Modifications

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.D2.a (10.2.4.3 [1][a], page 122)

Recommendation: Revise text as follows:

~~Exhaust systems may be combined to enhance the efficiency of recovery devices required for energy conservation.~~

Substantiation: Difficult to understand need for this statement. It makes sense to “combine” exhaust systems in many areas (for cost and maintenance reasons) even if heat recovery is not included.

Level of Support: Supported with Modifications

Modified proposal as follows:

Exhaust systems may be combined, to enhance the efficiency of recovery devices required for energy conservation.

Meeting discussion: This is a clarification, not a requirement. The group felt that it was important to clarify that exhaust systems can be combined.

Proposal 080

Not Supported

Submitter: Don M. Iverson, P.E.
Section: Guidelines 7.34.D4 (a) (1)
Recommendation: Revise text as follows:

...air supply for operating and delivery rooms shall be from non-aspirating ceiling diffusers with a face velocity of...above the center of the work area. Linear diffusers that form a protective air curtain around the work area may also be utilized in conjunction with the non-aspirating ceiling diffusers. Return air shall be...

Substantiation: There are several manufacturers that offer operating room diffuser systems that include linear diffusers (that operate at above 35 fpm) for air curtains. Unless there is conclusive research showing that these products are inferior to the exclusive use of non-aspirating diffusers, perhaps the designers should continue to be allowed to use them were they are felt to be beneficial.

Level of Support: Not Supported

Meeting discussion: Current research supports the use of only non-aspirating diffusers over the sterile field. A question was raised on the research being conclusive enough to eliminate an option.

Proposal 081

Supported as Submitted

Submitter: Dick Moeller - WSSHE
Section: Guidelines 7.34.D7 (b) (10.2.5.2, page 124)
Recommendation: Revise text as follows:

Where two filter beds are required, filter bed no. 1 shall be located upstream of the air conditioning equipment and filter bed no. 2 shall be located downstream of ~~any fan or blower~~ the last component of any central air-handling unit and plenum/duct liner except: steam injection-type humidifiers; terminal heating coils; and mixing boxes and acoustical traps that have special covering over lining. Terminal cooling coils and linings are permitted downstream of filter bed no. 2 with additional filtration downstream of coil meeting requirements of filter bed no. 2.

Substantiation: Existing requirement as stated in Guideline section ‘7.34.D7.b’ does not prevent the installation of other potential sources of contamination such as cooling coils, duct lining, equipment insulation, etc. other than fans or blowers from being installed downstream of filter bed no. 2.

Level of Support: Supported as Submitted

Meeting discussion:**Proposal 082****Supported with Modifications**

Submitter: Don M. Iverson, P.E.
Section: Guidelines 7.34.D7 (e) (10.2.5.5, page 24)
Recommendation: Revise text as follows:

A manometer shall be installed across filter beds...including hoods requiring HEPA filters. Manometers may be omitted at HEPA-filtered ceiling diffusers if pressure-independent terminal units provides the operator a means to verify the actual airflow to the HEPA-filtered diffusers in each room. Provisions shall be made to allow access for field testing all filters.

Substantiation: Operating and delivery rooms are often equipped with several HEPA diffusers. Having a manometer for each diffuser is costly and impractical. Having one manometer for all diffusers would not provide useful information. The terminal unit provides the most important information...how much air is being supplied to the room given the condition of the filters. Terminal units can be programmed to alarm the operator if air volume drops below design due to dirty filters.

Level of Support: Supported with Modifications

Modified proposal as follows:

A manometer shall be installed across filter beds...including hoods requiring HEPA filters. Manometers may be omitted at HEPA-filtered ceiling diffusers if pressure-independent terminal units provides the operator a means to verify the actual airflow to the HEPA-filtered diffusers in each room. Provisions shall be made to allow access for field testing all filters. A recognized air flow measuring device would be acceptable, in lieu of terminal units.

Meeting discussion: The group wanted to ensure that the airflow measuring devices were recognized by a testing agency and met minimum quality standards.

Proposal 083**Supported as Submitted**

Submitter: Don M. Iverson, P.E.
Section: Guidelines 7.34.D8 (a) (2.2.2 [2][a], page 32)
Recommendation: Revise text as follows:

7.34.D8 ~~Duct~~ Humidifiers

a. If ~~duct~~ humidifiers are located within a ventilation system upstream of final filters, they shall be at least 15 feet (4.57 meters) upstream of the final filters.

Substantiation: Large humidifier manifolds located within air handling units are not always thought of as “duct humidifiers”.

Level of Support: Supported as Submitted

Meeting discussion:**Proposal 084****Supported as Submitted**

Submitter: WSSHE – Jim Grimm
Section: Guidelines 7.34.D20 (10.2.1.1 [2][b], page 118)
Recommendation: Revise text as follows:

VAV systems. The energy-saving potential of variable-air-volume systems is recognized, and the standards herein are intended to maximize the appropriate use of those systems. Any system used for occupied areas shall include provisions to avoid air stagnation in interior spaces where thermostat demands are met by temperatures of surrounding areas, and air movement relationship changes if constant volume and variable volume are supplied by one air-handling system with a common pressure dependent return system.

Substantiation: The combining of VAV and CV on a single source supply system with a common return is becoming more common in healthcare design. While a single VAV terminal unit does not affect the other terminal units when it modulates air volume, the return system modulation (if not separated properly) can have detrimental affects on the pressurization of individual rooms. Proper segregation of the return system serving portions of the facility served by the VAV and CV systems can ensure that room pressurization and air movement is properly maintained as the systems adjust and modulate for space temperature and pressure control.

Level of Support: Supported as Submitted

Meeting discussion:

Proposal 085

Not Supported

Submitter: Dick Moeller - WSSHE
Section: Guidelines 7.34.D23 (a)
Recommendation: Revise text as follows:

“Non-central air-handling systems shall be equipped with permanent (cleanable) or replaceable filters. The filters shall have a minimum efficiency of MERV 1 (50 percent) filtration meeting the requirements of Table 7.3 and conform to the requirements of Guideline section ‘7.34.D7.b’.”

Substantiation: The requirements for equipment/ductwork, etc. are already specified in sections ‘7.34.D7.b’. To allow equipment with the same basic components (cooling coils, equipment lining, etc.) to be installed within a protected environment and not require the same level of filtration only because it serves as a recirculating unit is contrary to the overall intent of the filtration process. Airborne contaminants such as bacteria from cooling coils, particulate from linings, etc. are still a potential issue with recirculating units.

Level of Support: Not Supported

Meeting discussion: Concerns mentioned:

- This is a huge change in current standard of care in patient areas.
- It would cause a huge cost in space and equipment.

Comments:

- Continues the same thought from #84.
- It won’t affect existing areas but new design areas
- This will effectively eliminate the use of supplemental cooling devices.

Questions:

- Is there data to support this change?

Proposal 086

Supported in Principle

Submitter: Don M. Iverson, P.E.
Section: Guidelines 7.34.E (2.1.1, page 31)
Recommendation: Revise text as follows:

...plumbing systems shall be designed and installed in accordance with ~~National Standard~~ Uniform Plumbing Code.

Substantiation: Uniform code is adopted by State and most local jurisdictions.

Level of Support: Supported in Principle

Modified proposal as follows:

...plumbing systems shall be designed and installed in accordance with Plumbing Code as adopted by SBCC.

Meeting discussion: The intent of the group was that the local plumbing standard was all that was required to be met.

Proposal 087

Supported with Modifications

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.E1 (c) (2.1.3.2 page 32)

Recommendation: Revise text as follows:

...handles shall ~~not exceed 4 ½ inches~~ be at least ? inches, but not exceed ? inches in length...

Substantiation: Seems like there should be a minimum blade length for a wrist blade.

Level of Support: Supported with Modifications

Modified proposal as follows:

...handles shall ~~not exceed 4 ½ inches~~ be at least 4 inches in length.

Meeting discussion: The group saw no concern with wrist blades that were larger than 4 ½”, but was concerned with blades that were under 4” and their operation with the wrist and potential infection control issues.

Proposal 088

Supported as Submitted

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.E4 (a) (3) (10.1.2.5 [1][c], page 116)

Recommendation: Revise text as follows:

~~Insofar as possible, drainage piping shall not be installed~~ Reasonable effort shall be made to avoid installing drainage piping within the ceiling or exposed... Where ~~exposed~~ overhead drain piping in these areas is unavoidable...

Substantiation: The interpretation of “possible” will be influenced by the competency of the designer. Suggested wording will not penalize the hospitals that choose to retain the most competent designers.

Level of Support: Supported as Supported

Meeting discussion:

Proposal 089

Supported with Modifications

Submitter: Don M. Iverson, P.E.

Section: Guidelines 7.34.E4 (f)

Recommendation: Revise text as described:

Substantiation: Reconsider wording of requirement. If all grease traps must be “accessible from outside the building”, then there is no need to require “access without the need to enter food preparation or storage areas”. Please note that there may be a need for a small grease trap that could be installed inside the building. Requiring all traps to be accessible from outside seems excessive and will sometimes not be possible.

Level of Support: Supported with Modifications

Modified proposal as follows:

Grease traps. Kitchen grease traps shall be located and arranged to permit easy access without the need to enter food preparation or storage areas. ~~Grease traps shall be of capacity required and shall be accessible from outside of the building without need to interrupt any services.~~

Meeting discussion:

Proposal 090 **Supported in Principle**

Submitter: WSSHE – Jim Grimm
Section: Guidelines 7.34.E4 (3) (10.1.2.5 [1][c], page 116)

Recommendation: Revise text as follows:
 Insofar as possible, drainage piping shall not be installed within the ceiling or exposed in operating and delivery rooms, nurseries, food preparation center, food-serving facilities, food storage areas, central services, electronic data processing areas, electric closets, ~~and other sensitive areas.~~

Substantiation: There is a long list of areas that are included in this paragraph and the addition of the statement “and other sensitive areas” negates the specific list, leaving the areas included in this requirement vague and open to interpretation by every AHJ. By the time review is complete, interpretation of what other sensitive areas are can incur a large change order cost on a project.

Level of Support: Supported in Principle

Meeting discussion: Comments:

- The general consensus of the group was that this was not the complete list.
- For sensitive areas like ICU, this would be impractical.
- Provides inflexibility to use other options.
- A definition of the characteristics of “sensitive areas” need to be created.
- Reduce the list to those adversely affected by waste products.

Proposal 091 **Supported with Modifications**

Submitter: Don M. Iverson, P.E.
Section: Guidelines 7.34.E10 (7.1.2.1[3], page 197)

Recommendation: Revise text as follows:
 No plumbing lines shall be exposed overhead or on walls in occupied areas where...

Substantiation: Requirement should not apply in mechanical rooms or similar areas.

Level of Support: Supported with Modifications

Modified proposal as follows:

To prevent food contamination, no plumbing lines shall be exposed overhead or on walls where...

Meeting discussion:

Proposal 092 **Not Supported**

Submitter: Don M. Iverson, P.E.
Section: Guidelines 9.31.D4 (a)
Recommendation: Revise text as follows:

...air supply for operating rooms shall be from non-aspirating diffusers with a face velocity of...above the center of the work area. Linear diffusers that form a protective air curtain around the work area may also be utilized in conjunction with the non-aspirating ceiling diffusers.

Substantiation: There are several manufacturers that offer operating room diffuser systems that include linear diffusers (that operate at above 35 fpm) for air curtains. Unless there is conclusive research showing that these products are inferior to the exclusive use of non-aspirating diffusers, perhaps the designers should continue to be allowed to use them were they are felt to be beneficial.

Level of Support: Not Supported

Meeting discussion: Current research supports the use of only non-aspirating diffusers over the sterile field. A question was raised on the research being conclusive enough to eliminate an option.

Proposal 093
Supported with Modifications

Submitter: Don M. Iverson, P.E.
Section: Guidelines 9.31.D7 (e) (10.2.5.5, page 124)
Recommendation: Revise text as follows:

A manometer shall be installed across filter beds...including hoods requiring HEPA filters. Manometers may be omitted at HEPA- filtered ceiling diffusers if pressure-independent terminal units provides the operator a means to verify the actual airflow to the HEPA-filtered diffusers in each room. Provisions shall be made to allow access for field testing all filters.

Substantiation: Operating and delivery rooms are often equipped with several HEPA diffusers. Having a manometer for each diffuser is costly and impractical. Having one manometer for all diffusers would not provide useful information. The terminal unit provides the most important information...how much air is being supplied to the room given the condition of the filters. Terminal units can be programmed to alarm the operator if air volume drops below design due to dirty filters.

Level of Support: Supported with Modifications

Modified proposal as follows:

A manometer shall be installed across filter beds...including hoods requiring HEPA filters. Manometers may be omitted at HEPA-filtered ceiling diffusers if pressure-independent terminal units provides the operator a means to verify the actual airflow to the HEPA-filtered diffusers in each room. Provisions shall be made to allow access for field testing all filters. A recognized air flow measuring device would be acceptable, in lieu of terminal units.

Meeting discussion:

Proposal 094
Supported with Modifications

Submitter: Don M. Iverson, P.E.
Section: Guidelines 9.31.E (2.1.1, page 31)
Recommendation: Revise text as follows:

...plumbing systems shall be designed and installed in accordance with ~~National Standard~~ Uniform Plumbing Code.

Substantiation: Uniform Code is adopted by State and most local jurisdictions.

Level of Support: Supported with Modifications

Modified proposal as follows:

...plumbing systems shall be designed and installed in accordance with the Plumbing Code as adopted by SBCC...

Meeting discussion:

Proposal 095

Supported with Modifications

Submitter: Don M. Iverson, P.E.
Section: Guidelines 9.31.E1 (c)
Recommendation: Revise text as follows:

...handles shall ~~not exceed 4 ½ inches~~ be at least ? inches, but not exceed ? inches in length...

Substantiation: Seems like there should be a minimum blade length for a wrist blade.

Level of Support: Supported with Modifications

Modified proposal as follows:

...handles shall ~~not exceed 4 ½ inches~~ be at least 4 inches in length...

Meeting discussion:

Proposal 096

Supported as Submitted

Submitter: Don M. Iverson, P.E.
Section: Guidelines 9.31.E4.a (3) (10.1.2.5, page 116)
Recommendation: Revise text as follows:

~~Insofar as possible, drainage piping shall not be installed~~ Reasonable effort shall be made to avoid installing drainage piping within the ceiling or exposed... Where ~~exposed~~ overhead drain piping in these areas is unavoidable...

Substantiation: The interpretation of “possible” will be influenced by the competency of the designer. Suggested wording will not penalize the hospitals that choose to retain the most competent designers.

Please note: There are a lot of requirement for food preparation facilities in the “Outpatient Surgery Center” requirements. Seems out of place!

Level of Support: Supported as Submitted

Meeting discussion:

Proposal 097

Supported with Modifications

Submitter: Don M. Iverson, P.E.
Section: Guidelines 9.31.E4 (g) (10.1.2.5[5][c], page 117)
Recommendation: Revise text as described:

Substantiation: Reconsider wording of requirement. If all grease traps must be “accessible from outside the building”, then there is no need to require “access without the need to enter food preparation or storage areas”. Please note that there may be a need for a small grease trap that could be installed inside the building. Requiring all traps to be accessible from outside seems excessive and will sometimes not be possible.

Level of Support: Supported with Modifications

Modified proposal as follows:

Grease traps. Kitchen grease traps shall be located and arranged to permit easy access without the need to enter food preparation or storage areas. ~~Grease traps shall be of capacity required and shall be accessible from outside of the building without need to interrupt any services.~~

Meeting discussion:

Proposal 098 **Supported with Modifications**

Submitter: Don M. Iverson, P.E.
Section: Guidelines 9.31.E10 (7.1.2.1 [3], page 197)
Recommendation: Revise text as follows:

No plumbing lines shall be exposed overhead or on walls in occupied areas where...

Substantiation: Requirement should not apply in mechanical rooms or similar areas.

Level of Support: Supported with Modifications

Modified proposal as follows:

To prevent food contamination, no plumbing lines shall be exposed overhead or on walls where...

Meeting discussion:

ATTACHMENT “A”

FROM PROPOSAL NUMBER 037 HOSPITAL LICENSING REGULATIONS WAC 246-320-365

RN Circulator Quick 50-State Overview:

Number of states that have some statutory or regulatory language regarding the circulating duties of the RN: 34

For Hospitals:	30
For Ambulatory Surgical Centers ¹ :	22

Number of states that have mandatory language: 22

For Hospitals:	18
For Ambulatory Surgical Centers*:	12

RN Circulator requirement:

Effective RN Circulator language must do two things: (1) require that there be a circulator for all surgical or invasive procedures; and (2) requires that the registered nurse serve as the circulator in all surgical settings. In other words, the language must not only specify that the circulator is to be a registered nurse but it must also place the registered nurse in the operating room for the duration of the procedure. (see attached table for RN circulator regulatory provisions)

Definition of RN Circulator:

AORN: The circulating nurse's duties are performed outside the sterile field. The circulating nurse is responsible for managing the nursing care within the operating room (OR), observing the surgical team from a broad perspective, assisting the team to create and maintain a safe, comfortable environment for the patient's surgery. The circulating nurse

¹ Includes states that have circulator language for other settings (e.g., outpatient surgical centers) or procedure-based procedures (e.g., open-heart surgery).

makes sure each member of the surgical team performs in a united effort. One perioperative RN is dedicated to one patient during that patient’s entire intra-operative experience to serve as the patient advocate during the procedure. Using critical thinking, assessment, diagnosing, outcome identification, planning and evaluation skills, the RN circulator directs the nursing care and coordinates activities for the patient whose protective reflexes or self-care abilities are compromised by the procedure. The critical nursing functions of the RN circulator are not delegatable in the operating room.

Oregon – Circulating nurse means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs operating room team members during surgery.

Wisconsin – Circulating nurse means a registered nurse who is present during an operation or infant delivery to provide emotional support to the patient, assist with the anesthesia induction, and, throughout the surgical procedure or deliver, to coordinate the activities of the room, monitor the traffic in the room and maintain an accurate account of urine and blood loss and who, before the surgical procedure or delivery is completed, informs the recovery room of special needs and ensures that the sponge, needle and instrument counts have been done according to hospital policy.

REGISTERED NURSE AS CIRCULATOR FOR HOSPITALS AND ASCs

Bolded = Hospital Language Regular = ASC Language

<p>Alabama</p>	<p>ALABAMA ADMINISTRATIVE CODE ALABAMA STATE BOARD OF HEALTH ALABAMA DEPARTMENT OF PUBLIC HEALTH; DIVISION OF LICENSURE AND CERTIFICATION CHAPTER 420-5-2: AMBULATORY SURGICAL TREATMENT FACILITIES</p>	<p>(e) Other required Nursing Service Personnel. 1. Operating Room (i) Personnel in the operating room must include at least one (1) registered professional nurse to serve as the circulating nurse in each operating room. Additional personnel may include another RN, LPN or surgical technician to scrub.</p>
<p>Alaska</p>	<p>ALASKA ADMINISTRATIVE CODE TITLE 7 HEALTH AND SOCIAL SERVICES PART 1 ADMINISTRATION CHAPTER 12 FACILITIES AND LOCAL UNITS ARTICLE 3 GENERAL AND ACUTE CARE AND RURAL PRIMARY CARE HOSPITALS</p>	<p>7 AAC 12.120. SURGICAL SERVICE (g) A registered nurse must be present to circulate for each surgical procedure.</p>

<p>Alaska</p>	<p>ALASKA ADMINISTRATIVE CODE TITLE 7. HEALTH AND SOCIAL SERVICES PART 1. ADMINISTRATION CHAPTER 12. FACILITIES AND LOCAL UNITS ARTICLE 7. AMBULATORY SURGICAL FACILITIES</p>	<p>7 AAC 12.355. Services required (a) An ambulatory surgical facility must provide surgical services and anesthesia services. These services must comply with the standards in 7 AAC 12.120 * and 7 AAC 12.130 for surgical and anesthesia services in general acute care hospitals. The medical staff shall comply with the requirements of 7 AAC 12.110(c). * 7 AAC 12.120. SURGICAL SERVICE (g) A registered nurse must be present to circulate for each surgical procedure.</p>
<p>Arizona</p>	<p>ARIZONA ADMINISTRATIVE CODE TITLE 9. HEALTH SERVICES CHAPTER 10. DEPARTMENT OF HEALTH SERVICES HEALTH CARE INSTITUTIONS: LICENSING: ARTICLE 17. OUTPATIENT SURGICAL CENTERS</p>	<p>R9-10-1701. Definitions 2. "Circulating nurse" means a licensed nurse who is responsible for the functioning of the operating room during a surgical procedure and who does not directly assist the surgeon. R9-10-1706. Nursing Services B. A licensed nurse shall function as a circulating nurse during each surgical procedure.</p>
<p>California</p>	<p>CALIFORNIA CODE OF REGULATIONS TITLE 22. SOCIAL SECURITY DIVISION 5. LICENSING AND CERTIFICATION OF HEALTH FACILITIES, HOME HEALTH AGENCIES, CLINICS, AND REFERRAL AGENCIES CHAPTER 1. GENERAL ACUTE CARE HOSPITALS</p>	<p>§ 70217. Nursing Service Staff (2) The surgical service operating room shall have at least one registered nurse assigned to the duties of the circulating nurse and a minimum of one additional person serving as scrub assistant for each patient-occupied operating room. The</p>

	<p>ARTICLE 3. BASIC SERVICES</p>	<p>scrub assistant may be a licensed nurse, an operating room technician, or other person who has demonstrated current competence to the hospital as a scrub assistant, but shall not be a physician or other licensed health professional who is assisting in the performance of surgery.</p> <p>§ 70225. Surgical Service Staff (d) There shall be sufficient nursing personnel so that one person is not serving as circulating assistant for more than one operating room.</p>
<p>Colorado</p>	<p>COLORADO CODE OF REGULATIONS</p> <p>DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT</p> <p>HEALTH FACILITIES AND EMERGENCY MEDICAL SERVICES DIVISION:</p> <p>Chapter IV General Hospitals</p>	<p>9 DELIVERY SUITE</p> <p>9.10. NURSING. The nursing service of the delivery suite shall be under the supervision of a registered nurse qualified by training and experience to direct obstetric nursing. A registered nurse qualified by training and experience in delivery room nursing shall be present as a circulating nurse during each delivery.</p> <p>23 SURGICAL SUITE AND RECOVERY ROOM(S)</p> <p>23.31 NURSING. The nursing service of the surgical suite shall be under the supervision of a registered nurse qualified by training and experience to direct operating room nursing. A registered nurse qualified by training and experience in operating room nursing shall be present as a circulating nurse during operative procedures.</p>
<p>Colorado</p>	<p>COLORADO CODE OF REGULATIONS</p> <p>DEPARTMENT OF PUBLIC HEALTH AND</p>	<p>XI NURSING SERVICES</p> <p>H. Circulating Nurse: A registered nurse, qualified by education and experience in operating room nursing, shall be present as a circulating nurse in each operating room during operative procedures.</p>

	<p style="text-align: center;">ENVIRONMENT</p> <p style="text-align: center;">HEALTH FACILITIES AND EMERGENCY MEDICAL SERVICES DIVISION:</p> <p>Chapter XX Ambulatory Surgical Center</p>	
<p>Delaware</p>	<p>CODE OF DELAWARE REGULATIONS</p> <p>AGENCY 16. DEPARTMENT OF HEALTH AND SOCIAL SERVICES SUB-AGENCY 4000. DIVISION OF PUBLIC HEALTH CHAPTER 4405. FREE STANDING SURGICAL CENTERS HEALTH SYSTEMS PROTECTION</p>	<p>16 4000 4405. FREE STANDING SURGICAL CENTERS 4405 Free Standing Surgical Centers</p> <p>7.0 Nursing Services 7.8 Circulating Nurse: A registered nurse, qualified by education and experience in operating room nursing, shall be present as a circulating nurse in each operating room during operative procedures.</p>
<p>Florida</p>	<p>FLORIDA ADMINISTRATIVE CODE</p> <p>TITLE 59 AGENCY FOR HEALTH CARE ADMINISTRATION 59A HEALTH FACILITY AND AGENCY LICENSING CHAPTER 59A-5 AMBULATORY SURGICAL CENTER LICENSURE</p>	<p>59A-5.0085 Departments and Services (d) A registered nurse shall serve as O.R. Circulating Nurse.</p> <p>(3) NURSING SERVICE. This service shall be organized under written policies and procedures relating to patient care, establishment of standards for nursing care and mechanisms for evaluating such care, and nursing services. (c) A registered professional nurse shall be the</p>

		operating room circulating nurse.
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Hawaii	<p>CODE OF HAWAII RULES</p> <p>TITLE 11. DEPARTMENT OF HEALTH CHAPTER 93. HOSPITALS</p>	<p>§ 11-93-35 Surgical department.</p> <p>(a) If surgical services are provided, the surgical department shall:</p> <p>(3) Have a registered professional nurse in charge of the operating room suite</p> <p>(c) Each operating room shall be supervised by an experienced registered professional nurse.</p> <p>(g) Surgical technicians and licensed practical nurses are not permitted to serve as circulating nurses in the operating rooms.</p>
Hawaii	<p>CODE OF HAWAII RULES</p> <p>TITLE 11. DEPARTMENT OF HEALTH CHAPTER 95. FREESTANDING SURGICAL OUTPATIENT FACILITIES</p>	<p>§ 11-95-23 Nursing service.</p> <p>(a) Each facility shall have a nursing staff which shall be directed by the director of nursing. The director of nursing shall be a qualified registered professional nurse who shall be appointed by the administrator with the approval of the governing body. The director of nursing shall develop such nursing service policies and procedures, recruit such nursing personnel, and provide such supervision as is necessary to achieve the objectives of the facility.</p> <p>(e) Working personnel in each operating room must include at least one registered professional nurse who shall serve as the circulating nurse.</p>
Idaho	<p>IDAHO ADMINISTRATIVE CODE</p> <p>IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE TITLE 03: DIVISION OF WELFARE CHAPTER 14: RULES AND MINIMUM STANDARDS FOR HOSPITALS IN IDAHO</p>	<p>07. Surgical Staff. The surgical staff of a hospital shall consist of the following personnel: Effective Date: (10-14-88)</p> <p>a. A registered nurse with experience in operating room techniques who acts as supervisor; and Effective Date: (10-14-88)</p> <p>b. Sufficient numbers of personnel to assure there is a registered nurse serving as circulating nurse for each separate operating room where surgery is being performed;</p>
	LOUISIANA	

<p>Louisiana</p>	<p>ADMINISTRATIVE CODE</p> <p>Title 48 PUBLIC HEALTH" GENERAL</p> <p>Part I. General Administration Subpart 3. Licensing Chapter 93. Hospitals Subchapter A. General Provisions <i>(29 LR 2399</i> <i>LOUISIANA REGISTER</i> <i>ISSUE: Volume 29,</i> <i>Number 11</i> <i>ISSUE DATE: November 20, 2003)</i></p>	<p>§9401. Organization and Staffing</p> <p>C. A qualified registered nurse shall perform circulating duties for surgical procedures performed. In accordance with the needs of patients and the complexity of services performed, licensed practical nurses and operating room technicians may assist in circulatory duties under the supervision of a registered nurse who is immediately available to respond to emergencies. Licensed practical nurses and operating room technicians may perform scrub functions under the supervision of a registered nurse.</p>
<p>Nevada</p>	<p>NEVADA ADMINISTRATIVE CODE</p> <p>CHAPTER 449. MEDICAL AND OTHER RELATED FACILITIES HOSPITALS Policies and Procedures for Operation of Hospital</p>	<p>449.385 Surgical services. (NRS 449.037) 4. Circulating duties in an operating room must be performed by a qualified registered nurse, who shall not perform circulating duties in more than one operating room at a time.</p>
<p>New Jersey</p>	<p>NEW JERSEY ADMINISTRATIVE CODE</p> <p>TITLE 8. DEPARTMENT OF HEALTH AND SENIOR SERVICES CHAPTER 43G. HOSPITAL LICENSING STANDARDS</p> <p>SUBCHAPTER 32. SAME-DAY STAY;</p> <p>SUBCHAPTER 34. SURGERY;</p> <p>SUBCHAPTER 7.</p>	<p>§ 8:43G-32.3 Same-day surgery services policies and procedures (c) A registered professional nurse shall be assigned to circulating nurse duties in each room where same-day surgery is being performed.</p> <p>§ 8:43G-34.5 Surgery staff time and availability (a) A registered professional nurse shall be assigned to circulating nurse duties in each room where surgery is being performed.</p> <p>§ 8:43G-7.16 Cardiac catheterization staff time and availability (a) The following staff shall be present for all cardiac catheterization procedures: 2. A registered professional nurse, trained and experienced in assisting in cardiac catheterization procedures, who acts as the circulating nurse; and</p>

	<p>CARDIAC;</p>	<p>§ 8:43G-7.30 PTCA staff time and availability (a) The following staff shall be present for all PTCA procedures: 2. A registered professional nurse certified in basic cardiac life support, and trained and experienced in cardiac catheterization and PTCA who acts as the circulating nurse; and</p>
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<p>New Jersey</p>	<p>NEW JERSEY ADMINISTRATIVE CODE</p> <p>TITLE 8. DEPARTMENT OF HEALTH AND SENIOR SERVICES CHAPTER 43A. MANUAL OF STANDARDS FOR LICENSING OF AMBULATORY CARE FACILITIES SUBCHAPTER 12. SURGICAL AND ANESTHESIA SERVICES</p>	<p>§ 8:43A-12.6 Surgical policies and procedures (a) The facility shall develop and implement written bylaws, rules, regulations, policies, and procedures for surgical and anesthesia services, in accordance with the governing authority and medical staff bylaws. The policies and procedures shall be reviewed at least every three years and revised as needed, and shall include at least the following: 6. A registered professional nurse shall be assigned to circulating nurse duties in each room where surgery is being performed;</p>
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<p>New Mexico</p>	<p>NEW MEXICO ADMINISTRATIVE CODE</p> <p>TITLE 7. HEALTH CHAPTER 7. HOSPITALS PART 2. REQUIREMENTS FOR ACUTE CARE, LIMITED SERVICES AND SPECIAL HOSPITALS</p>	<p>§ 7.7.2.26. NURSING SERVICES J. Additional Patient Care Requirements. (1) In this subsection, "circulating nurse" means a professional registered nurse who is present during an operation to provide emotional support to the patient, assist with the anesthesia induction, and throughout the surgical procedure or delivery, coordinate the activities of the room, monitor the traffic in the room, maintain an accurate account of urine and blood loss, and who, before the surgical procedure or delivery is completed, informs the recovery rooms of specials needs and ensures that the sponge, needle and instrument counts have been done according to hospital policy. (3) Surgical: (b) A qualified professional registered nurse shall function as the circulating nurse in the surgical and obstetrical room whenever general anesthesia is used and on all local anesthesia cases involving a high degree of patient risk. Individual surgical technologists and licensed practical nurses may function as assistants under the direct</p>
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		<p>supervision of a qualified professional registered nurse.</p>
<p>Oregon</p>	<p>OREGON REVISED STATUTES</p> <p>TITLE 52. OCCUPATIONS AND PROFESSIONS CHAPTER 678. NURSES; NURSING HOME ADMINISTRATORS PROFESSIONAL NURSES GENERALLY</p> <p>678.010. Definitions for ORS 678.010 to 678.410.</p> <p>-and-</p> <p>678.445. Authority of nursing assistants to administer noninjectable medication; authority of nurse to report questions about continuation of medication.</p>	<p>As amended by HB 2800 (2005): “As used in this section: (a) ‘Circulating nurse’ means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of operating room team members during surgery. (b) ‘Type I ambulatory surgical center’ means a licensed health care facility for the performance of outpatient surgical procedures including, but not limited to, cholestectomies, tonsillectomies or urological procedures, involving general anesthesia or a relative high infection control consideration. 2(a) The duties of a circulating nurse performed in an operating room of a Type I ambulatory surgical center or a hospital shall be performed by a registered nurse licensed under ORS 678.010 to 678.410. (b) In any case requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient procedure. (c) Nothing in this section precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.</p>
<p>Oregon</p>	<p>OREGON REVISED STATUTES</p> <p>TITLE 52. OCCUPATIONS AND PROFESSIONS CHAPTER 678. NURSES; NURSING HOME ADMINISTRATORS PROFESSIONAL NURSES GENERALLY</p> <p>678.010. Definitions for ORS 678.010 to 678.410.</p> <p>-and-</p>	<p>As amended by HB 2800 (2005): “As used in this section: (a) ‘Circulating nurse’ means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of operating room team members during surgery. (b) ‘Type I ambulatory surgical center’ means a licensed health care facility for the performance of outpatient surgical procedures including, but not limited to, cholestectomies, tonsillectomies or urological procedures, involving general anesthesia or a relative high infection control consideration. 2(a) The duties of a circulating nurse performed in an operating room of a Type I ambulatory surgical center or a hospital shall be performed by a registered nurse licensed under ORS 678.010 to 678.410. (b) In any case requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an</p>

	<p>678.445. Authority of nursing assistants to administer noninjectable medication; authority of nurse to report questions about continuation of medication.</p>	<p>operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient procedure.</p> <p>(c) Nothing in this section precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.</p>
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<p>Wisconsin</p>	<p>WISCONSIN ADMINISTRATIVE CODE</p> <p>DEPARTMENT OF HEALTH AND FAMILY SERVICES CHAPTER HFS 124. HOSPITALS SUBCHAPTER IV – SERVICES</p>	<p>HFS 124.13 Nursing services</p> <p>(7) ADDITIONAL PATIENT CARE REQUIREMENTS.</p> <p>(a) Definition. In this subsection, "circulating nurse" means a registered nurse who is present during an operation or infant delivery to provide emotional support to the patient, assist with the anesthesia induction and, throughout the surgical procedure or delivery, to coordinate the activities of the room, monitor the traffic in the room and maintain an accurate account of urine and blood loss and who, before the surgical procedure or delivery is completed, informs the recovery room of special needs and ensures that the sponge, needle and instrument counts have been done according to hospital policy.</p> <p>(b) Obstetrical. Every patient admitted in labor shall be assessed initially by a registered nurse. There shall be a circulating nurse at every infant delivery.</p> <p>(c) Surgical.</p> <p>1. A registered nurse shall supervise the operating rooms.</p> <p>2. A qualified registered nurse shall function as the circulating nurse in the surgical and obstetrical room whenever general anesthesia is used and on all local cases involving a high degree of patient risk. Individual surgical technologists and licensed practical nurses may function as assistants under the direct supervision of a qualified registered nurse.</p>
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AORN

TOP TEN REASONS TO HAVE A RN CIRCULATOR IN THE OR

10.	Education Grounded in Practice	The RN has years of didactic and clinical education resulting in a firmly-grounded understanding of all aspects of the perioperative arena beginning in pre-op, continuing through the surgical procedure in the operating room and culminating in post-op.
9.	Time-Tested Knowledge	The RN's knowledge of anatomy, physiology and pharmacology are indispensable to the successful treatment of patients, who may present widely-varied conditions.
8.	Clear Communication Skills	The unique combination of professionalism, proficiency and perception that define the RN provide the ability to continually interact with all members of the surgical team, resulting in the highest level of care available to the patient.
7.	Accurate Assessment	The valuable combination of the RN's formal education, professional training and personal commitment to patient welfare make it possible for them to respond quickly and appropriately to the surgical patient's biological, psychological and social health.
6.	Critical Thinking	The RN's qualification and accuracy in recording, interpreting and responding to a continuous stream of data is an essential aspect of the responsibility to serve as the guardian of the patient's well-being.
5.	Expert Evaluation	The RN is specifically trained in the practice of accurate perception and decision-making, enabling not only an accurate assessment of the patient's present state, but the capability to plan, implement and continually evaluate that patient's care.
4.	Skillful Clinical Judgment	The RN's knowledge, observation and assessment skills, combined with the ability to anticipate needs, are invaluable to the successful performance of the operating room and are crucial components of the coordinated decision-making process that defends the patient's well-being throughout the procedure.
3.	The Patient's Advocate	The combination of thorough medical training, enhanced by reading, listening, writing and speaking skills, the RN is the singular position of serving as the patient's primary spokesperson.
2.	Informed Monitoring	The RN serves the well-being of the patient as well as the success of the surgical team by acting as the active observer, vigilantly watching for any unforeseen or unintended event that might compromise the patient during the surgery.
..... and the number one reason to have a RN as circulator in the OR:		
1.	Patient Safety	Every surgical patient deserves to have a skilled, trained and knowledgeable professional RN in the operating room with them, acting as the patient's champion and in the patient's best interests when the patient cannot.



AORN POLICY PROFILE

The Registered Nurse as Circulator

The issue

Ensuring that there is a perioperative registered professional nurse in the role of circulator in the operating room is the top legislative priority of AORN, Association of periOperative Registered Nurses.

AORN asserts that it is the right of the patient to receive the highest quality nursing care. No other person is more knowledgeable or qualified to handle the multiple critical issues surrounding patient safety in the operating room than the registered nurse (RN) who is specifically trained in perioperative nursing. The perioperative RN, through professional and patient-centered expertise, is the primary patient advocate in the operating room and is responsible for monitoring all aspects of the patient's condition. The presence of the RN in the circulating role throughout each surgical procedure is essential to achieve timely delivery of quality surgical care and optimal patient outcomes.

WHO IS AORN?

AORN is the professional association of perioperative registered nurses. AORN's mission is to support RNs in achieving optimal outcomes for patients undergoing operative and other invasive procedures. AORN, as the recognized leader in patient safety, promotes quality patient care by providing its members with education, practice standards, consultation services, and representation. AORN is comprised of over 40,000 perioperative RNs in approximately 6,700 hospitals and 3,500 ambulatory surgical centers in all 50 states and around the world.

WHO IS THE PERIOPERATIVE REGISTERED NURSE?

Perioperative nursing is a specialized area of nursing practice. As a fundamental member of the surgical team, the perioperative RN works in collaboration with other health care professionals including the surgeon, anesthesia provider, surgical assistant, and assistive personnel. The perioperative RN provides expert nursing care to surgical patients before, during, and after surgery. Perioperative nursing requires a unique and highly-developed set of knowledge and skills as well as specialized training and education. The perioperative RN plans and directs all nursing care for patients undergoing operative and other invasive procedures. The perioperative RN provides high-quality nursing care through patient assessment, diagnosis, outcome identification, planning, implementation, and evaluation. In this role, the perioperative RN is often the single advocate for the patient's safety during surgery.

**DEFINITION OF A
CIRCULATING NURSE**

The circulating nurse's duties in the operating room are performed outside the sterile field. The circulating nurse is responsible for managing all nursing care within the operating room, observing the surgical team from a broad perspective, and assisting the team to create and maintain a safe, comfortable environment for the patient's surgery. The circulating nurse ensures that each member of the surgical team performs in a united effort. One perioperative RN is dedicated to the patient during that patient's entire intra-operative experience. In the operating room, most patients are anesthetized or sedated and are powerless to make decisions on their own behalf. By employing their critical thinking, assessment, diagnosing, outcome identification, planning, and evaluation skills, the RN circulator directs the nursing care and coordinates activities for the patient whose protective reflexes or self-care abilities are compromised by the procedure. These critical nursing functions of the RN circulator are not delegable in the operating room.

**LEGISLATION
IN THE STATES**

At least thirty-four (34) states have legislative or regulatory language specific to the RN serving in the role of circulator in hospitals, ambulatory surgical centers, or both. Eighteen (18) of these states require that the perioperative RN be present in each operating room throughout each surgical or invasive procedure. Many State Boards of Nursing affirm through public directives or advisory opinions that the circulating role belongs to the RN.

CONCLUSION

The role of the RN in the perioperative setting is vital to the provision of optimal and safe patient care. The perioperative RN is the health care practitioner with the knowledge, training, and skills to successfully perform circulating duties in the surgical setting.

To ensure that patients receive the highest quality and standard of nursing care, it is essential that there is a perioperative registered professional nurse in the role of the circulator throughout every operative or invasive procedure.



ATTACHMENT “B”

FROM PROPOSAL NUMBER 045 HOSPITAL LICENSING REGULATIONS WAC 246-320-145

The following text is not a complete version of 2SHB 2292 and only contains those sections pertinent to the Hospital statutes, RCW 70.41.

Increasing Patient Safety Through Disclosure and Analysis of Adverse Events

NEW SECTION. Sec. 105 The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adverse health event" or "adverse event" means the list of serious reportable events adopted by the national quality forum in 2002, in its consensus report on serious reportable events in health care. The department shall update the list, through adoption of rules, as subsequent changes are made by the national quality forum. The term does not include an incident.

(2) "Ambulatory surgical facility" means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, whether or not the facility is certified under Title XVIII of the federal social security act.

(3) "Childbirth center" means a facility licensed under chapter 18.46 RCW.

(4) "Correctional medical facility" means a part or unit of a correctional facility operated by the department of corrections under chapter 72.10 RCW that provides medical services for lengths of stay in excess of twenty-four hours to offenders.

(5) "Department" means the department of health.

(6) "Health care worker" means an employee, independent contractor, licensee, or other individual who is directly involved in the delivery of health services in a medical facility.

(7) "Hospital" means a facility licensed under chapter 70.41 RCW.

(8) "Incident" means an event, occurrence, or situation involving the clinical care of a patient in a medical facility that:

(a) Results in unanticipated injury to a patient that is not related to the natural course of the patient's illness or underlying condition and does not constitute an adverse event; or

(b) Could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient.

"Incident" does not include an adverse event.

(9) "Independent entity" means that entity that the department of health contracts with under

section 108 of this act to receive notifications and reports of adverse events and incidents, and carry out the activities specified in section 108 of this act.

(10) "Medical facility" means a childbirth center, hospital, psychiatric hospital, or correctional medical facility. An ambulatory surgical facility shall be considered a medical facility for purposes of this chapter upon the effective date of any requirement for state registration or licensure of ambulatory surgical facilities.

(11) "Psychiatric hospital" means a hospital facility licensed as a psychiatric hospital under chapter 71.12 RCW.

NEW SECTION. Sec. 106 (1) The legislature intends to establish an adverse health events and incident reporting system that is designed to facilitate quality improvement in the health care system, improve patient safety and decrease medical errors in a nonpunitive manner. The reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(2) Each medical facility shall notify the department of health regarding the occurrence of any adverse event and file a subsequent report as provided in this section. Notification must be submitted to the department within forty-eight hours of confirmation by the medical facility that an adverse event has occurred. A subsequent report must be submitted to the department within forty-five days after confirmation by the medical facility that an adverse event has occurred. The notification and report shall be submitted to the department using the internet-based system established under section 108(2) of this act.

(3) The notification and report shall be filed in a format specified by the department after consultation with medical facilities and the independent entity. The format shall identify the facility, but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department of health or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180.

(4) As part of the report filed under this section, the medical facility must conduct a root cause analysis of the event, describe the corrective action plan that will be implemented consistent with the findings of the analysis, or provide an explanation of any reasons for not taking corrective action. The department shall adopt rules, in consultation with medical facilities and the independent entity, related to the form and content of the root cause analysis and corrective action plan. In developing the rules, consideration shall be given to existing standards for root cause analysis or corrective action plans adopted by the joint commission on accreditation of health facilities and other national or governmental entities.

(5) If, in the course of investigating a complaint received from an employee of a medical facility, the department determines that the facility has not reported an adverse event or undertaken efforts to investigate the occurrence of an adverse event, the department shall direct the facility to report or to undertake an investigation of the event.

(6) The protections of RCW 43.70.075 apply to reports of adverse events that are submitted in good faith by employees of medical facilities.

NEW SECTION. Sec. 107 (1) The department shall:

(a) Receive and investigate, where necessary, notifications and reports of adverse events, including root cause analyses and corrective action plans submitted as part of reports, and communicate to individual facilities the department's conclusions, if any, regarding an adverse event reported by a facility; and

(b) Adopt rules as necessary to implement this chapter.

(2) The department may enforce the reporting requirements of section 106 of this act using their existing enforcement authority provided in chapter 18.46 RCW for childbirth centers, chapter 70.41 RCW for hospitals, and chapter 71.12 RCW for psychiatric hospitals.

NEW SECTION. Sec. 108 (1) The department shall contract with a qualified, independent entity to receive notifications and reports of adverse events and incidents, and carry out the activities specified in this section. In establishing qualifications for, and choosing the independent entity, the department shall strongly consider the patient safety organization criteria included in the federal patient safety and quality improvement act of 2005, P.L. 109-41, and any regulations adopted to implement this chapter.

(2) The independent entity shall:

(a) In collaboration with the department of health, establish an internet-based system for medical facilities and the health care workers of a medical facility to submit notifications and reports of adverse events and incidents, which shall be accessible twenty-four hours a day, seven days a week. The system shall be a portal to report both adverse events and incidents, and notifications and reports of adverse events shall be immediately transmitted to the department. The system shall be a secure system that protects the confidentiality of personal health information and provider and facility specific information submitted in notifications and reports, including appropriate encryption and an accurate means of authenticating the identify of users of the system;

(b) Collect, analyze, and evaluate data regarding notifications and reports of adverse events and incidents, including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of the state;

(c) Develop recommendations for changes in health care practices and procedures, which may be instituted for the purpose of reducing the number or severity of adverse events and incidents;

(d) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce adverse events or incidents;

(e) Issue recommendations to medical facilities on a facility-specific or on a statewide basis regarding changes, trends, and improvements in health care practices and procedures for the purpose of reducing the number and severity of adverse events or incidents. Prior to issuing recommendations, consideration shall be given to the following factors: Expectation of improved quality of care, implementation feasibility, other relevant implementation practices, and the cost impact to patients, payers, and medical facilities. Statewide recommendations shall be issued to medical facilities on a continuing basis and shall be published and posted on a publicly accessible web site. The recommendations made to medical facilities under this section shall not be considered mandatory for licensure purposes unless they are adopted by the department as rules pursuant to chapter 34.05 RCW; and

(f) Monitor implementation of reporting systems addressing adverse events or their equivalent in other states and make recommendations to the governor and the legislature as necessary for modifications to this chapter to keep the system as nearly consistent as possible with similar systems in other states.

(3) The independent entity shall report no later than January 1, 2008, and annually thereafter to the governor and the legislature on the activities under this chapter in the preceding year. The report shall include:

(a) The number of adverse events and incidents reported by medical facilities on a geographical basis and their outcomes;

(b) The information derived from the data collected, including any recognized trends concerning patient safety; and

(c) Recommendations for statutory or regulatory changes that may help improve patient safety in the state.

The annual report shall be made available for public inspection and shall be posted on the department's and the independent entity's web site.

(4) The independent entity shall conduct all activities under this section in a manner that preserves the confidentiality of facilities, documents, materials, or information made confidential by section 110 of this act.

(5) Medical facilities and health care workers may report incidents to the independent entity. The report shall be filed in a format specified by the independent entity, after consultation with the department and medical facilities, and shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180. The protections of RCW 43.70.075 apply to reports of incidents that are submitted in good faith by employees of medical facilities.

Sec. 109 RCW 43.70.075 and 1995 c 265 s 19 are each amended to read as follows:

(1) The identity of a whistleblower who complains, in good faith, to the department of health about the improper quality of care by a health care provider, or in a health care facility, as defined in RCW 43.72.010, or who submits a notification or report of an adverse event or an incident, in good faith, to the department of health under section 106 of this act or to the independent entity under section 108 of this act, shall remain confidential. The provisions of RCW 4.24.500 through 4.24.520, providing certain protections to persons who communicate to government agencies, shall apply to complaints and notifications or reports of adverse events or incidents filed under this section. The identity of the whistleblower shall remain confidential unless the department determines that the complaint or notification or report of the adverse event or incident was not made in good faith. An employee who is a whistleblower, as defined in this section, and who as a result of being a whistleblower has been subjected to workplace reprisal or retaliatory action has the remedies provided under chapter 49.60 RCW.

(2)(a) "Improper quality of care" means any practice, procedure, action, or failure to act that violates any state law or rule of the applicable state health licensing authority under Title 18 or chapters 70.41, 70.96A, 70.127, 70.175, 71.05, 71.12, and 71.24 RCW, and enforced by the department of health. Each health disciplinary authority as defined in RCW 18.130.040 may, with consultation and interdisciplinary coordination provided by the state department of health, adopt rules defining accepted standards of practice for their profession that shall further define improper quality of care. Improper quality of care shall not include good faith personnel actions related to employee performance or actions taken according to established terms and conditions of employment.

(b) "Reprisal or retaliatory action" means but is not limited to: Denial of adequate staff to perform duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated report of misconduct pursuant to Title 18 RCW; letters of reprimand or unsatisfactory performance evaluations; demotion; reduction in pay; denial of promotion; suspension; dismissal; denial of employment; and a supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower.

(c) "Whistleblower" means a consumer, employee, or health care professional who in good faith reports alleged quality of care concerns to the department of health.

(3) Nothing in this section prohibits a health care facility from making any decision exercising its authority to terminate, suspend, or discipline an employee who engages in workplace reprisal or retaliatory action against a whistleblower.

(4) The department shall adopt rules to implement procedures for filing, investigation, and resolution of whistleblower complaints that are integrated with complaint procedures under Title 18 RCW for health professionals or health care facilities.

NEW SECTION. Sec. 110 (1) When a notification or report of an adverse event or incident under section 106 or 108 of this act is made by or through a coordinated quality improvement program under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee for the purpose of preparing a notification or report of an adverse event or incident, and the notification or report itself, shall be subject to the confidentiality protections of those laws and RCW 42.17.310(1)(hh) and 42.56.360(1)(c).

(2) When a notification or report of an adverse event or incident made by a health care worker under section 106 or 108 of this act uses information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200 or a peer review committee under RCW 4.24.250, the notification or report itself and the information or documents used for the purpose of preparing the notification or report, shall be subject to the confidentiality protections of those laws and RCW 42.17.310(1)(hh) and 42.56.360(1)(c).

Sec. 111 RCW 42.17.310 and 2005 c 424 s 16, 2005 c 349 s 1, 2005 c 312 s 6, 2005 c 284 s 1, 2005 c 172 s 13, and 2005 c 33 s 4 are each reenacted and amended to read as follows:

(1) The following are exempt from public inspection and copying:

(a) Personal information in any files maintained for students in public schools, patients or clients of public institutions or public health agencies, or welfare recipients.

(b) Personal information in files maintained for employees, appointees, or elected officials of any public agency to the extent that disclosure would violate their right to privacy.

(c) Information required of any taxpayer in connection with the assessment or collection of any tax if the disclosure of the information to other persons would (i) be prohibited to such persons by RCW 84.08.210, 82.32.330, 84.40.020, or 84.40.340 or (ii) violate the taxpayer's right to privacy or result in unfair competitive disadvantage to the taxpayer.

(d) Specific intelligence information and specific investigative records compiled by investigative, law enforcement, and penology agencies, and state agencies vested with the responsibility to discipline members of any profession, the nondisclosure of which is essential to effective law enforcement or for the protection of any person's right to privacy.

(e) Information revealing the identity of persons who are witnesses to or victims of crime or who file complaints with investigative, law enforcement, or penology agencies, other than the public disclosure commission, if disclosure would endanger any person's life, physical safety, or property. If at the time a complaint is filed the complainant, victim or witness indicates a desire for disclosure or nondisclosure, such desire shall govern. However, all complaints filed with the public disclosure commission about any elected official or candidate for public office must be made in writing and

signed by the complainant under oath.

(f) Test questions, scoring keys, and other examination data used to administer a license, employment, or academic examination.

(g) Except as provided by chapter 8.26 RCW, the contents of real estate appraisals, made for or by any agency relative to the acquisition or sale of property, until the project or prospective sale is abandoned or until such time as all of the property has been acquired or the property to which the sale appraisal relates is sold, but in no event shall disclosure be denied for more than three years after the appraisal.

(h) Valuable formulae, designs, drawings, computer source code or object code, and research data obtained by any agency within five years of the request for disclosure when disclosure would produce private gain and public loss.

(i) Preliminary drafts, notes, recommendations, and intra-agency memorandums in which opinions are expressed or policies formulated or recommended except that a specific record shall not be exempt when publicly cited by an agency in connection with any agency action.

(j) Records which are relevant to a controversy to which an agency is a party but which records would not be available to another party under the rules of pretrial discovery for causes pending in the superior courts.

(k) Records, maps, or other information identifying the location of archaeological sites in order to avoid the looting or depredation of such sites.

(l) Any library record, the primary purpose of which is to maintain control of library materials, or to gain access to information, which discloses or could be used to disclose the identity of a library user.

(m) Financial information supplied by or on behalf of a person, firm, or corporation for the purpose of qualifying to submit a bid or proposal for (i) a ferry system construction or repair contract as required by RCW 47.60.680 through 47.60.750 or (ii) highway construction or improvement as required by RCW 47.28.070.

(n) Railroad company contracts filed prior to July 28, 1991, with the utilities and transportation commission under RCW 81.34.070, except that the summaries of the contracts are open to public inspection and copying as otherwise provided by this chapter.

(o) Financial and commercial information and records supplied by private persons pertaining to export services provided pursuant to chapter 43.163 RCW and chapter 53.31 RCW, and by persons pertaining to export projects pursuant to RCW 43.23.035.

(p) Financial disclosures filed by private vocational schools under chapters 28B.85 and 28C.10 RCW.

(q) Records filed with the utilities and transportation commission or attorney general under RCW 80.04.095 that a court has determined are confidential under RCW 80.04.095.

(r) Financial and commercial information and records supplied by businesses or individuals during application for loans or program services provided by chapters 43.163, 43.160, 43.330, and 43.168 RCW, or during application for economic development loans or program services provided by any local agency.

(s) Membership lists or lists of members or owners of interests of units in timeshare projects, subdivisions, camping resorts, condominiums, land developments, or common-interest communities affiliated with such projects, regulated by the department of licensing, in the files or possession of the department.

(t) All applications for public employment, including the names of applicants, resumes, and other related materials submitted with respect to an applicant.

(u) The residential addresses, residential telephone numbers, personal wireless telephone numbers, personal electronic mail addresses, Social Security numbers, and emergency contact information of employees or volunteers of a public agency, and the names, dates of birth, residential addresses, residential telephone numbers, personal wireless telephone numbers, personal electronic mail addresses, Social Security numbers, and emergency contact information of dependents of employees or volunteers of a public agency, which are held by any public agency in personnel records, public employment related records, or volunteer rosters, or are included in any mailing list of employees or volunteers of any public agency. For purposes of this subsection, "employees" includes independent provider home care workers as defined in RCW 74.39A.240.

(v) The residential addresses and residential telephone numbers of the customers of a public utility contained in the records or lists held by the public utility of which they are customers, except that this information may be released to the division of child support or the agency or firm providing child support enforcement for another state under Title IV-D of the federal social security act, for the establishment, enforcement, or modification of a support order.

(w)(i) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health, except this exemption does not apply to requests made directly to the department from federal, state, and local agencies of government, and national and state licensing, credentialing, investigatory, disciplinary, and examination organizations; (ii) the current residential address and current residential telephone number of a health care provider governed under chapter 18.130 RCW maintained in the files of the department, if the provider requests that this information be withheld from public inspection and copying, and provides to the department an accurate alternate or business address and business telephone number. On or after January 1, 1995, the current residential address and residential telephone number of a health care provider governed under RCW 18.130.040 maintained in the files of the department shall automatically be withheld from public inspection and copying unless the provider specifically requests the information be released, and except as provided for under RCW 42.17.260(9).

(x) Information obtained by the board of pharmacy as provided in RCW 69.45.090.

(y) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420.

(z) Financial information, business plans, examination reports, and any information produced or obtained in evaluating or examining a business and industrial development corporation organized or seeking certification under chapter 31.24 RCW.

(aa) Financial and commercial information supplied to the state investment board by any person when the information relates to the investment of public trust or retirement funds and when disclosure would result in loss to such funds or in private loss to the providers of this information.

(bb) Financial and valuable trade information under RCW 51.36.120.

(cc) Client records maintained by an agency that is a domestic violence program as defined in RCW 70.123.020 or 70.123.075 or a rape crisis center as defined in RCW 70.125.030.

(dd) Information that identifies a person who, while an agency employee: (i) Seeks advice, under an informal process established by the employing agency, in order to ascertain his or her rights in connection with a possible unfair practice under chapter 49.60 RCW against the person; and (ii) requests his or her identity or any identifying information not be disclosed.

(ee) Investigative records compiled by an employing agency conducting a current investigation of a possible unfair practice under chapter 49.60 RCW or of a possible violation of other federal, state, or local laws prohibiting discrimination in employment.

(ff) Business related information protected from public inspection and copying under RCW

15.86.110.

(gg) Financial, commercial, operations, and technical and research information and data submitted to or obtained by the clean Washington center in applications for, or delivery of, program services under chapter 70.95H RCW.

(hh) Information and documents created specifically for, and collected and maintained by, a quality improvement committee pursuant to RCW 43.70.510 or 70.41.200, by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, and notifications or reports of adverse events or incidents made under section 106 or 108 of this act, regardless of which agency is in possession of the information and documents.

(ii) Personal information in files maintained in a data base created under RCW 43.07.360.

(jj) Financial and commercial information requested by the public stadium authority from any person or organization that leases or uses the stadium and exhibition center as defined in RCW 36.102.010.

(kk) Names of individuals residing in emergency or transitional housing that are furnished to the department of revenue or a county assessor in order to substantiate a claim for property tax exemption under RCW 84.36.043.

(ll) The names, residential addresses, residential telephone numbers, and other individually identifiable records held by an agency in relation to a vanpool, carpool, or other ride-sharing program or service. However, these records may be disclosed to other persons who apply for ride-matching services and who need that information in order to identify potential riders or drivers with whom to share rides.

(mm) The personally identifying information of current or former participants or applicants in a paratransit or other transit service operated for the benefit of persons with disabilities or elderly persons.

(nn) The personally identifying information of persons who acquire and use transit passes and other fare payment media including, but not limited to, stored value smart cards and magnetic strip cards, except that an agency may disclose this information to a person, employer, educational institution, or other entity that is responsible, in whole or in part, for payment of the cost of acquiring or using a transit pass or other fare payment media, or to the news media when reporting on public transportation or public safety. This information may also be disclosed at the agency's discretion to governmental agencies or groups concerned with public transportation or public safety.

(oo) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310. If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this section as exempt from disclosure. If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality.

(pp) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110.

(qq) Financial and commercial information supplied by or on behalf of a person, firm, corporation, or entity under chapter 28B.95 RCW relating to the purchase or sale of tuition units and contracts for the purchase of multiple tuition units.

(rr) Any records of investigative reports prepared by any state, county, municipal, or other law enforcement agency pertaining to sex offenses contained in chapter 9A.44 RCW or sexually violent offenses as defined in RCW 71.09.020, which have been transferred to the Washington association of sheriffs and police chiefs for permanent electronic retention and retrieval pursuant to RCW 40.14.070(2)(b).

(ss) Credit card numbers, debit card numbers, electronic check numbers, card expiration dates, or bank or other financial account numbers, except when disclosure is expressly required by or governed by other law.

(tt) Financial information, including but not limited to account numbers and values, and other identification numbers supplied by or on behalf of a person, firm, corporation, limited liability company, partnership, or other entity related to an application for a horse racing license submitted pursuant to RCW 67.16.260(1)(b), liquor license, gambling license, or lottery retail license.

(uu) Records maintained by the employment security department and subject to chapter 50.13 RCW if provided to another individual or organization for operational, research, or evaluation purposes.

(vv) Individually identifiable information received by the work force training and education coordinating board for research or evaluation purposes.

(ww) Those portions of records assembled, prepared, or maintained to prevent, mitigate, or respond to criminal terrorist acts, which are acts that significantly disrupt the conduct of government or of the general civilian population of the state or the United States and that manifest an extreme indifference to human life, the public disclosure of which would have a substantial likelihood of threatening public safety, consisting of:

(i) Specific and unique vulnerability assessments or specific and unique response or deployment plans, including compiled underlying data collected in preparation of or essential to the assessments, or to the response or deployment plans; and

(ii) Records not subject to public disclosure under federal law that are shared by federal or international agencies, and information prepared from national security briefings provided to state or local government officials related to domestic preparedness for acts of terrorism.

(xx) Commercial fishing catch data from logbooks required to be provided to the department of fish and wildlife under RCW 77.12.047, when the data identifies specific catch location, timing, or methodology and the release of which would result in unfair competitive disadvantage to the commercial fisher providing the catch data. However, this information may be released to government agencies concerned with the management of fish and wildlife resources.

(yy) Sensitive wildlife data obtained by the department of fish and wildlife. However, sensitive wildlife data may be released to government agencies concerned with the management of fish and wildlife resources. Sensitive wildlife data includes:

(i) The nesting sites or specific locations of endangered species designated under RCW 77.12.020, or threatened or sensitive species classified by rule of the department of fish and wildlife;

(ii) Radio frequencies used in, or locational data generated by, telemetry studies; or

(iii) Other location data that could compromise the viability of a specific fish or wildlife population, and where at least one of the following criteria are met:

(A) The species has a known commercial or black market value;

(B) There is a history of malicious take of that species; or

(C) There is a known demand to visit, take, or disturb, and the species behavior or ecology renders it especially vulnerable or the species has an extremely limited distribution and concentration.

(zz) The personally identifying information of persons who acquire recreational licenses under RCW 77.32.010 or commercial licenses under chapter 77.65 or 77.70 RCW, except name, address of contact used by the department, and type of license, endorsement, or tag. However, the department of fish and wildlife may disclose personally identifying information to:

- (i) Government agencies concerned with the management of fish and wildlife resources;
- (ii) The department of social and health services, child support division, and to the department of licensing in order to implement RCW 77.32.014 and 46.20.291; and
- (iii) Law enforcement agencies for the purpose of firearm possession enforcement under RCW 9.41.040.

(aaa)(i) Discharge papers of a veteran of the armed forces of the United States filed at the office of the county auditor before July 1, 2002, that have not been commingled with other recorded documents. These records will be available only to the veteran, the veteran's next of kin, a deceased veteran's properly appointed personal representative or executor, a person holding that veteran's general power of attorney, or to anyone else designated in writing by that veteran to receive the records.

(ii) Discharge papers of a veteran of the armed forces of the United States filed at the office of the county auditor before July 1, 2002, that have been commingled with other records, if the veteran has recorded a "request for exemption from public disclosure of discharge papers" with the county auditor. If such a request has been recorded, these records may be released only to the veteran filing the papers, the veteran's next of kin, a deceased veteran's properly appointed personal representative or executor, a person holding the veteran's general power of attorney, or anyone else designated in writing by the veteran to receive the records.

(iii) Discharge papers of a veteran filed at the office of the county auditor after June 30, 2002, are not public records, but will be available only to the veteran, the veteran's next of kin, a deceased veteran's properly appointed personal representative or executor, a person holding the veteran's general power of attorney, or anyone else designated in writing by the veteran to receive the records.

(iv) For the purposes of this subsection (1)(aaa), next of kin of deceased veterans have the same rights to full access to the record. Next of kin are the veteran's widow or widower who has not remarried, son, daughter, father, mother, brother, and sister.

(bbb) Those portions of records containing specific and unique vulnerability assessments or specific and unique emergency and escape response plans at a city, county, or state adult or juvenile correctional facility, the public disclosure of which would have a substantial likelihood of threatening the security of a city, county, or state adult or juvenile correctional facility or any individual's safety.

(ccc) Information compiled by school districts or schools in the development of their comprehensive safe school plans pursuant to RCW 28A.320.125, to the extent that they identify specific vulnerabilities of school districts and each individual school.

(ddd) Information regarding the infrastructure and security of computer and telecommunications networks, consisting of security passwords, security access codes and programs, access codes for secure software applications, security and service recovery plans, security risk assessments, and security test results to the extent that they identify specific system vulnerabilities.

(eee) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW.

(fff) Proprietary data, trade secrets, or other information that relates to: (i) A vendor's unique methods of conducting business; (ii) data unique to the product or services of the vendor; or (iii) determining prices or rates to be charged for services, submitted by any vendor to the department of social and health services for purposes of the development, acquisition, or implementation of state purchased health care as defined in RCW 41.05.011.

(ggg) The personally identifying information of persons who acquire and use transponders or other technology to facilitate payment of tolls. This information may be disclosed in aggregate form as long as the data does not contain any personally identifying information. For these purposes aggregate data may include the census tract of the account holder as long as any individual personally identifying information is not released. Personally identifying information may be released to law enforcement agencies only for toll enforcement purposes. Personally identifying information may be released to law enforcement agencies for other purposes only if the request is accompanied by a court order.

(hhh) Financial, commercial, operations, and technical and research information and data submitted to or obtained by the life sciences discovery fund authority in applications for, or delivery of, grants under chapter 43.350 RCW, to the extent that such information, if revealed, would reasonably be expected to result in private loss to the providers of this information.

(iii) Records of mediation communications that are privileged under chapter 7.07 RCW.

(2) Except for information described in subsection (1)(c)(i) of this section and confidential income data exempted from public inspection pursuant to RCW 84.40.020, the exemptions of this section are inapplicable to the extent that information, the disclosure of which would violate personal privacy or vital governmental interests, can be deleted from the specific records sought. No exemption may be construed to permit the nondisclosure of statistical information not descriptive of any readily identifiable person or persons.

(3) Inspection or copying of any specific records exempt under the provisions of this section may be permitted if the superior court in the county in which the record is maintained finds, after a hearing with notice thereof to every person in interest and the agency, that the exemption of such records is clearly unnecessary to protect any individual's right of privacy or any vital governmental function.

(4) Agency responses refusing, in whole or in part, inspection of any public record shall include a statement of the specific exemption authorizing the withholding of the record (or part) and a brief explanation of how the exemption applies to the record withheld.

Sec. 112 RCW 42.56.360 and 2005 c 274 s 416 are each amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, and notifications or reports of adverse events or incidents made under section 106 or 108 of this act, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170; and

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1).

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

ATTACHMENT “C”

FROM PROPOSAL NUMBER 046 HOSPITAL LICENSING REGULATIONS

ENGROSSED SUBSTITUTE HOUSE BILL 1672

AN ACT Relating to reducing injuries among patients and health care workers; adding a new section to chapter 70.41 RCW; adding a new section to chapter 72.23 RCW; adding a new section to chapter 51.16 RCW; adding a new section to chapter 82.04 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 1 The legislature finds that:

(1) Patients are not at optimum levels of safety while being lifted, transferred, or repositioned manually. Mechanical lift programs can reduce skin tears suffered by patients by threefold. Nurses, thirty-eight percent of whom have previous back injuries, can drop patients if their pain thresholds are triggered.

(2) According to the bureau of labor statistics, hospitals in Washington have a nonfatal employee injury incidence rate that exceeds the rate of construction, agriculture, manufacturing, and transportation.

(3) The physical demands of the nursing profession lead many nurses to leave the profession. Research shows that the annual prevalence rate for nursing back injury is over forty percent and many nurses who suffer a back injury do not return to nursing. Considering the present nursing shortage in Washington, measures must be taken to protect nurses from disabling injury.

(4) Washington hospitals have made progress toward implementation of safe patient handling programs that are effective in decreasing employee injuries. It is not the intent of this act to place an undue financial burden on hospitals.

NEW SECTION. Sec. 2 A new section is added to chapter 70.41 RCW to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Lift team" means hospital employees specially trained to conduct patient lifts, transfers, and repositioning using lifting equipment when appropriate.

(b) "Safe patient handling" means the use of engineering controls, lifting and transfer aids, or assistive devices, by lift teams or other staff, instead of manual lifting to perform the acts of lifting, transferring, and repositioning health care patients and residents.

(c) "Musculoskeletal disorders" means conditions that involve the nerves, tendons, muscles, and supporting structures of the body.

(2) By February 1, 2007, each hospital must establish a safe patient handling committee either by creating a new committee or assigning the functions of a safe patient handling committee to an existing committee. The purpose of the committee is to design and recommend the process for implementing a safe patient handling program. At least half of the members of the safe patient handling committee shall be frontline nonmanagerial employees who provide direct care to patients unless doing so will adversely affect patient care.

(3) By December 1, 2007, each hospital must establish a safe patient handling program. As part of this program, a hospital must:

(a) Implement a safe patient handling policy for all shifts and units of the hospital.

Implementation of the safe patient handling policy may be phased-in with the acquisition of equipment under subsection (4) of this section;

(b) Conduct a patient handling hazard assessment. This assessment should consider such variables as patient-handling tasks, types of nursing units, patient populations, and the physical environment of patient care areas;

(c) Develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and medical condition and the availability of lifting equipment or lift teams. The policy shall include a means to address circumstances under which it would be medically contraindicated to use lifting or transfer aids or assistive devices for particular patients;

(d) Conduct an annual performance evaluation of the program to determine its effectiveness, with the results of the evaluation reported to the safe patient handling committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder claims and days of lost work attributable to musculoskeletal disorder caused by patient handling, and include recommendations to increase the program's effectiveness; and

(e) When developing architectural plans for constructing or remodeling a hospital or a unit of a hospital in which patient handling and movement occurs, consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment at a later date.

(4) By January 30, 2010, each hospital must complete, at a minimum, acquisition of their choice of: (a) One readily available lift per acute care unit on the same floor unless the safe patient handling committee determines a lift is unnecessary in the unit; (b) one lift for every ten acute care available inpatient beds; or (c) equipment for use by lift teams. Hospitals must train staff on policies, equipment, and devices at least annually.

(5) Nothing in this section precludes lift team members from performing other duties as assigned during their shift.

(6) A hospital shall develop procedures for hospital employees to refuse to perform or be involved in patient handling or movement that the hospital employee believes in good faith will expose a patient or a hospital employee to an unacceptable risk of injury. A hospital employee who in good faith follows the procedure developed by the hospital in accordance with this subsection shall not be the subject of disciplinary action by the hospital for the refusal to perform or be involved in the patient handling or movement.

NEW SECTION. Sec. 3 A new section is added to chapter 72.23 RCW to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Lift team" means hospital employees specially trained to conduct patient lifts, transfers, and repositioning using lifting equipment when appropriate.

(b) "Safe patient handling" means the use of engineering controls, lifting and transfer aids, or assistive devices, by lift teams or other staff, instead of manual lifting to perform the acts of lifting, transferring, and repositioning health care patients and residents.

(c) "Musculoskeletal disorders" means conditions that involve the nerves, tendons, muscles, and supporting structures of the body.

(2) By February 1, 2007, each hospital must establish a safe patient handling committee either by creating a new committee or assigning the functions of a safe patient handling committee to an existing committee. The purpose of the committee is to design and recommend the process for implementing a safe patient handling program. At least half of the members of the safe patient handling committee shall be frontline nonmanagerial employees who provide direct care to patients unless doing so will adversely affect patient care.

(3) By December 1, 2007, each hospital must establish a safe patient handling program. As part of this program, a hospital must:

(a) Implement a safe patient handling policy for all shifts and units of the hospital.

Implementation of the safe patient handling policy may be phased-in with the acquisition of equipment under subsection (4) of this section;

(b) Conduct a patient handling hazard assessment. This assessment should consider such variables as patient-handling tasks, types of nursing units, patient populations, and the physical environment of patient care areas;

(c) Develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and medical condition and the availability of lifting equipment or lift teams;

(d) Conduct an annual performance evaluation of the program to determine its effectiveness, with the results of the evaluation reported to the safe patient handling committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder claims and days of lost work attributable to musculoskeletal disorder caused by patient handling, and include recommendations to increase the program's effectiveness; and

(e) When developing architectural plans for constructing or remodeling a hospital or a unit of a hospital in which patient handling and movement occurs, consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment at a later date.

(4) By January 30, 2010, hospitals must complete acquisition of their choice of: (a) One readily available lift per acute care unit on the same floor, unless the safe patient handling committee determines a lift is unnecessary in the unit; (b) one lift for every ten acute care available inpatient beds; or (c) equipment for use by lift teams. Hospitals must train staff on policies, equipment, and devices at least annually.

(5) Nothing in this section precludes lift team members from performing other duties as assigned during their shift.

(6) A hospital shall develop procedures for hospital employees to refuse to perform or be involved in patient handling or movement that the hospital employee believes in good faith will expose a patient or a hospital employee to an unacceptable risk of injury. A hospital employee who

in good faith follows the procedure developed by the hospital in accordance with this subsection shall not be the subject of disciplinary action by the hospital for the refusal to perform or be involved in the patient handling or movement.

NEW SECTION. Sec. 4 A new section is added to chapter 51.16 RCW to read as follows:

(1) By January 1, 2007, the department shall develop rules to provide a reduced workers' compensation premium for hospitals that implement a safe patient handling program. The rules shall include any requirements for obtaining the reduced premium that must be met by hospitals.

(2) The department shall complete an evaluation of the results of the reduced premium, including changes in claim frequency and costs, and shall report to the appropriate committees of the legislature by December 1, 2010, and 2012.

NEW SECTION. Sec. 5 A new section is added to chapter 82.04 RCW to read as follows:

(1) In computing the tax imposed under this chapter, a hospital may take a credit for the cost of purchasing mechanical lifting devices and other equipment that are primarily used to minimize patient handling by health care providers, consistent with a safe patient handling program developed and implemented by the hospital in compliance with section 2 of this act. The credit is equal to one hundred percent of the cost of the mechanical lifting devices or other equipment.

(2) No application is necessary for the credit, however, a hospital taking a credit under this section must maintain records, as required by the department, necessary to verify eligibility for the credit under this section. The hospital is subject to all of the requirements of chapter 82.32 RCW. A credit earned during one calendar year may be carried over to be credited against taxes incurred in a subsequent calendar year. No refunds shall be granted for credits under this section.

(3) The maximum credit that may be earned under this section for each hospital is limited to one thousand dollars for each acute care available inpatient bed.

(4) Credits are available on a first in-time basis. The department shall disallow any credits, or portion thereof, that would cause the total amount of credits claimed statewide under this section to exceed ten million dollars. If the ten million dollar limitation is reached, the department shall notify hospitals that the annual statewide limit has been met. In addition, the department shall provide written notice to any hospital that has claimed tax credits after the ten million dollar limitation in this subsection has been met. The notice shall indicate the amount of tax due and shall provide that the tax be paid within thirty days from the date of such notice. The department shall not assess penalties and interest as provided in chapter 82.32 RCW on the amount due in the initial notice if the amount due is paid by the due date specified in the notice, or any extension thereof.

(5) Credit may not be claimed under this section for the acquisition of mechanical lifting devices and other equipment if the acquisition occurred before the effective date of this section.

(6) Credit may not be claimed under this section for any acquisition of mechanical lifting devices and other equipment that occurs after December 30, 2010.

(7) The department shall issue an annual report on the amount of credits claimed by hospitals under this section, with the first report due on July 1, 2008.

(8) For the purposes of this section, "hospital" has the meaning provided in RCW 70.41.020.

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