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Patient Care at Risk at Washington Hospital Center

**A Report Submitted to the
District of Columbia Department of Health
November 1, 2010**

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Introduction

***"We strive to deliver the very best to every patient every day.
The patient is the first priority in everything we do."
-- Washington Hospital Center¹***

Washington Hospital Center (WHC) staff RNs should be commended for their commitment to the safety of their patients and for having taken seriously the duty placed upon them by the District of Columbia Municipal Regulations for Registered Nursing to advocate for their patients. This patient care report is a representative summary of written Assignment Despite Objection (ADO) documents. The ADO form is a tool for identifying and tracking professional practice issues within the hospital when a nurse objects to an unsafe, or potentially unsafe, patient care assignment, or when a nurse lacks consistently available working equipment and sufficient supplies, or faces professional conduct and behaviors, clinical practice, or unsafe staffing to meet the needs of each patient.

The ADOs are submitted by nurses and are forwarded by the Union to the Senior Vice President of Nursing. The Union advocated for and successfully negotiated in the 2000 collective bargaining agreement a Quality Patient Care Committee (QPCC). The QPCC is a committee of four members designated by the Union and four members designated by the hospital.

From April 2002 to March 2005, the QPCC developed recommendations and presented them on March 24, 2005 to Senior Nursing Management and Washington Hospital Center's president. Most of the recommendations made to senior management by the QPCC were ignored and problems concerning staffing have continued. In fact over the years, the number of ADOs submitted for inadequate patient care staffing has increased. *(See Appendix for the Preamble to the QPCC's 2005 Presentation.)*

The Union has made numerous attempts since 2005 to address patient care staffing issues. In addition to the QPCC, ongoing patient staffing issues have been presented at the Labor Management Committee, the Staffing and Productivity Committee (negotiated in 2009), and the Staffing Committee (a subcommittee of the Labor Management Committee formed in 2008). Earlier this year, nurses hand-delivered ADOs to the office of the President of the Hospital, the Senior Vice President of Nursing and the Assistant Vice President of Human Resources.

Since April 2009 to the present, over 500 ADOs documenting occurrences of inadequate patient care staffing have been submitted. However, not every incident of short staffing is documented on these forms. Nurses have reported to union leaders fear of threats, retaliation and reprisal by their supervisors if they submit an ADO. Since 2009 to present, the new identified trend is that the Critical Care Units (CCUs) are now reporting inadequate patient staffing. Traditionally these areas were generally immune to inadequate staffing. This coincides with a new arbitrary unilateral implementation of staffing ratios for CCUs which is not evidenced based as indicated by guidelines of the American Association of Critical-Care Nurses (AACN). (See Appendix for ACCN Guidelines.)

¹ www.whcenter.org

WHC claims to have hired approximately 300 newly graduated Registered Nurses in the year 2010. In the same year nearly 300 experienced Registered Nurses have left direct patient care at WHC. Many nurses who have left report leaving because of poor staffing or the harsh treatment by management.

WHC has increased the number of Patient Care Technicians (PCT). A PCT is a nursing assistant who may assist the RN with duties like pulling the patient up in bed, answering call lights, and assist patients with toileting. Increasingly PCT's are utilized as sitters and are reassigned to other units which mean the PCT is not available to assist RNs with direct patient care.

The Union feels strongly that optimum staffing will improve patient care. Inadequate staffing may result in delays in medication administration including pain meds, turning patients, inability to provide emotional support, delays in treatment, therapy and tests, and interventions that may prevent falls. Direct care RNs support the facility's mission to deliver exceptional PATIENT FIRST health care. The RNs are dedicated to excellence in patient care.

Each of the bulleted cases listed in this report was a specific and separate incident. Each incident took place in 2010. The exact dates have been redacted to ensure patient privacy; however, the exact dates are being provided in the confidential report submitted to the District of Columbia Department of Health. All incidents reported herein are believed to be not only accurate in their particulars but also representative of common or typical assignments. The incidents included in this report are just a sample of the total incidents reported on ADOs this year. All reporting is consistent with HIPAA guidelines.

Federal and local laws and standards must be applied and enforced to ensure safe patient care.

Chapter 36 (Civil Infractions) of Title 16 DCMR, Section 3606.1, of the District of Columbia Municipal Regulations states that it is a Class 1 infraction for a health care facility to fail "to maintain a sufficient number of staff with appropriate qualifications, skills and training twenty-four (24) hours a day)" ([j] 22 DCMR 2016.1).

The same regulations state that it is a Class 2 infraction for a health care facility to fail "to comply with requirements on the responsibilities of nursing staff" [(t) 22 DCMR 202].

Title 22, Chapter 20 of the D.C. Municipal Regulations states, "Supervisory and staff personnel shall be provided for each department of patient care unit to ensure the immediate availability of a professional nurse for bedside care of all patients at all times. Qualified personnel shall be provided in sufficient numbers to provide nursing care not requiring the services of a licensed registered nurse."

The same regulations further provide in Section 2021.8, "Each hospital shall provide a nursing staff that is adequate for the diagnostic facilities and services, therapeutic facilities and services, and rehabilitation facilities and services that the hospital undertakes to provide."

Title 22, Chapter 2007.1 states that the "Director [of Public Health] may receive any and all complaints alleging violations of the requirements contained in the applicable laws and regulations, and may conduct unannounced investigations to determine the validity of the complaints. "

Title 22, Chapter 2007.4 further states, "The Director shall communicate the findings of the complaint investigation directly to the facility and the complainant, if the complainant is identified to the Director, at the conclusion of the investigation."

Title 42-- Public Health Chapter IV--Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services Part 482: Conditions of Participation for Hospitals, Section 482.12 Condition of participation: Patients' Rights, states, "A hospital must protect and promote each patient's rights." Part 482.23 Conditions of Participation, Nursing, further states, "The nursing services must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed."

We believe the incidents contained in this report merit investigation by the Director of Public Health and that Washington Hospital Center and its managers, supervisors and administrators should be held responsible for adverse effects on patient care when they delegate unsafe assignments to their health care professional staff, or when they employ an insufficient number of staff.

Women and Infant Services

- **###/###/2010 5D/5F Postpartum Unit.** An RN reported verbally and in writing that the assignment as resource nurse for two units and liaison for Labor and Delivery (L&D) regarding admissions was unsafe and placed the patients at risk. A registered nurse in the resource role at this facility is in charge of other staff on the unit, patient care assignments, and must be available for assistance with immediate patient care needs (among other duties). There were six unit staff nurses, one outside staff nurse, two (PCTs), two unit clerks, and the resource supervising others. There were 54 patients. These units have recently merged; the resource nurse was assigned to both units and coordinating admissions with the labor and delivery area.

The three units are physically removed from one another and all three are locked units. Assigned staff on patient care has seven to eleven patients assigned to each RN. This includes mothers and babies. It is unsafe for an RN to be assigned more than eight patients (mothers and babies). It was not possible for the resource nurse to provide clinical supervision of nursing staff on behalf of the mothers and newborn infants and to coordinate the care and routine tasks necessary for the units.

The American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics "Guidelines for Perinatal Care" are the national standard. These guidelines are required for hospital licensure in several states. The maximum number of patients (mothers and babies) is eight. (See Appendix.)

- **###/###/2010 5BN Postpartum Unit.** There were only three RNs for 12 patients with the resource nurse assigned to four newborn infants. One of her assigned babies needed a blood transfusion. She had never been educated, trained or oriented to blood transfusion on a baby before that day. The Nursing Supervisor stated, "We have no staff." Initiation of the blood transfusion took a long time during which the other three newborn babies were screaming with hunger. A neonate receiving blood requires near constant assessments. According to ACOG, newborns requiring intermediate care should be staffed at 1:2 or 1:3 depending on acuity. (See Appendix.) As patient advocates the Washington Hospital Center RNs protest this inadequate staffing because it endangers the babies at the start of life.
- **###/###/2010 Labor and Delivery Unit.** There was no OB equipment technician, and the pneumatic tube system to the emergency stat lab was not working. Registered Nurses had to walk umbilical cord blood for testing platelets and other laboratory tests to the ER lab clean rooms and also go to the blood bank. During this time the RN was off the unit and not available to provide needed nursing care.
- **###/###/ 2010 5D and 5F Postpartum Unit.** The resource nurse was responsible for clinical supervision and coordination of multiple units with the potential for responsibility for 72 patients. The units are 5D, 5F, and labor and delivery (L&D). There were 38 patients for six RNs. On another day there were 32 patients for seven RNs. Since approximately March/April the facility has been transitioning to 5D and 5F being "one" unit. The original plan was to have a resource nurse for each unit; however, since "going live" there has been one resource nurse

responsible for two and now three units. This means that the one resource nurse is doing what three RNs previously did. The resource nurse has been instructed to call the supervisor with any problems via the Central Staffing Office (CSO), but not to call the supervisor directly.

- **##/##/ 2010 Labor and Delivery Unit.** There were five RNs including one from the float pool and one agency nurse. There were 15 laboring patients. Six patients were admitted in labor on that shift. The resource nurse was assigned to two to four patients at any one time during the shift. Three women had cesarean sections (C/S). Each cesarean section requires a minimum of two nurses, thus six RNs were required. One nurse is to function as the circulating nurse and one nurse competent in neonatal resuscitation. Two of the cesarean sections needed to be done STAT to save the life of the mother and/or baby. Two were babies less than 26 weeks gestation (14 weeks premature). A term baby needed to be resuscitated with CPR after a vaginal delivery before the neonatal intensive care team could arrive.
- **##/##/ 2010 5F Postpartum/Newborn Unit.** The unit was staffed with only three RNs. One RN was assigned to another unit. Twelve newborns were admitted to the nursery which left them with 12 extra patients and only two nurses. Two babies required phototherapy treatment for jaundice caused by increased bilirubin. These babies are classified as “continuing care” requiring staffing at four or fewer patients per nurse. There was only one working vital sign machine for the whole floor. The resource nurse was assigned to two high risk antepartum patients along with three mothers plus three babies. The unit received four admissions. Staffing was notified at 8:00 pm that more nurses were needed. The supervisor was asked for help at 11:30 pm.
- **##/##/2010, 5D Postpartum Unit.** The unit was staffed with four RNs for 37 patients. The resource nurse had 16 patients, eight mothers and eight newborn infants. This is twice the minimum safe staff assignment. One RN was assigned to ten patients - two of whom required circumcisions. There were 37 patients (19 mothers and 18 babies). (See ACOG in Appendix.)

Critical Care Services

- **##/##/2010 2H Critical Care Unit.** Night shift RNs reported that the 2H Critical Care Unit was unsafe and placed their patients at risk due to inadequate staffing and high patient acuity. The unit was staffed with seven RNs for 14 patients. This included one nurse reassigned into the unit. One PCT and a clerk assisted the RNs. One patient experienced a hypotensive crisis and required rapid stabilization of blood pressure. Because the patient's condition was so acute the RN could not leave the bedside. The resource nurse spoke to the Nursing Supervisor. The supervisor stated, "The patient is not a 1:1."

The supervisor did not perform an assessment of the patient before contradicting the professional judgment of the resource nurse and of the RN who was observing the patient, performing a comprehensive assessment, instantly developing a comprehensive nursing plan that establishing nursing diagnoses, performing life saving interventions, evaluating the effectiveness of the interventions, changing the plan of care according to the patient's response to interventions, and recording the above on the patient's chart.

As patient advocates professional registered nurses are required to promote a safe and therapeutic environment. The RN assigned to one 1:1 patient and another patient were acting as patient advocates as required by moral, ethical, and legal obligations. (*See ACCN Criteria for 1:1 Staffing Guidelines.*)

- **##/##/ 2010 4G Critical Care Unit.** The resource nurse was forced to accept the assignment of two critically ill patients. One patient suffered hemodynamic compromise necessitating frequent assessments, pharmacological interventions, including norepinephrine (Levophed), and required 1:1 nursing care. Direct patient care duties precluded resource nurse functions of clinical supervision and coordination of the unit. This RN reported that this assignment posed a risk to the health and safety of the patients. As a result the facility is responsible for any adverse effect on patient care, for incomplete documentation, or for poor patient satisfaction. The RN did, under protest, attempt to carry out the assignment as best possible under the circumstance.
- **##/##/2010 3H Critical Care Unit.** There were six RNs including the resource nurse for ten critically ill patients. The resource nurse was assigned to a critically ill patient with severe respiratory disease and high potential for pulmonary complications. The patient had already pulled out needed tubing, and was at high risk for a fall. In addition the resource RN was the rapid response nurse responsible for responding to a healthcare emergency on any unit to assist in saving a life and performed tasks usually done by a unit clerk. Then the situation became extremely unsafe when the resource nurse had to admit a sick bleeding patient requiring blood products and titrated vasoactive medications. These medications must be titrated according to hemodynamic parameters by micrograms per kilogram per minute. The rate often must be recalculated every five to fifteen minutes. This patient clearly met all national criteria for 1:1 care. The resource nurse was told that no one else could care for the other patient. This resource nurse was forced to attempt an assignment that could have caused her to be needed to save lives in three locations at one time. Clearly this was not possible. Patients could easily die due to the hospitals failure to plan for adequate safe patient care.

- **##/##/2010 3H Critical Care Unit.** Staffing was insufficient to provide safe effective care for all patients. There were six RNs including the resource nurse for ten critically ill patients. The resource RN was the rapid response nurse responsible for responding to a healthcare emergency on any unit to assist in saving a life and perform tasks usually done by a unit clerk. The patient suffered hemodynamic instability requiring pressers, egad, and multiple blood products. Such patients require near constant assessments and interventions to maintain life. An RN assigned to an unstable patient also had an agitated patient trying to get out of bed, pulling out the IV and other tubing, and was at very high risk for a fall or self harm. Eventually a Sitter was sent, but the patient did not receive safe and effective nursing care because the assigned RN was too busy keeping the hemodynamically unstable patient alive. The resource nurse had to respond to rapid response calls. While she was off the unit functioning as a rapid response nurse , other RNs had to keep leaving their patients to take calls from family and visitors who wanted to see their loved ones. A patient’s call light rang for a lengthy period of time. Nursing supervisors were made aware they were short a nurse. A patient was brought from the cardiac catheterization lab but no nurse was there available to receive the patient.
- **##/##/ 2010 4G Critical Care Unit.** The shift began with no ability to safely care for a patient whose condition worsened or to admit a new patient. Each nurse, including the resource nurse, was assigned to two patients. No critical care unit can safely assign a nurse to more than two critical care patients. Then they worked together to admit a patient from 4F who had stopped breathing and suffered a cardiac arrest. The patient eventually had to go back to the OR. If the RNs on 4F had been assigned to four patients instead of six or seven, the subtle signs and symptoms of the impending crisis could have been noticed. This constitutes a sentinel event, failure to rescue.

A Sentinel Event is defined by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as, “Any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient’s illness.”

- **##/##/2010 2E Intermediate Critical Care Unit.** The unit was unsafe. One RN was assigned as resource nurse, to respond to any “Code One”, and assigned responsibility for one critically ill patient. Direct patient care duties precluded coordination of the unit and clinical supervision which is expected of the resource nurse. When a patient comes to the hospital with symptoms of a stroke, a “Code One” is activated. "Code One" nurse responders are a group of highly-skilled and specially trained Registered Nurses that respond to these medical emergencies. They accompany the patient to brain imaging studies and are trained to administer clot-busting medications. It is impossible for the nurse to respond to a "Code One" while providing care for a critically ill patient on another unit. Clearly no nurse should be expected to be in more than one place at a time. There was no patient care technician and no clerk so RNs had to do everything. RNs had to choose whether to ignore a ringing telephone or leave a patient being cared for. This unsafe staffing is not acceptable.
- **##/##/2010 Emergency Department.** A Registered Nurse reported that the safety of the triage nurse at the front desk with his or her back to the patients is potentially unsafe. The protective services security person(s) are sitting by the front door. This location is not accessible if a patient

attacks the nurse. Violence against emergency staff is a growing problem. The RNs believe think it is possible for a nurse to be the first person people see when entering the ER without compromising their safety.

Cardiac Services (Step Down, Telemetry, Progressive Care Units)

- **##/##/2010 4F Vascular Surgery Unit.** RN reported to the supervisor that there was inadequate staffing based on patient acuity and the assignment posed potential harm to the health and safety of patients. There were 31 patients on the unit (seven were post heart procedure, three post surgery, five are confused, and multiple patients had continuous medication administrations). The Travel Nurse assigned to that unit was cancelled by her/his staffing agency but it was not reported to the staffing office. RN was unable to be replaced. The Charge Nurse had three patients. An RN was reassigned to this unit. Three of the RNs are new nurses (two have four months of experience, and one nurse has just finished her 90 day probationary period). Because the Charge Nurse was responsible for three patients' direct care, this did not allow time to adequately perform clinical supervision and coordination of care.

The goal of the experienced nurse is to foster, mentor, and support new RNs. It is nearly impossible to support new RNs with inadequate patient staffing.

- **##/##/2010 4 North West Unit.** The cardiac unit had insufficient staff for the high acuity and the needs of six newly admitted patients.
- **##/##/ 2010 4D Heart Failure Unit.** The nurses reported that in their professional judgment staffing was insufficient and placed their patients at risk. As a result Washington Hospital Center is responsible for any adverse effects on patient care. The nurses did, under protest, attempt to carry out their assignments to the best of their ability.

Acuity was very high. All the patients require continuous cardiac monitoring. This unit would be classified as a "Progressive Care Unit" or "Step Down" unit. According to the American Association of Critical Care Nurses, "With an increased demand for and decreased availability of critical care beds, patients were often transferred from critical care units while still requiring an increased level of nursing care and vigilance. Patients who were admitted to critical care units five years ago are now routinely admitted to progressive care."

Four patients required a left ventricular assist device (LVAD) to maintain life. The LVAD is placed in the patient's upper left abdomen and fed by an inflow cannula (a tube) originating in the left ventricle of the heart. The LVAD is a device that pumps blood and provides forward flow through a graft joined into the patient's ascending aorta, the largest blood vessel in the body. Hospitalized patients requiring treatment with the LVAD are very sick. Their care requires a high level of scientific knowledge and technical skill. For example, the RN must perform comprehensive assessments and always be prepared to switch the controller if the pump fails.

Five patients required isolation. Patients with infections requiring isolation require the nurse to take time to wash hands more often, don gloves, mask, and face shield, gown, shoe covers, and/or shoe covers before entering the room. Removing these and washing before leaving the room takes additional time. When patients are placed on isolation, they require more of the nurses' time. In addition LVAD patients have a tube in the heart and cannot be assigned to a nurse or other caregiver who also provides care to a patient in isolation. This presents a high risk of infection.

With four patients requiring LVAD life support and only five RNs, it was not possible for the resource nurse to make safe assignments due to the high acuity of cardiac patients requiring isolation and the even higher acuity of patients with an LVAD. The Nursing Supervisor said, "We have enough nurses. We are short all over." This is an example of supervisors and other members of management failing to recognize that they need to pay attention to registered nurses' concerns. How can it be that they are short-staffed "all over" if they claim to employ enough nurses?

- **##/##/ 2010 4 North East Cardiac Unit.** RNs reported that four RNs were required to care for 28 patients, many of whom with high acuity, which was unsafe. The resource nurse was assigned to five patients. The other RNs were responsible for seven or eight patients each. The maximum number of patients that should be assigned to one RN to prevent death due to failure to rescue is four.
- **##/##/ 2010 4 North West Cardiac Unit.** The unit reported unsafe staffing with high patient acuity. There were five staff which included two agency nurses. There were 29 patients. All patients required continuous cardiac monitoring.
- **##/##/2010 4 North West Cardiac Unit.** The four RNs working day shift reported that in their professional judgment staffing was unsafe. There were four RNs for 20 patients. Acuity was high.
- **##/##/ 2010 4F Medical-Surgical/Cardiac Unit.** An agency nurse left at 11:00 pm. She had not administered medications that were ordered for 10:00 pm. She stated she was tired and didn't have time to give the patients their 10:00 pm medications. There were 26 patients and only three RNs.

The staffing office was called. The nursing supervisor spoke with the agency nurse but was unable to provide a nurse to care for her patients so unit staff had to pick up her patients and complete her assignment. The resource nurse was assigned four patients. Three patients were confused and at risk for a fall and one with a sitter. A patient required an Amiodarone drip for a cardiac arrhythmia and a Heparin drip. Two patients needed to be placed on special beds to prevent pneumonia and pressure sores. Four patients needed blood transfusions and frequent ongoing assessments. Because the Pyxis broke for 2 1/2 hours the RNs had to re-order all other medications.

The Pyxis is a convenient unit-based, locked medication cabinet which only the RNs have access to. When this is broken, all medications that were previously ordered for patients on the unit must be retrieved from the pharmacy again. Registered Nurses, being understaffed, are very unlikely to have the precious time needed to re-do this task. Patient health and safety is compromised, whether the RN decides to leave patients unattended and retrieve medications or delay administration of these medications and stay with the patients.

- **##/##/ 2010 4D Heart Failure Unit.** The night shift had 19 patients for four RNs. The only tech was assigned to sit with a patient to prevent a fall or injury and was not replaced. The resource nurse was assigned to five patients. An RN was given an LVAD patient, another patient being treated for acute congestive heart failure (CHF), another patient requiring treatment with multiple intravenous (IV) medications, and a confused patient with a sitter. The Nursing Supervisor was informed, "I was told to take an LVAD with a patient on CHF Solutions along with

2 other pts.” She stated that the Nursing Director is aware of it. There was no patient care tech to assist the RNs in pulling patients up in bed, answer patient’s call lights, answer the telephone, help lift patients, or help with tasks that require two nursing personnel.

- **##/##/2010 4F Cardiac Unit.** The day shift RNs reported that in their professional judgment their assignments were unsafe and placed the patients at risk. As a result the facility is responsible for any adverse effects on patient care. These patients require continuous cardiac monitoring, ongoing cardiac and complete assessment, and treatment for any cardiac arrhythmia. The six RNs attempted, under protest, to carry out their assignments to the best of their ability. The resource nurse was assigned four patients. The other five RNs were assigned to six patients each. There was no PCT to assist the nurses. One nurse’s assignment included two patients requiring preoperative care, teaching and completion of all requirements for a patient going to surgery; one patient with peritoneal dialysis needing a blood transfusion; and three patients with no ability for self care. These three patients so had to be regularly repositioned in bed, bathed, given oral hygiene, and fed their meals.
- **##/##/ 2010 4 North West Cardiac Unit.** The unit was unsafe for the severity of illness of many patients. There were 28 patients. Eight nurses were provided. Two patients were admitted on the shift. Two patients required titrated insulin drips. This means that the serum glucose i.e. “blood sugar” level must be tested at least every hour and insulin drip adjusted according to protocol or the physician’s order for that patient. Three patients were identified as at risk for a fall. They required additional surveillance. When notified, the supervisor stated, "Let your unit director know."
- **##/##/2010 Cardiac Catheterization Lab.** Staffing was unsafe with the resource nurse unavailable as a resource because direct patient care duties precluded this. Four RNs had to care for patients who should have been admitted to the 3H critical care unit. Two patients required mechanical ventilation to breathe. They needed the intra aortic balloon pump (IABP). No patient requiring intra-aortic balloon pumping should be left alone EVER. The IABP is a large diameter catheter placed into a large artery and threaded into the aorta. If any part becomes disconnected, a stopcock is turned wrong, the patient moves slightly, or sits up this can cause rapid bleeding. The patient could die in a few minutes. The RN caring for the IABP patient ensures the computerized automatic timing of the pump is responding accurately in response to arterial pressure, cardiac rhythm, and hemodynamic measurements. These RNs also needed to care for the short stay post catheterization patients after working in the Cardiac Cath Lab all day.
- **##/##/2010 4F Medical-Surgical Unit.** Day shift on the unit didn’t meet the hospital's guidelines. Severity of illness was high. A patient required a blood transfusion, another needed neurological assessments at least every two hours, and several needed to be turned and repositioned a minimum of every two hours. Patients could not feed themselves so had to be fed by nursing staff; patients were incontinent requiring frequent interventions to keep them clean, provide comfort, and prevent skin breakdown. Sick patients were confused and/or disoriented and needed more frequent observation and interventions.

Medical-Surgical Services

- **##/##/ 2010 2 North East Unit.** The night shift had five registered nurses working and reported that staffing was very unsafe. They received a patient from the ER who required mechanical ventilation. A patient had to be transferred to the ICU. The PCT was pulled to another unit.
- **##/##/2010 3 North East Unit.** Night shift registered nurses reported to the supervisor that as patient advocates, in accordance with Section 504 of the D.C Official Code, their assignments were unsafe and placed the patients at risk. As a result, the facility is responsible for any adverse effects on patient care. Most patients were severely ill, had secondary diagnoses, and were unable to care for themselves. As a result of insufficient staff, registered nurses were required to perform professional services under conditions that did not support quality health care.

Some RNs on 3 North East were assigned to five patients that night. The census was 28 medical and surgical patients. Staff provided was six registered nurses. One technician was assigned to be with one patient for safety. There were no PCTs on the floor to provide the care that the unlicensed PCTs generally provide under the supervision of a registered nurse such as passing ice and water, bathing patients, and assisting the RNs with lifting and turning patients. The RNs were required to attempt to do all the care for the patients without any assistance. Because the resource nurse was responsible for two patients' direct patient care duties, it did not allow time to adequately perform clinical supervision, coordination of care, and other duties of the resource nurse.

In 2002 the Journal of the American Medical Association (JAMA) reported a University of Pennsylvania study that showed that four or fewer patients per RN increased the survival of surgical patients. For each additional patient assigned to an RN, the likelihood of death within 30 days increased by seven percent. Four additional patients increased the risk of death by 31 percent.

- **##/##/ 2010 3 North East Medical-Surgical Oncology Unit.** RNs reported to the Nursing Supervisor that staffing was insufficient to meet the individual needs of their patients. Only one PCT was working on the floor. The other PCT was pulled to sit. Six RNs, one technician, and one clerk were the only staff. The resource nurse was responsible for three patients so could not perform all resource duties.

The RN is responsible for the observation, comprehensive assessment, evaluation and recording of physiological and behavioral signs and symptoms, development of a comprehensive nursing plan that establishes nursing diagnoses, sets goals to meet identified health care needs, and prescribes and implements nursing interventions of a therapeutic, preventive, and restorative nature in response to the assessment, implementing the care plan by interventions such as performance of counseling, advocating, and education for the safety, comfort, personal hygiene, protection of patients, and administration of medications and treatment as prescribed.

The critical thinking skills needed to assess, identify, evaluate, and meet the needs of the patients are RN duties that cannot be performed in the exceptional manner the RNs aspire to in order to fulfill the Washington Hospital Center mission when staffing is insufficient or unsafe. The Nursing Supervisor was notified at 11:45 pm. Another Nursing Supervisor called at 12:30 am to confirm the number of RNs. The night shift nursing supervisors must have the authority to provide additional nursing staff to meet the needs of each patient.

- **###/###/ 2010 3 North East Medical-Surgical Unit.** The unit reported that in their professional judgment their assignments were unsafe and placed the patients at risk. Only one PCT was assisting for the entire floor. The other PCT was pulled to sit. Staffing was six RNs, one technician, and one clerk. The resource nurse was assigned to three patients. Having only one PCT on the unit deprived patients of care as the RNs attempted to perform nursing tasks that are usually done by a PCT. The Nursing Supervisor was notified at 11:45 pm. Another Nursing Supervisor called at 30 minutes after midnight to confirm the number of RNs.
- **###/###/ 2010 3 North East Medical-Surgical Unit.** Registered nurses working night shift reported that in their professional judgment staffing was unsafe and placed the patients at risk. As a result the facility is responsible for any adverse effects on patient care. The census was 23 medical and surgical patients. Only four RNs were provided. There were two new admissions. The pneumatic tube system was inoperable on this floor all night. At 7:00 pm there were only four RNs with 23 patients. The resource nurse was responsible for five patients. At 8:30 pm the unit was provided another RN. The nurses worked as a team. A CSO employee stated, "All supervisors are working on the staffing issue." He stated that supervisors are aware of the staffing crisis and actually working on it. An RN spoke with the administrator on-call to notify her of the staffing crisis at 9:30 pm.
- **###/###/2010 3 North East Medical-Surgical Unit.** The day shift nurses had reported that in their professional judgment five patients per RN with the resource nurse assigned to four patients was unsafe and placed the patients at risk. Then on that evening, all RNs were assigned to five patients, except the resource nurse who had three high acuity patients.
- **###/###/2010 3 North East unit Medical-Surgical Unit.** From 7:00 pm until 11:00 pm four RNs were provided to care for 19 patients. From 11:00 pm until 7:00 am there were five RNs. They admitted two patients. Acuties were high. The resource nurse was assigned to four patients at 7:00 pm and to three at 11:00 pm. The nursing supervisor said, "I will come to see the schedule."
- **###/###/2010 3 North East Medical-Surgical Oncology Unit.** Five RNs reported that patient care remains unsafe. There were five RNs, two technicians, and one clerk for 25 patients. The resource nurse was assigned four patients. Working under pressure all the time reduces an RN's effectiveness. An RN had six patients at 11 pm; all the other RNs had five patients; resource had four patients when an RN left at 11 pm and was not replaced.
- **###/###/2010 3 North East Medical-Surgical Unit.** Nurses reported that according to her professional judgment her assignment was unsafe and placed her patients at risk. She started out with five patients (three were complete care with multiple antibiotics and frequent pain assessments and interventions) then received a newly admitted patient as a sixth patient. A new

patient should receive undivided attention from the RN until the admission assessment, check off orders, test results, and initial care planning is complete. It was impossible to provide adequate care for all six assigned patients.

- **##/##/ 2010 3C Medical-Surgical Unit.** All five staff members reported that the night shift was unsafe.
- **##/##/ 2010 2 North East Unit.** The day shift RNs reported inadequate staffing for the high patient acuity. There were six RNs and three technicians for 29 patients. One RN had six patients of very high acuity including a tracheostomy patients and did not feel it was possible to safely take care of all of them.
- **##/##/2010 3E Burn/Trauma Unit.** A nurse reported that they couldn't provide safe effective care to their 21 patients and six new admissions in 12 hours. They were assisted by two technicians. One RN was assigned to six patients-- one was pre-op, one post-op, two admissions, and two other sick patients requiring nursing care. The resource nurse was assigned five patients. The nursing supervisor was notified of the unsafe situation. She said, "Ok, I am sorry."
- **##/##/2010 2F Stroke Unit.** RN reported staffing was unsafe. There were five RNs for 23 patients. A patient required mechanical ventilation. Title 22 Chapter 20 of the D.C. Municipal Regulations states, "Supervisory and staff personnel shall be provided for each department of patient care unit to ensure the immediate availability of a professional nurse for bedside care of all patients at all times." It is imperative for Washington Hospital Center to ensure that supervisory nursing personnel have the control to ensure the immediate availability of a professional nurse for the bedside care of ALL patients at all times.
- **##/##/2010 3 North East Medical-Surgical/Oncology Unit.** Staffing was unsafe on the day shift. Only five RNs, one being agency, were provided for 27 patients. Patients needed tube feedings. Five of the patients were administered chemotherapy on that shift. These patients need very frequent ongoing observations and assessments, changes in the care plan in response to their response to the chemo, evaluation of their response to the intervention, and a great deal of education, comfort care, including pain control, and emotional support. The nursing supervisor stated, "Staffing on 3 North East is better than most other comparable units."
- **##/##/2010 3 North East Medical-Surgical Oncology Unit.** The six RNs reported that they needed seven RNs for the safety of their 27 high acuity patients. Fifteen patients had little to no ability for self care such as moving in bed, feeding themselves, or participating in hygiene. The RNs were assisted by three technicians and a clerk.
- **##/##/2010 2 East Medical-Surgical Unit.** Only two registered nurses were scheduled. There were nine patients. No technician was working because the person scheduled was pulled to sit with a patient. One of the RNs was floated from 4C. They admitted four new patients. Having only two nursing staff on the unit is unsafe regardless of the number of patients. One medical emergency requiring both nurses would have left all the others with no care. This gambling with the health, safety, and lives of the patients continued from 7:00 am until it was resolved at 1:30 pm.

- **##/##/2010 3 East Unit.** Staffing was unsafe. There were only three RNs to care for 20 patients. The resource nurse was assigned to five patients.
- **##/##/2010 3 North East Unit.** Staffing was unsafe. Each RN, including the resource nurse, was assigned to five patients. Six patients were admitted that night. One RN wrote, “My assignment posed potential of harm to health and safety of my patients, myself or other staff. New patients were admitted to the unit without adequate staff.”
- **##/##/2010 3 North East Unit.** There were only three RNs provided to care for 25 high acuity cancer patients. One of the RNs was from the float pool. The resource nurse was assigned to five patients. Because there was no unit clerk, nursing staff needed to answer the phones and enter physician’s orders. Four patients received chemotherapy on the shift. Chemotherapy was initiated for two patients. A patient suffered a healthcare emergency requiring rapid response. Other patients required more frequent assessment, care planning, interventions, and evaluation of response to high potency medications such as high dose patient controlled narcotic analgesia, Argatroban, and administration of blood products. It was unsafe and not fair for the patients to have to share their nurse with five other patients.
- **##/##/2010 3 North East Unit.** Five nurses were provided for 27 patients. All RNs were assigned to five or six patients each, including the resource nurse. The clerk was assigned to three units so nurses had to answer the telephone. One patient’s severity of illness was extreme. The patient’s condition was unstable all night.
- **##/##/2010 3C Medical Surgical Unit.** The unit was staffed unsafely with five nurses for 32 patients. The resource RN was assigned to six patients. Two RNs were assigned to seven patients. Many of these were surgical patients. It has been shown that the maximum number of surgical patients per RN is four. Each additional patient increases the odds of dying by 7%.
- **##/##/ 2010 2D Medical-Surgical Unit.** The unit was not provided sufficient staff to provide safe effective care. There were six nurses for 34 patients. There was no clerk. Each RN was assigned to six patients.

Perioperative Services

- **##/##/2010 Operating Room.** RN reported that the assignment was unsafe due to lack of current competence. The RN told nursing management, “I have not scrubbed for this surgical procedure for more than two years.” The response was, “You need to find somebody to switch assignment.” It is the responsibility of nursing management to ensure sufficient competent nursing staff. The District of Columbia Municipal Regulations for Registered nurses states: “A registered nurse shall not accept or perform professional responsibilities which the nurse is not competent to perform.”
- **##/##/2010 Perioperative Unit.** A registered nurse was suddenly forced to begin call at 3:30 pm when scheduled to start on-call at 6:30 pm. Unscheduled overtime leads to fatigue, accidents, and errors.

APPENDIX

District of Columbia Department of Health Licensure and Certification

The District of Columbia Department of Health licenses and certifies health care facilities for compliance with state and federal health and safety standards. Facilities include nursing homes, hospitals, home health agencies, dialysis centers, ambulatory surgical centers, intermediate care facilities for the mentally retarded, and laboratories. The Health Care Facilities Division conducts regular on-site surveys to ensure health, safety, sanitation, fire, and quality of care requirements. HCFD identifies deficiencies that may affect state licensure or eligibility for federal reimbursements under the Medicare and Medicaid programs.

For more information contact the Health Regulation Administration at (202) 724-8800.

Chapter 36 (Civil Infractions) of Title 16 DCMR is amended by adding a new section 3606 and repealing the current section 3606 to read as follows:

3606 LICENSING OF HOSPITALS

3606.1 Violation of any of the following provisions shall be a Class 1 infraction:

- (a) 22 DCMR 2002 (operating a hospital without a license);
- (b) 22 DCMR 2002.17 (failure to meet the minimum requirements for insurance);
- (c) 22 DCMR 2002.18 (failure to comply with Certificate of Need requirements);
- (d) 22 DCMR 2003 (failure to comply with certificate requirements, including Certificate of Occupancy and fire approval);
- (e) 22 DCMR 2006.1 (failure to obtain a permit before moving the hospital or part of the hospital from the licensed premises);
- (f) 22 DCMR 2007.2 (failure to permit the Director entry to investigate complaints);
- (g) 22 DCMR 2014.1 (failure to have a governing body that is authorized and responsible for the direction and policy of the hospital);

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- (h) 22 DCMR 2015.1 (failure to have an administrator who is responsible for planning, organizing and directing the day to day operation of the hospital);
- (i) 22 DCMR 2015.2 (failure of the administrator to be present in the hospital forty (40) hours per week during regular business hours and failure of the administrator to be responsible for the day to day operation twenty-four (24) hours a day seven (7) days of a week);
- (j) 22 DCMR 2016.1 (failure to maintain a sufficient number of staff with appropriate qualifications, skills and training twenty-four (24) hours a day);
- (k) 22 DCMR 2017 (failure to comply with requirements on health examinations for those involved in direct patient care, except that sections 2017.5 and 2017.8 are class 2 offenses);
- (l) 22 DCMR 2020 (failure to comply with requirements on availability of physicians);
- (m) 22 DCMR 2024 (failure to comply with requirements on patient care and treatment);
- (n) 22 DCMR 2027 (failure to comply with requirements on restraint and seclusion of patients);

(o) Section 6(c) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-505(c)) (failure to allow authorized government officials to enter premises to conduct an inspection); and

(p) Section 6(d)(1) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-505(d)(1)) (failure to notify the Mayor of the loss of accreditation or federal certification within five (5) calendar days of the loss).

3606.2 Violation of any of the following provisions shall be a Class 2 infraction:

(a) 22 DCMR 2000.2 (failure to comply with requirements of Medicare, the Joint Commission, medical, nursing and public health standards);

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(b) 22 DCMR 2000.3 (failure to deliver services in compliance with the laws of the District when the contract entity delivering the services is not licensed in the District);

(c) 22 DCMR 2002.2 (failure to submit license application timely, to submit the appropriate license fee, to state the offered services in the application or the number of beds provided or other information required);

(d) 22 DCMR 2002.4 (failure to list certificate approvals on license application);

(e) 22 DCMR 2002.5 (failure to submit license renewal application no later than sixty (60) days prior to expiration date and to submit license renewal fee);

(f) 22 DCMR 2002.6 (failure to pay a late application fee);

(g) 22 DCMR 2002.8 (failure to inform the Director of a change in operation within thirty (30) days after the change);

(h) 22 DCMR 2002.9 (failure to return a license to the Director when a license is suspended, revoked, not renewed, forfeited or when the operation voluntarily ceases operation);

(i) 22 DCMR 2002.10 (transfer of a license to a person or premises not named in the license application);

(j) 22 DCMR 2007.3 (failure to submit a plan of correction no later than ten (10) days after receipt of a complaint investigation report);

(k) 22 DCMR 2007.7 (failure to correct deficiencies within thirty (30) days of receipt of the complaint investigation report);

(l) 22 DCMR 2014.2 (failure of the governing body to fulfill its responsibilities);

(m) 22 DCMR 2015.3 (failure of the administrator to fulfill his or her responsibilities);

(n) 22 DCMR 2016.2 (failure to ensure and maintain evidence of staff and contract staff licensure, registration, certification or other credentials and to have procedures to verify current status);

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(o) 22 DCMR 2016.3 (failure to report the termination of a licensed professional to the applicable professional board when the termination is due to a job-related incident);

(p) 22 DCMR 2017.5 (failure to maintain on file a report of each health examination of employees);

(q) 22 DCMR 2017.8 (failure to maintain and make available for examination by the Department a copy of certification that a direct

patient care employee who has been ill can return to work);
(r) 22 DCMR 2018 (failure to comply with requirements on staff training);
(s) 22DCMR 2019 (failure to comply with requirements on the responsibilities of medical staff);
(t) 22 DCMR 2021 (failure to comply with requirements on the responsibilities of nursing staff);
(u) 22 DCMR 2022 (failure to comply with requirements on patient rights);
(v) 22 DCMR 2023 (failure to establish and implement a written process that promptly addresses grievances by patients and their representatives);
(w) 22 DCMR 2025 (failure to comply with requirements on errors in provision and administration of medications);
(x) 22 DCMR 2026 (failure to comply with requirements on separate patient care);
(y) 22 DCMR 2028 (failure to comply with requirements on patient nutrition);
(z) 22 DCMR 2029 (failure to comply with requirements on discharge planning);
(aa) 22 DCMR 2030 (failure to comply with requirements on recordkeeping);
(bb) 22 DCMR 2031 (failure to comply with requirements on physical plant standards);
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(cc) 22 DCMR 2032 (failure to comply with requirements on Medicare/Medicaid participation);
(dd) 22 DCMR 2033 (failure to comply with provisions on prohibitions against sharing care and treatment areas);
(ee) 22 DCMR 2034 (failure to comply with provisions on construction standards);
(ff) 22 DCMR 2035 (failure to comply with requirements on maintaining a safe environment);
(gg) 22 DCMR 2036 (failure to comply with requirements on maintaining building systems for the safety, comfort and wellbeing of patients);
(hh) 22 DCMR 2037 (failure to comply with requirements on housekeeping and maintenance); and
(ii) Section 8 of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-507) (failure to comply with requirements on clinical privileges).
3606.3 Violation of any of the following provisions shall be a Class 3 infraction:
(a) 22 DCMR 2002.3 (failure to provide enumerated information on license application);
(b) 22 DCMR 2002.19 (failure to post the license in a conspicuous

place at all times); and
(c) 22 DCMR 2008.2 (failure to submit requisite information to the
Director when requesting a variance).

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Title 22 District of Columbia Municipal Regulations

- 2007 COMPLAINT INVESTIGATIONS

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- 2007.1 The Director may receive any and all complaints alleging violations of the requirements contained in the applicable laws and regulations, and may conduct unannounced investigations to determine the validity of the complaints.

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- 2007.2 The facility shall permit the Director entry to investigate complaints. The Director shall conduct complaint investigations during time periods and staff shifts consistent with the allegations in the complaint when considered appropriate.

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- 2007.3 The Director may require the facility to respond to the written report of findings with a written plan of correction no later than ten (10) days after the receipt of the report

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- 2007.4 The Director shall communicate the findings of the complaint investigation directly to the facility and the complainant, if the complainant is identified to the Director, at the conclusion of the investigation.

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- 2007.5 The Director shall investigate complaint allegations of a life threatening nature or those that represent immediate danger within two (2) business days of receipt of the complaint by the Department. All other complaints shall be investigated by the Director no later than thirty (30) days from receipt of the complaint or as considered appropriate.

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- 2007.6 The Director shall immediately suspend or revoke a license or issue a provisional or restricted license in accordance with the applicable statutes and the rules of this chapter if a facility is found to have life threatening deficiencies or deficiencies which seriously endanger the public's health and safety.

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- 2007.7 The Director shall require a facility which is found in violation of the applicable statutes and the rules of this chapter, but whose deficiencies are not life threatening or seriously endangering to the public's health, safety and welfare, to correct the deficiencies within thirty (30) days from receipt of the complaint investigation report.

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- 2007.8 The Director shall issue a provisional or a restricted license, as appropriate, to a facility that has not corrected deficiencies within thirty (30) days.

2007.9 If appropriate, the Director shall issue a restricted license to a facility which is found to have life threatening deficiencies or deficiencies which seriously endanger the public's health and safety. If not appropriate, the Director shall suspend or revoke the facility's license consistent with the applicable statutes and this chapter.

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DC Hospital Regulations

Title 22

District of Columbia Municipal Regulations

August 15, 2008

DISTRICT OF COLUMBIA MUNICIPAL REGULATIONS for HOSPITALS

CHAPTER 20

HOSPITALS

2000 General Provisions 2001 Standards of Compliance 2002 License Requirements 2003
Certificates Required 2004 Initial Licensure 2005 License Renewal 2006 Removal
Permits 2007 Complaint Investigations 2008 Variances 2009 Civil Penalties 2010 Denial,
Suspension, and Revocation Of A Health
Care Facility License 2011 Summary Suspension and Licensure Conversion,
Hearings 2012 Service of Notice
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Medications 2026 Separate Patient Care
2027 Restraint or Seclusion of Patients 2028 Patient Nutrition 2029 Discharge Planning 2030
Record Keeping Requirements. 2031 Physical Plant Standards
2032 Medical Services 2033 Care and Treatment Areas 2034 Construction Standards 2035
Environment 2036 Building Systems 2037 Housekeeping and Maintenance 2099 Definitions

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CHAPTER 20 HOSPITALS GENERAL PROVISIONS

This chapter shall provide minimum standards for the establishment and maintenance of hospitals in order to protect the public interest by promoting the health, welfare, and safety of individuals in hospitals.

In the absence of requirements in this chapter or in other applicable regulations, the management and operation of each hospital shall be in accordance with applicable Medicare Certificate of Participation requirements, and in the absence of other standards, in accordance with the Joint Commission standards, if applicable, and good medical, nursing and public health practices.

If a hospital delivers services through a contract with a business that is licensed only by another jurisdiction, the hospital shall be responsible for the delivery of services in compliance with the laws of the District of Columbia.

The Director of the Department of Health shall make the final determination as to whether any building, or part of a building, or any group of buildings constitutes a hospital.

STANDARDS OF COMPLIANCE

The provisions of this chapter set forth the minimal requirements for the establishment, maintenance, and operation of hospitals.

Wherever in this chapter or in other applicable standards the performance requirements are not specified, the Director may formulate and publish standards which, if followed, shall constitute substantial compliance with the requirements of this chapter.

The standards formulated and published by the Director pursuant to § 2001.2 shall be made available to the public, and shall be maintained on file in the Director's office for inspection during regular business hours.

LICENSE REQUIREMENTS

Except as otherwise expressly provided for in this chapter, no person shall operate or hold himself or herself out as operating a hospital in the District of Columbia, whether public or private, for profit or not for profit, without being licensed as required by § 3 of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983,

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effective February 24, 1984, D.C. Law 5-48, D.C. Official Code § 44- 501 et seq. (2005 Repl.) (hereinafter, the Act).

A facility shall submit an application for initial licensure to the Director no later than ninety (90) days prior to the stated date of operation. The license fee shall accompany the application. The application for a hospital license shall state each service for which the applicant undertakes to furnish hospital care and the number of beds allocated to each service; and shall furnish other information as may be required.

In addition to the requirements of § 2002.2, an applicant for licensure shall also provide the following:

- (a) Hospital location;
- (b) Previous owner, license number, Medicare and Medicaid numbers;
- (c) Type of hospital (special or general);
- (d) Type of current certification(s);
- (e) Accreditation status;
- (f) Bed capacity;
- (g) Offsite location(s);
- (h) Services to be provided;
- (i) Staffing;
- (j) Description of facility;
- (k) Proposed use of idle space;
- (l) Hospital Administrator/Chief Executive Officer;
- (m) Person in charge in absence of administrator;
- (n) Nurse administrator;
- (o) Name of Medical Director and Director of Nursing;
- (p) Applicant (owner);
- (q) Type of organization;

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- (r) Interested parties;
- (s) Other providers owned by the applicant;
- (t) Subsidiary/parent information;
- (u) Chain organization (organization structure);
- (v) Background information (affiliations, adverse actions, etc);
- (w) Owner of building/land;
- (x) Type of organization;
- (y) Name of the lease holder if the hospital has a lease agreement for hospital space;
- (z) Name of management company; (aa) Contact person; and (bb) Designee for acceptance of service.

A facility making application for initial licensure shall have obtained a Certificate of Occupancy and a Certificate of Need and shall list approvals on the application.

A facility shall submit an application for license renewal to the Director no later than sixty (60) days before the expiration date of the current license. The facility shall submit the license fee with the application.

The Director may impose a late application filing fee, in addition to the license fee, for a facility that fails to submit a license renewal application within the time prescribed.

The Director may conduct background checks on the applicant or licensee to determine his or her suitability or capability to operate or to continue operating a health care facility. Background checks shall consist of, but not be limited to, the following:

- (a) Contacts with the police to ascertain criminal convictions;
- (b) Verification of licensure status;
- (c) Verification of educational credentials;

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- (d) Verification of residency status;
- (e) Verification of solvency; and
- (f) Contacts with District and other state officials to determine outstanding warrants, complaints, criminal convictions, and records of malpractice actions.

The licensee of a health care facility shall inform the Director of a change in operation within thirty (30) days after the change. Change of operation means any alteration in function, program, or services that is substantially different from that reported on the hospital's most recent license application.

Each license in the licensee's possession shall be the property of the District Government and shall be returned to the Director immediately upon any of the following events:

- (a) Suspension or revocation of the license;
- (b) Refusal to renew the license;
- (c) Forfeiture consistent with § 2002.10; or
- (d) Voluntary discontinuance of the operation by the licensee.

The Director shall issue each license in the name of the owner and operator only for the premises and person or persons named as applicants in the application and the license shall not be valid for use by any other person or persons or at any place other than that designated in the license. Any transfer as to person or place without the approval of the Director shall cause the immediate forfeiture of the license.

Each hospital license shall specify the following: (a) The name of the person to whom the license is issued; (b) The name and location of the hospital; (c) The total rated bed capacity per service; (d)

The expiration date; and (e) Any special limitations imposed by the Director.

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The Director shall classify each license as follows:

- (a) General hospitals; or
- (b) Special hospitals.

The Director shall classify each facility license as regular, provisional or restricted.

The D.C. Fire and Emergency Medical Services shall conduct inspections of a facility to determine compliance with fire safety requirements.

The D.C. Fire and Emergency Medical Services shall submit to the Director the findings from inspections with a determination regarding licensure of a facility. The Director shall incorporate the determination in the licensure recommendation.

The D.C. Fire and Emergency Medical Services shall take action as deemed necessary against a facility for noncompliance with regulations under its jurisdiction.

Each facility shall meet the minimum requirements for insurance as appropriate for the number and types of beds in the facility and the number and types of services available as determined by the Director.

Each facility shall comply with all Certificate of Need requirements. The Director may subject a facility to an adverse action based on failure to comply.

The license shall be posted in a conspicuous place at all times.

CERTIFICATES REQUIRED

No license to operate a hospital shall be issued by the Director until the certifications required under this section have been issued.

Upon satisfactory proof being submitted, the Director shall certify that the services that are, or are proposed to be, furnished on the premises are, or will be, primarily to provide the following facilities and services by or under the supervision of a physician or provider eligible to admit, or by an oral surgeon where a physician is available at all times on call:

(a) Diagnostic facilities and services and therapeutic facilities and services for surgical or medical diagnosis, treatment, and care of injured, disabled, or sick persons; or

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(b) Obstetric facilities and services for the care of maternity patients and newborn infants.

Upon proof satisfactory to them, and after examination of the premises, the Director of the Department of Consumer and Regulatory Affairs, and the Fire Chief shall certify that the premises that are proposed to be used for that purpose are, in their judgment, suitable for that purpose.

INITIAL LICENSURE

Prior to initial licensure of a facility, the Director shall conduct an on-site inspection to determine compliance with the applicable statutes and rules governing the facility.

The Director shall send a written report of the findings to the facility no later than fifteen (15) days from the conclusion of the inspection.

A facility with deficiencies shall correct them within thirty (30) days upon receipt of the written report prior to the issuance of a license. The facility may submit written proof of correction of deficiencies where appropriate.

The Director may conduct a follow-up inspection to determine correction of deficiencies cited within ten (10) days following the thirty (30) day correction period or upon notification from the facility that the deficiencies have been corrected.

The Director may deny the application for licensure or issue a restricted or provisional license to a facility that has not corrected deficiencies. The facility shall reapply for licensure when deficiencies are corrected, or for a more limited license, if appropriate.

The Director shall issue a provisional license, not to exceed ninety (90) days, to a facility initially approved.

The Director shall conduct an unannounced on-site inspection of the facility within ninety (90) days of operation to assess the facility's continued compliance with the statutes and rules governing the facility. The Director shall issue a regular license not to exceed one (1) year to a facility that is in full or substantial compliance.

The Director shall renew a provisional license for a facility not in substantial compliance with the applicable statutes and rules of this chapter. Facilities taking ameliorative action to correct violations, but without deficiencies that pose a serious and imminent danger to the public's health, safety and welfare, may apply for renewal.

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The facility shall correct the deficiencies within sixty (60) days and the Director may require the facility to submit a plan of correction.

The Director shall conduct an on-site inspection after sixty (60) days to determine correction. The Director shall issue a regular license, not to exceed one (1) year, to the facility if found in substantial compliance.

The Director shall not renew a provisional license or grant a regular license to a facility not in substantial compliance, not taking ameliorative action, or with violations that pose a serious and imminent danger to the public's health, safety and welfare.

LICENSE RENEWAL

The Director shall conduct an on-site inspection of a facility to determine compliance with the statutes and rules governing the facility prior to the expiration of the license. Unless otherwise notified, inspections shall be unannounced.

The Director shall send a written report of the findings to the facility no later than fifteen (15) days from the conclusion of the inspection.

Consistent with applicable statutes and the rules governing the facility, the Director shall take adverse action, provided in sections 2009 - 2011 of this chapter, against a facility found to have life threatening deficiencies, or a continuing pattern of deficiencies which pose a serious threat to the public's health and safety.

The Director may require the facility to submit a written, signed and dated plan of correction to abate deficiencies cited no later than ten (10) business days following the receipt of the written report of findings.

The Director shall issue a renewal license for a period not to exceed one (1) year to a facility with no deficiencies or with minor deficiencies that can be corrected within thirty (30) days.

The Director shall issue a provisional license not to exceed ninety (90) days to a facility that is not in substantial compliance with the applicable statutes and rules of this chapter, but does not have deficiencies that are life threatening or that endanger the public's health and safety.

The Director shall issue a regular license not to exceed one (1) year to a facility issued a provisional license pursuant to § 2004.6 that is in full or substantial compliance after ninety (90) days, based on a follow-up inspection.

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The Director shall renew the provisional license for a facility initially issued a license pursuant to § 2004.7 that is not in substantial compliance after ninety (90) days, but is making significant progress toward correction of deficiencies cited.

The Director may prohibit a facility from accepting new patients and providing a service by issuing a restricted license when he or she finds that the facility has violations of a serious nature, and no substantial corrective action has been taken.

Consistent with the applicable statutes and rules governing the facility, the Director shall take adverse action against a facility that is not making substantial progress after issuance of the first provisional license, or its renewal, or a restricted license.

The Director shall automatically suspend or convert to a provisional or restricted status the license of a facility that loses its federal certification until a determination is made regarding its continued operation and license status.

REMOVAL PERMITS

No hospital or part of a hospital shall move from the premises for which a license has been issued to any other premises without first having obtained from the Director a permit to move to the premises not covered by the license issued to the hospital.

The removal permit shall indicate on its face the special conditions governing the moving of the hospital or part of the hospital as the Director may find to be in the interest of the public health.

COMPLAINT INVESTIGATIONS

The Director may receive any and all complaints alleging violations of the requirements contained in the applicable laws and regulations, and may conduct unannounced investigations to determine the validity of the complaints.

The facility shall permit the Director entry to investigate complaints. The Director shall conduct complaint investigations during time periods and staff shifts consistent with the allegations in the complaint when considered appropriate.

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The Director may require the facility to respond to the written report of findings with a written plan of correction no later than ten (10) days after the receipt of the report.

The Director shall communicate the findings of the complaint investigation directly to the facility and the complainant, if the complainant is identified to the Director, at the conclusion of the investigation.

The Director shall investigate complaint allegations of a life threatening nature or those that represent immediate danger within two (2) business days of receipt of the complaint by the Department. All other complaints shall be investigated by the Director no later than thirty (30) days from receipt of the complaint or as considered appropriate.

The Director shall immediately suspend or revoke a license or issue a provisional or restricted license in accordance with the applicable statutes and the rules of this chapter if a facility is found to have life threatening deficiencies or deficiencies which seriously endanger the public's health and safety.

The Director shall require a facility which is found in violation of the applicable statutes and the rules of this chapter, but whose deficiencies are not life threatening or seriously endangering to the public's health, safety and welfare, to correct the deficiencies within thirty (30) days from receipt of the complaint investigation report.

The Director shall issue a provisional or a restricted license, as appropriate, to a facility that has not corrected deficiencies within thirty (30) days.

If appropriate, the Director shall issue a restricted license to a facility which is found to have life threatening deficiencies or deficiencies which seriously endanger the public's health and safety. If not appropriate, the Director shall suspend or revoke the facility's license consistent with the applicable statutes and this chapter.

VARIANCES

The Director may grant a variance from any of the requirements of the applicable statutes and the rules of this chapter, if the applicant can show undue hardship and the variance can satisfy the following conditions:

(a) It is not inconsistent with other statutory provisions; (b) It is not deleterious to the public health and safety; and

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(c) It would not have the effect of permitting a violation of other laws or regulations of the District of Columbia.

A facility requesting a variance shall submit in writing to the Director the following:

(a) The regulatory requirement(s) for which a variance from strict compliance is being requested;

(b) Specific justification as to why the facility cannot meet the requirement(s); and

(c) Alternative measures provided to ensure quality care and services consistent with the applicable statutes and this chapter.

The Director shall grant a variance only to the extent necessary to ameliorate an undue hardship and only when compensating factors are present to give adequate protection to the public health without impairing the intent and purpose of this chapter.

If the Director believes that the conditions in § 2008.1 are not met, the Director shall issue a written proposed denial together with advice to the applicant as to his or her right to a hearing on the matter which shall be conducted by the Office of Administrative Hearings in accordance with § 2013.

The Director shall maintain a record, to which the public shall have access through the Freedom of Information Act, of all variances granted. The record shall contain a complete written explanation of the basis for each variance.

If a variance is requested from standards established pursuant to § 5(a) (3) of the Act, the Director shall provide an opportunity to comment before a decision is made.

CIVIL PENALTIES

Violation of any provision of this chapter may be subject to penalties in accordance with § 10 of the Act. In accordance with § 10(e) of the Act, civil fines, penalties, and related costs may be imposed against a hospital for the violation of any provision of this chapter. Adjudication, enforcement and applicable fines, penalties and costs shall be those established by or pursuant to Chapter 18 of Title 2 of the D.C. Official Code.

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In accordance with § 10(f)(1) of the Act, any person who commits a violation of any provision of this chapter that results in demonstrable harm to a patient, resident, or client of a facility or agency, shall be subject to a fine for each offense not to exceed \$ 10,000. For each violation, each day of violation shall constitute a separate offense, and the penalties prescribed shall apply to each separate offense. The total fine for a series of related offenses shall not exceed \$ 100,000. Procedures for adjudication of violations under this subsection shall be those established pursuant to Chapter 18 of Title 2.

DENIAL, SUSPENSION, AND REVOCATION OF A HEALTH CARE FACILITY LICENSE

The Director may refuse to issue or renew or may revoke, or may suspend a license issued pursuant to this chapter for one or more of the reasons listed in § 5(a)(2)(F) of the Act.

Except for a conversion or summary suspension undertaken pursuant to § 6(d)(1) of the Act, every applicant for or holder of a license, or applicant for reinstatement after revocation, shall be afforded notice and an opportunity to be heard prior to the action of the Director, if the effect of the Director's action would be one of the following:

(a) To deny a license for cause which raised an issue of fact; (b) To suspend a license; (c) To revoke a license; (d) To refuse to restore a license;

(e) To issue a limited renewal license; or

(f) To refuse to issue a renewal license for any cause other than failure to pay the prescribed fees.

When the Director contemplates taking any action of the type specified in 2010.2 of this chapter, the Director shall give to the applicant, or to another designee chosen by the applicant, a written notice containing the following statements:

(a) In the case of a license denial, that the applicant has failed to satisfy the Director as to the applicant's qualifications;

(b) The respect in which the applicant has failed to satisfy the Director; and

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(c) That the denial shall become final unless the applicant files a request for a hearing with the Director within fifteen (15) days of receipt of the notice.

(d) That the Director has sufficient evidence (setting forth the nature of the evidence), which if not rebutted or explained, justifies taking the proposed action; and

(e) That the Director shall take the proposed action unless within fifteen (15) days of the receipt of the notice the facility files with the Office of Administrative Hearings a written request for a hearing or in the alternative submits documentary evidence for the court's consideration before final action is taken.

If the facility does not respond to the notice within the time specified, the Director may, without a hearing, take the action contemplated in the notice. The applicant or licensee shall be informed in writing of the action taken.

If the applicant or licensee chooses to submit to the Office of Administrative Hearings documentary evidence but does not request a hearing, the Director may submit a written response to the Office of Administrative Hearings within fifteen (15) days of the receipt of the documentary evidence by the Office of Administrative Hearings or otherwise within a time period allotted by the Office of Administrative Hearings.

Grounds for suspension, revocation or refusal to issue or renew a license shall include the following:

(a) Failure to meet or maintain the standards required by this chapter;

(b) Willful submission of false or misleading information to the Director in connection with an application for licensure or related to licensing procedures;

(c) Violation of this chapter, or other laws and regulations of the District of Columbia or the United States relating to the operation of a hospital and which are applicable to hospitals operating in the District of Columbia;

(d) Failure to allow inspections pursuant to this chapter;

(e) Failure to obey any lawful order of the Director, pursuant to the rules of this chapter;

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(f) Conviction of a member of the governing body, a Director, Administrator, the Chief Executive Officer, department head, or other key staff member of a felony involving the management or operation of a hospital, or which is directly related to the integrity of the facility or the public health or safety; or

(g) Any act which constitutes a threat to the public's health or safety.

SUMMARY SUSPENSION AND LICENSURE CONVERSION, HEARINGS

Notwithstanding any other provision of this chapter, the Director, pursuant to § 6(d)(l) of the Act, and under conditions described in that section may do the following:

(a) Convert the facility's license to a provisional or restricted; or (b) Summarily suspend the facility's license.

The Director may summarily suspend the license of any hospital or convert its license to a provisional or restricted license if the Director determines that existing deficiencies constitute an immediate or serious and continuing danger to the health, safety or welfare of its patients.

Upon summarily suspending a license pursuant to §§ 2011.2, the Director shall immediately give the hospital written notice of the action, including a copy of the order of suspension, a statement of the grounds for the action and notification that the hospital may, within seven (7) business days from the day written notice is received, file with the Office of Administrative Hearings a written request for an expedited hearing with respect to the action.

The Office of Administrative Hearings shall convene a hearing within three (3) business days following receipt of the facility's timely request for a hearing to review the reasonableness of the suspension. If a summary suspension is requested, the request for hearing shall not serve to stay the order suspending the license.

Except as otherwise noted in this chapter all procedures relating to hearings as set forth in this chapter shall apply to hearings in summary suspensions.

Conversions of licenses to restricted or provisional licenses shall be in accordance with § 7 of the Act.

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SERVICE OF NOTICE

Any notice required by this chapter may be served either personally or by certified mail, return receipt requested, directed to the applicant or licensee at the last known address as shown by the records of the Department.

If notice is served personally, it shall be considered by the Director to have been served at the time when delivery is made to the applicant or licensee.

If notice is served by certified mail, it shall be considered by the Director to have been served on the date written or stamped upon the return receipt showing delivery of the notice to the applicant or licensee, or refusal of the applicant or licensee to receive the notice.

In the event that the applicant or licensee is no longer at the last known address as shown by the records of the Department and no forwarding address is available, the notice shall be considered by the Director to have been served on the date the return receipt bearing the notification is received by him or her.

If an applicant or licensee scheduled for a hearing does not appear and no continuance has been or is granted, the Director may take the contemplated action without a hearing.

CONDUCT OF HEARINGS

Every hearing before the Office of Administrative Hearings shall be open to the public and shall be in accordance with its rules of procedure and this chapter.

An applicant or licensee entitled to a hearing shall have the following rights:

- (a) To be represented by counsel;
- (b) To present testimony;
- (c) To present witnesses and evidence on his or her behalf;
- (d) To examine all opposing witnesses on any matter relevant to the issues; and
- (e) To have subpoenas issued to compel the attendance of witnesses and the production of relevant books, papers, and documents upon

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making written request therefore to the Office of Administrative Hearings.

In any proceeding resulting from the Director's contemplated action to deny new licensure, the applicant shall have the burden of proving his or her qualification for licensure.

In any proceeding resulting from the Director's contemplated action to refuse to renew, to revoke, or to suspend a license, the Department shall have the burden of proving that such action should be taken, or in the case of a summary suspension, that the action was valid.

In all hearings, a complete record shall be made of all evidence presented during the course of a hearing. Any party to the proceedings desiring it shall be furnished with a copy of the record, upon payment of the fee prescribed by the Office of Administrative Hearings.

Final decisions shall be rendered, petitions for reconsiderations taken and appeals filed in accordance with the rules of the Office of Administrative Hearings.

GOVERNING BODY AND ADMINISTRATION

Each hospital shall have a governing body which shall have the authority and responsibility for the direction and policy of the hospital.

The governing body's responsibilities shall include:

- (a) Monitoring policies to assure appropriate administration and management of the facility;
- (b) Maintaining the hospital's compliance with all applicable state and federal statutes, relevant state and federal rules and regulations, the hospital's policies and procedures as well as the hospital's plans of correction;
- (c) Ensuring the quality of all services, care and treatment provided to patients whether those services, care or treatment are furnished by hospital staff or through contract with the hospital;
- (d) Designating an administrator who is responsible for the day-to-day management of the hospital and defining the administrator's duties and responsibilities;

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- (e) Notifying the Department in writing within thirty (30) working days when a vacancy in the administrator position occurs, including who will be responsible for the position until another administrator is appointed;
- (f) Notifying the Department in writing within thirty (30) working days when the administrator vacancy is filled indicating effective date and name of person appointed administrator;
- (g) Appointment and reappointment of medical staff members who are credentialed in accordance with the District of Columbia Health Occupations Revision Act of 1985 (D.C. Law 6-99) and delineating their clinical privileges, according to the procedures for credentials review established by the medical staff and approved by the governing authority;
- (h) In collaboration with the medical staff, establishing criteria for membership on the medical staff or clinical privileges;
- (i) Rendering within a fixed period of time the final decision regarding medical staff recommendations for denial of staff appointments and reappointments, as well as for the denial, limitation, suspension or revocation of privileges. There shall be a mechanism provided in the medical staff bylaws, rules and regulations for review of decisions, including the right to be heard when requested by the practitioner;
- (j) Ensuring the medical staff is accountable to the governing body for the quality of medical care and treatment;

(k) Ensuring a medical staff and a utilization review process is formed and operated for the purpose of reviewing the medical and hospital care provided and the use of hospital resources to assist individual physicians, administrators and nurses in maintaining and providing a high standard of medical and hospital care and efficient use of the hospital;

(l) At least once each year, reviewing reports and recommendations regarding all Quality Assurance/Performance Improvement activities and the Medical Staff and Utilization Review process. Reports shall be utilized to implement programs and policies to maintain and improve the quality of patient care and treatment;

(m) Establishing a means for liaison and communication between the governing authority, the medical staff and administration and promoting effective communication and coordination of services

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among the various hospital departments, administration and the medical staff;

(n) Requiring the medical staff to be organized with a chief of staff, president, or chairperson and approving the organization, bylaws, rules and regulations, and policies and procedures of the medical staff and the departments in the hospital;

(o) Establishing visitation policies which are in the best interest of patients, including, but not limited to, protection from communicable diseases, protection from exposure to deleterious substances and hazardous equipment and assurance of health and safety of patients; and

(p) In addition to the requirements of section 2032.1(d), establishing a written infection control program which includes a description of risks, strategies to address the risks, a statement of goals, a system to evaluate the program and applicable policies and procedures.

ADMINISTRATOR

The administrator shall be responsible for planning, organizing, and directing the day to day operation of the hospital. The administrator shall report and be directly responsible to the governing body in all matters related to the maintenance, operation, and management of the hospital.

The Administrator shall be present forty (40) hours per week during regular business hours, and shall be responsible for the operation of the facility twenty-four (24) hours per day, seven (7) days per week.

The administrator's responsibilities include:

(a) Making sure there is adequate attention to the management of the hospital twenty-four (24) hours of day;

(b) Providing for the protection of patients' health, safety, and well- being;

(c) Maintaining staff appropriate to meet patient needs;

(d) Designating a substitute, who shall be responsible and accountable for management of the facility, to act in the absence of the administrator;

(e) Developing and implementing procedures on collecting and reporting information on abuse, neglect and exploitation;

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(f) Ensuring that investigations of suspected abuse, neglect or exploitation are completed and that steps are taken to protect patients;

(g) Developing and implementing procedures for the collection of data on and reporting of adverse events and unusual incidents, which may also be known as or include, sentinel events and near misses. Procedures must also include the implementation of corrective actions.

(h) Ensuring that bodies are held in the morgue no longer than thirty (30) days and that the hospital complies with the following:

- (1) Reporting requirements provided by the Vital Records Act of 1981 (D.C. Law 4-34), and
- (2) Notification and reporting requirements in the the Establishment of the Office of the Chief Medical Examiner Act of 2000 (D.C. Law 13-172); and

(i) Developing and implementing policies to ensure adequate and appropriate monitoring of infants and children when they are placed in patient care units without adult patients

GENERAL STAFF REQUIREMENTS

Each hospital shall maintain a sufficient number of staff with the qualifications, training and skills necessary to meet patient needs. The hospital shall be staffed twenty-four (24) hours per day.

Each hospital shall ensure and maintain evidence of, for employees and contract staff, current active licensure, registration, certification or other credentials in accordance with applicable District of Columbia law, prior to staff assuming job responsibilities and shall have procedures for verifying that the current status is maintained.

Whenever a licensed health-care professional is terminated as a result of a job-related incident, the hospital shall refer a report of the incident to the appropriate professional health-care board which shall review the report in accordance with the District of Columbia Health Occupations Revision Act of 1985 (D.C. Law 6-99).

HEALTH EXAMINATIONS

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Each person, other than a physician, involved in the performance of duties involving direct patient care shall have an occupational health screening by a physician or other qualified health professional within thirty (30) calendar days prior to entering active status or within thirty (30) calendar days after entering, and at least once every two (2) years thereafter. Each physician shall have a health examination performed by another physician or other qualified health care professional at the time of appointment and once every two (2) years thereafter.

Each health screening shall include a medical history, physical examination, intradermal tuberculin test and any indicated laboratory work, except that the intradermal tuberculin test and subsequent tests shall be performed in accordance with section 2017.3.

Preventative measures, testing and frequency of testing for tuberculosis shall be in accordance with standards and guidelines developed by the Centers for Disease Control and Prevention.

A report, signed by an examining physician or other qualified health professional, shall be made of each examination.

The report of each examination shall be kept on file in the hospital and shall be open to inspection by the Department.

In lieu of the pre-employment intradermal tuberculin test required by this subsection, the examining physician may accept a written report of the test or x-ray made by a qualified person within twelve (12) months prior to the date of the examination.

Each person who is involved in direct patient care and who has been absent from duty because of an illness required to be reported to the Department shall, prior to returning to duty, obtain certification from a physician or other qualified health professional, as provided for in the hospital's policies, that he or she may return to duty without apparent danger of transmitting the cause of the illness to any patient.

A copy of each certification as required in § 2017.7 shall be kept on file and made available for examination by the Department.

Hospital work shall be deemed to be an occupation the duties of which are such that the activity of each individual performing the work is likely to be dangerous to the lives or health of other persons, within the meaning of §213 of chapter 2 of this title relating to the reporting and control of communicable diseases.

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Immunization against communicable disease shall be required of all employees and all other persons who routinely come in contact with patients or patient areas. Immunizations shall be in accordance with current standards and guidelines developed by the Centers for Disease Control and Prevention.

STAFF TRAINING

Each hospital shall ensure that staff receive training in order to perform assigned job responsibilities. Each hospital shall provide and maintain evidence of an orientation program for all new staff and, as needed, for existing staff who are given new assignments. The orientation program shall include an explanation of:

- (a) Job duties and responsibilities; (b) Hospital's sanitation and infection control programs; (c) Organizational structure within the hospital; (d) Patient rights; (e) Patient care policies and procedures relevant to the job; (f) Personnel policies and procedures; (g) Emergency procedures; (h) The Disaster preparedness plan; and (i) Reporting requirements for abuse, neglect or exploitation.

Each hospital shall provide and maintain evidence of ongoing/continuous in-services or continuing education for staff. A record shall be maintained including dates, topics and participants.

Each hospital shall maintain a current employment record for each staff person. The record shall contain, at a minimum, information on orientation, in-services, credentialing, health history screening and background check information, including information verifying compliance with the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998 (D.C. Law 12-238, as amended; D.C. Official Code § 44-551 et seq.).

MEDICAL STAFF

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Each hospital shall have a medical staff that shall be responsible for carrying out the provisions of the bylaws, consistent with rules and regulations, and shall recommend to the governing body bylaws, or amendments to the bylaws, as they deem appropriate to the operation of the particular hospital. The

medical staff shall be organized in a manner and shall function in a manner consistent with the size, needs and resources of the hospital and of the medical staff.

The clinical staff of each medical service, surgical service, obstetric service, pediatric service, psychiatric service, radiology service, and anesthesiological service shall be organized under the directorship of an internist, surgeon, obstetrician, pediatrician, psychiatrist, radiologist, and anesthesiologist respectively, each of whom shall be responsible for the policies, procedures, and supervision of the medical work in his or her respective service. Likewise, any medical service shall be organized under the directorship of a licensed professional who is a medical specialist in that medical service.

The medical staff shall be responsible to the governing authority for the quality of medical care and treatment provided in the hospital and shall:

- (a) Participate in a Quality Assurance/Performance Improvement program to determine the status of patient care and treatment;
- (b) Abide by hospital and medical staff policies;
- (c) Establish a disciplinary process for infraction of the policies; and
- (d) Recommend criteria and procedures for appointment and reappointment to the medical staff and for delineating clinical privileging to facilitate the provision of quality patient care and treatment.

Each licensee shall require all employees, contract workers, and volunteers working in the hospital to familiarize themselves with the provisions of this chapter as appropriate to the functions they perform and with all other regulations applicable to their duties.

Each hospital shall provide a medical staff that shall be adequate for the diagnostic facilities and services, therapeutic facilities and services, and rehabilitation facilities and services which the hospital undertakes to provide.

AVAILABILITY OF PHYSICIANS

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Each general hospital shall have a physician available on the premises at all times.

Each special hospital shall at all times have a physician available on the premises or available on call; Provided, that when the Director, after consultation with the chief of the involved service, finds that the condition of the patients in the hospital requires the presence of a physician on the premises at all times, the Director shall impose the requirement.

Each patient shall be under the care of a physician, regardless of whether the patient is also under the care of an allied health professional practitioner authorized to practice in the District.

NURSING STAFF

Each hospital shall provide a nursing staff that is adequate for the diagnostic facilities and services, therapeutic facilities and services, and rehabilitation facilities and services that the hospital undertakes to provide.

The Department of Nursing Service shall be under the direction of a registered nurse qualified by education, experience, and demonstrated ability for the position of Director of Nursing Service.

The Director of Nursing Service shall participate in the establishment of policies and procedures for the conduct of nursing service.

The Director of Nursing shall be a full-time employee during regular business hours, and shall be responsible for the operation of the nursing service twenty-four (24) hours per day, seven (7) days per week.

A well-organized departmental plan of administrative authority, with delineation of responsibilities and duties of each category of nursing shall be required both in relation to patient care and to the educational responsibilities of the nursing service.

An Assistant to the Director of Nursing shall be provided for the evening and night tours of duty.

Supervisory and staff personnel shall be provided for each department of patient care unit to ensure the immediate availability of a professional nurse for bedside care of all patients at all times.

Qualified personnel shall be provided in sufficient numbers to provide nursing care not requiring the services of a licensed registered nurse.

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Nursing personnel for the surgical operating suite, maternity and newborn service, outpatient service, and other services of the hospital shall be provided in keeping with their size and degree of activity.

All nursing personnel shall be qualified by education, experience, and demonstrated ability for the positions to which they are assigned.

Private duty nurses and licensed practical nurses and nursing assistants shall be under the supervision and direction of a registered nurse at all times.

Nursing care procedures and care plans (which may be interdisciplinary care plans), written in conformance with hospital policy, shall be provided for patients, either on an individual or patient care unit basis. follow the policy

PATIENT RIGHTS

Each hospital shall protect and promote each patient's rights. This includes the establishment and implementation of written policies and procedures, which include, but are not limited to, the following rights. Each patient or designee, when appropriate, shall have the right to:

- (a) Respectful and safe care given by competent personnel;
- (b) Be informed of patient rights during the admission process;
- (c) Be informed in advance about care and treatment and of any change;
- (d) Participate in the development and implementation of a plan of care and any changes;
- (e) Make informed decisions regarding care and to receive information necessary to make decisions;
- (f) Refuse treatment and to be informed of the medical consequences of refusing treatment;
- (g) Formulate advance directives and have the hospital comply with the directives unless the hospital notifies the patient of the inability to do so;
- (h) Personal privacy and confidentiality of medical records; (i) Be free from abuse, neglect, and exploitation;

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- (j) Access information contained in his/her medical record within a reasonable time frame when requested, subject to limited circumstances where the attending physician determines it would be harmful to disclose the information to the patient for therapeutic reasons;
- (k) Be free from chemical and physical restraints that are not medically necessary;
- (l) Receive hospital services without discrimination based upon race, color, religion, gender, national origin, or payer. Hospitals are not required to provide uncompensated or free care and treatment unless otherwise required by law; and
- (m) Voice complaints and file grievances without discrimination or reprisal and have those complaints and grievances addressed.

Each hospital shall establish and implement a process to provide patients and/or their designee appropriate education to assist in understanding the identified condition and the necessary care and treatment.

Each hospital shall document its assessment of each patient's ability to understand the scope and nature of the diagnosis and treatment needed.

GRIEVANCES

Each hospital shall establish and implement a written process that promptly addresses grievances filed by patients or their representatives. The process includes, but is not limited to:

- (a) A procedure for submission of grievances which is made available to patients or representatives;
- (b) Time frames and procedures for review of grievances and provision of a response; and
- (c) How information from grievances and responses are utilized to improve the quality of patient care and treatment.

PATIENT CARE AND TREATMENT

Except in the case of emergency, no medication or treatment other than dental shall be given to any patient without an order of a physician or

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other qualified health professional. A physician order shall include physician approved protocols.

No dental medication or treatment shall be given to any patient without an order of a dentist, physician, or other qualified health professional, except in an emergency.

The physician's, dentist's, or other qualified health professional's order shall be recorded at the time it is made and shall be signed by the physician, dentist, or other qualified health professional as soon as practicable.

Each hospital shall provide the necessary care and treatment to meet the needs of patients. Care and treatment provided shall meet prevailing professional standards and scope of practice requirements. Each hospital shall establish and implement written policies and procedures that encompass care and treatment provided to patients.

A plan of care shall be established, implemented and kept current to meet the identified needs for each inpatient. The plan of care shall be interdisciplinary when appropriate to meet individual needs of patients.

When the hospital is responsible for the administration of medication, medication shall be administered by a qualified health professional for whom medication administration is included within the scope of practice. The hospital shall ensure that medication is properly administered in accordance with prevailing professional standards.

The hospital shall allow patients to self-administer medications, with or without supervision, when assessment determines that self-medication is appropriate and that the patient is capable of doing so.

ERRORS IN PROVISION AND ADMINISTRATION OF MEDICATIONS

Each hospital shall establish and implement policies and procedures for reporting any errors in administration or provision of prescribed medications. Errors shall be reported to the prescriber in a timely manner upon discovery and a written report of the error prepared.

Documentation of medication errors shall be maintained by each hospital and made available for review by the Department.

Each hospital shall establish and implement policies and procedures for reporting any adverse reaction to a medication in a timely manner upon

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discovery to the prescriber and for documenting the event in the patient's medical record.

Each hospital shall establish and implement procedures on the handling of drugs to ensure that patients receive medications as prescribed by a medical practitioner. At a minimum, the following shall be evident:

- (a) An accounting during each shift at each nursing unit of all controlled substances that have been dispensed as multiple-dose floor stock and individual patient prescriptions; and
- (b) Authorized personnel designated by hospital policy in accordance with applicable law are allowed access to medications, including controlled substances.

Each hospital shall maintain records in sufficient detail to assure that patients receive the medications prescribed by a medical practitioner and maintain records to protect medications against theft and loss.

Each hospital shall develop and maintain for each inpatient an individual medication administration record that includes, but is not limited to:

- (a) The identification of the patient;
- (b) The name of the medication given;
- (c) The date, time, dosage, method of administration or provision for each medication;
- (d) Identification of the person who administered or provided the medication and any refusal by the patient; and
- (e) The patient's medication allergies and sensitivities.

SEPARATE PATIENT CARE

Each hospital regularly providing care for obstetric conditions, pediatric conditions, and psychiatric conditions shall have one (1) or more physically and functionally separate care units for each category of conditions for which care is regularly provided.

A newborn infant shall not be placed in the same room with any child or any adult except in a maternity nursing unit with mothers for whom there is no apparent danger of transmitting a communicable disease.

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Infants and children shall not be placed in patient rooms with adult patients other than with parents or legal guardians.

Patients with suspected or diagnosed contagious conditions shall be isolated from those not having the suspected or diagnosed condition except in an emergency and on a temporary basis.

The maternity and newborn care unit shall be separate from other patient care units and shall be used only for the care of maternity patients and newborn infants; provided, that when there are no other beds available, noninfectious gynecological patients may be cared for on a temporary basis in a maternity and newborn patient care unit.

RESTRAINT OR SECLUSION OF PATIENTS

Every general hospital, special hospital for adults with one hundred (100) or more beds, and every special hospital that maintains a psychiatric service for adults shall provide one (1) or more security rooms.

All other special hospitals shall maintain a seclusion room and provide an attendant to be with the patient constantly where needed prior to removal to a psychiatric service.

No patient shall be placed in mechanical restraint or other seclusion, unless ordered by a physician or other qualified health professional, and unless a nurse or attendant is continuously on duty in charge of and responsible for the patient.

No restraint shall be applied unless it is designed and applied so that the person responsible can readily remove the restraints in case of an emergency.

PATIENT NUTRITION

Each hospital shall provide for the daily nutritional needs of all patients, including the provision of any diets ordered by a medical practitioner.

A current diet manual acceptable to dietary, nursing and medical staff shall be maintained and available for reference.

Education on matters of diet and nutrition shall be available to patients when appropriate.

Assessments of the nutritional status of patients shall be conducted by an appropriate professional licensed to conduct nutritional assessments in

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accordance with the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99.

Each hospital shall document on-going nutritional assessments for patients who require and receive supplemental nutrition. Nutritional assessments shall include weighing, laboratory testing and other appropriate indicators.

DISCHARGE PLANNING

Each hospital shall provide discharge planning to patients. The discharge planning program includes, but is not limited to:

- (a) A system for timely evaluation of any discharge planning needs of patients;
- (b) Identification of staff responsible for the program;
- (c) Development of a discharge plan, including medication review, with the patient or representative when need is identified;
- (d) Medication review with the patient or representative;
- (e) Maintenance of a complete and accurate list of community-based services, resources and facilities to which patients can be referred; and
- (f) Arrangement for the initial implementation of a discharge plan including transfer of necessary medical information.

RECORD KEEPING REQUIREMENTS.

Each hospital shall maintain records and reports in a manner to ensure accuracy and easy retrieval. A medical record shall be maintained for every patient, including newborn infants, admitted for care in the hospital or treated in the emergency or outpatient service. Medical records may be created and maintained in written or electronic form, or a combination of both, provided that a complete record is accessible at all times. Medical records shall contain sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to document the results accurately.

Each medical record shall contain, when applicable, the following information:

- (a) Identification data;

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- (b) Chief complaint; (c) Present illness; (d) History and physical examination; (e) Admitting diagnosis; (f) All pathology/laboratory and radiology reports; (g) Properly executed informed consent forms; (h) Consultation reports; (i) Medical practitioner orders; (j) Documentation of all care and treatment, medical and surgical; (k) Tissue report; (l) Progress notes of all disciplines; (m) Discharge summary and final diagnosis; (n) Autopsy findings; and (o) Advanced directives, if available.

Medical records shall contain entries which are dated, legible and indelibly verified. The author of each entry shall be identified and authentic. Authentication shall include signature, written initials, or computer entry.

Telephone or verbal orders of authorized individuals are accepted and transcribed by qualified personnel who are identified by title or category in the medical staff bylaws or rules and regulations. Telephone or verbal orders shall be authenticated as soon as is practical by the medical practitioner who is responsible for ordering, providing or evaluating the service furnished.

The hospital shall monitor and require medical records be completed within thirty (30) days of discharge of the patient.

The medical record of each patient shall be maintained and preserved, in original, microfilm, electronic or other similar form, for a period of at least

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ten (10) years following discharge or in the case of minors, the records shall be kept until three years after the age of majority has been attained. In cases in which a hospital ceases operation, all medical

records of patients shall be transferred as directed by the patient or authorized representative to the hospital or other health care facility or health care service to which the patient is transferred. All other medical records that have not reached the required time for destruction shall be stored to assure confidentiality and the Department shall be notified of the address where stored.

Medical records shall be kept confidential, available only for use by authorized persons or as otherwise permitted by law. Records shall be available for examination by authorized representatives of the Department.

Patient information and/or records will be released only with consent of the patient or designee or as permitted by law. When a patient is transferred to another health care facility or service, appropriate information for continuity of care shall be sent to the receiving health care facility or service.

In addition to patient medical records, each hospital shall maintain, when applicable, the following:

- (a) A permanent patient index that includes, but is not limited to: (1) Name and identification numbers of each patient; (2) Dates of admission and discharge; (3) Name of admitting physician; and (4) Disposition or place to which patient was discharged/transferred.
- (b) Administrative records and reports including governing authority and departmental meeting minutes, staff orientation and in-service records and staff schedules as worked for a minimum of three years, unless longer is required by law.
- (c) Records of all reports made regarding abuse, neglect, misappropriation of property or exploitation.

In order to ensure the patient's right of confidentiality, medical records are destroyed or disposed of by shredding, incineration, electronic deletion, or another equally effective protective measure.

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PHYSICAL PLANT STANDARDS

All hospitals shall be designed, constructed and maintained in a manner that is safe, clean, and functional for the type of care and treatment to be provided. The physical plant standards for facilities, which include support services, care and treatment areas, construction standards and building systems are set forth below.

The hospital may share the following support service areas among detached structures, care and treatment areas, or with other licensed health care facilities.

- (a) Dietary: If food preparation is provided on site, the hospital shall dedicate space and equipment for the preparation of meals. Food service physical environment and equipment shall comply with Title 25 of the District of Columbia Municipal Regulations (the Food Code) except when used only for training or activity purposes.
- (b) Laundry: If the hospital provides laundry services, the services may be provided by contract or on-site by the hospital.
 - (1) Contract: If contractual services are used, the hospital shall have areas for soiled linen awaiting pickup and separate areas for storage and distribution of clean linen.
 - (2) On-site: If on-site services are provided, the hospital shall have areas dedicated to laundry.
 - (A) If personal laundry areas are provided, the areas shall be equipped with a washer and dryer for use by patients. In new construction, the hospital shall provide a conveniently located sink for soaking and hand-washing of laundry.
 - (B) Hospital laundry area for hospital processed bulk laundry shall be divided into separate soiled (sort and wash areas) and clean (drying, folding, and mending areas) rooms. In new facilities a separate soaking and hand-washing sink and housekeeping room shall be provided in the laundry area.

(C) Separate clean linen supply storage facilities shall be conveniently located in each care and treatment location.

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(c) Diagnostic: If the hospital provides radiology or laboratory services, the services shall comply with the following:

(i) Imaging rooms shall accommodate the operational and shielding requirements of the equipment installed and the condition of the patient and shall provide clear floor area adequate for the safety of staff and patients.

(ii) Laboratory areas shall provide for sample collection and protection, analyzing, testing and storage. The hospital shall handle all potentially contagious and hazardous samples in a manner as to minimize transmission of infectious diseases.

(d) Waste processing: The hospital shall provide areas to collect, contain, process, and dispose of medical and general waste produced within the hospital in such a manner as to prevent the attraction of rodents, flies and all other insects and vermin, and to minimize the transmission of infectious diseases.

2032 MEDICAL SERVICES

2032.1 In the absence of applicable requirements in this chapter, the following services shall be operated in accordance with the indicated provisions of the Medicare/Medicaid participation requirements:

(a) Pharmaceutical services, Title 42 of the Code of Federal Regulations (hereinafter "CFR") § 482.25;

(b) Radiological services, 42 CFR § 482.26; (c) Laboratory services, 42 CFR § 482.27; (d) Infection control services, 42 CFR § 482.42; (e) Surgical services, 42 CFR § 482.51; (f) Anesthesia services, 42 CFR § 482.52; (g) Outpatient services, 42 CFR § 482.54; (h) Emergency services, 42 CFR § 482.55; and

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(i) Rehabilitation services, 42 CFR § 482.56. 2033 CARE AND TREATMENT AREAS

2033.1 The hospital shall not share the following care and treatment areas among detached structures or with other facilities operated by another licensee:

(a)

(b)

Staff Areas: Facilities that provide nursing services shall provide the following support areas for each distinct group of care and treatment patient rooms.

(1) Control Point: The hospital shall have an area or areas for charting, and patient records, and call and alarm annunciation systems.

(2) Medication Station: The hospital shall have a medication station for storage and distribution of drugs and routine medications. Distribution may be done from a medicine preparation room or unit, from a self-contained medicine-dispensing unit, or by another system. If used, a medicine preparation room or unit shall be under visual control of nursing staff and shall contain a work counter, sink, refrigerator, and double-locked storage for controlled substances.

(3) Utility Areas: The hospital shall have a work area where clean materials are assembled. The work area shall contain a work counter, a hand-washing fixture, and storage facilities for clean and sterile supplies. If the area is used only for storage and holding as part of a system for distribution of clean and sterile supply materials, the work counter and hand-washing fixtures may be omitted. A hospital shall have separate work rooms or holding rooms for soiled materials. A work room for soiled materials shall contain a fixture for disposing wastes and a hand-washing sink.

Equipment and Supplies: The hospital shall have services and space to distribute, maintain, clean and sanitize durable medical instruments, equipment, and supplies required for the care and treatment performed in the hospital.

(1) Durable Medical: The hospital shall ensure that the durable medical equipment is tested and calibrated in accordance with the manufacturer's recommendations.

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(2)

Sterile Processing: The hospital shall have areas for decontamination and sterilizing of durable medical instruments and equipment.

(A) (B)

(C)

The hospital shall provide separate central sterile processing and waste processing areas.

In new construction and where provided, central processing areas shall have separate soiled (sorting and decontamination) and clean (sterilizing and processing) rooms. The hospital shall have hand-washing sinks in both clean and soiled rooms.

Equipment Storage: The hospital shall have space to store equipment, stretchers, wheelchairs, supplies, and linen out of the path of normal traffic.

(c) Surgery: A hospital providing surgical services shall have at least one operating or procedure room and the following support areas. In new construction and hospitals with more than two operating rooms, the following support areas and central processing areas shall be located in restricted access areas:

(1) Preoperative Patient Area: Preoperative patient area(s) shall have sufficient space and equipment to accommodate both ambulatory and non-ambulatory patients. These areas shall be under the direct visual control of the nursing staff.

(2) Recovery Area: Recovery area(s) shall contain a medication station, hand-washing sink, charting area, provisions for bedpan cleaning; and equipment and supply storage space.

(3) Dressing Area: A hospital providing outpatient surgery shall have patient dressing and toilet rooms separate from staff gowning areas.

(4) Housekeeping Room: The hospital shall have soiled utility and housekeeping areas exclusively for the surgical suite.

(d) Emergency Care: A hospital providing emergency services shall have at least one procedure or treatment room for emergency

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services. To support the provision of emergency care, the hospital shall have the following:

(1) Entrance: A well marked, illuminated covered entrance at grade level for emergency vehicle and pedestrian access;

(2) Waiting Area: Patient and visitor waiting area(s) that are in direct observation of the reception, triage, or control station, with access to a public phone and drinking fountain;

(3) Storage: Storage areas for general medical/surgical emergency supplies, medications and equipment under staff control and out of the path of normal traffic; and

(4) Toilet Room: A patient toilet room with hand-washing sink convenient to the procedure or treatment room(s).

(e) Rehabilitation: A hospital providing rehabilitation services in a distinct unit shall have at least one treatment room or cubicle, an area for specialized treatment and care, hand-washing sink(s), storage for equipment and supplies, call system, medication storage and distribution, and areas to allow for patient toileting, dressing, and consultation.

(f) Obstetrics: A hospital providing obstetric services in a distinct unit shall have at least one patient room, nursery with work area, space and equipment to allow for care and treatment of both mother and infant, hand-washing sink, storage for equipment and supplies, call and alarm annunciation systems, medication storage and distribution, and convenient accommodations for patient toileting, dressing, and consultation.

(g) Psychiatric or Mental Health: A hospital providing psychiatric or mental health services in a distinct unit shall provide space and equipment that allows for patient and staff safety. The hospital shall provide at least one observation room, separate quiet and noisy activity areas, dining areas, private and group areas for specialized treatment and care, a hand-washing sink, storage for equipment and supplies, security systems, and an area for medication storage and distribution. Patient toileting, 37

dressing, holding, and consultation rooms shall have durable finishes. In rooms where care and treatment is provided to patients exhibiting violent, aggressive or suicidal behavior, the rooms shall have:

- (1) Tamper-resistant air distribution devices, lighting fixtures, sprinkler heads, and safety devices;
- (2) Ventilation, exhaust, heating and cooling components that are inaccessible to patients;
- (3) Bedroom, toilet, and bathing room doors that are not lockable or capable of being obstructed from within; and
- (4) Electrical outlets protected by ground fault interrupting devices.

(h) In-patient Hospice Care: A hospital providing in-patient hospice services in a distinct unit shall have private patient bedrooms, over-night and dining accommodations for family members, private family visiting areas, areas that allow for toileting, bathing, dressing and hand-washing, storage for equipment and supplies, call system, medication storage and distribution.

(1) Alzheimer's, Dementia, and Related Conditions: A hospital providing in-patient services for Alzheimer's, dementia, and related conditions in a distinct unit shall have personalized patient bedrooms, activity areas, separate dining areas, features that support patient orientation to their surroundings, areas for specialized treatment and care, hand-washing sinks, secured storage for equipment and supplies, call and security systems, and an area for medication storage and distribution.

(i) Outpatient Areas: Areas for the care and treatment of patients not residing in the hospital shall comply with the following:

- (1) Areas shall not interfere with inpatients being served;
- (2) Furniture and equipment shall meet care and treatment needs of outpatients;

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(3) Toilets, which are easily accessible from all program areas shall be provided; and

(4) Sufficient inside and outside space to accommodate the full range of program activities and services shall be provided.

CONSTRUCTION STANDARDS

All hospitals shall be designed, constructed, and maintained in a manner that is safe, clean, and functional for the type of care and treatment to be provided. The standards for the facilities are set forth below.

New construction shall comply with the following codes and guidelines to provide a safe and accessible environment that is conducive to the care and treatment to be provided:

- (a) The BOCA (Building Officials and Code Administrators) National Building Code;
- (b) Life Safety Code (National Fire Protection Association 101);
- (c) Health Care Facilities (National Fire Protection Association 99);
- (d) Guidelines for Design and construction of Hospitals and Health Care Facilities;
- (e) National Electrical Code; and (f) Uniform Federal Accessibility Standards.

ENVIRONMENT

All facilities shall comply with the following applicable codes and standards to provide a safe environment:

(a) Life Safety Code (National Fire Protection Association 101); and (b) The Food Code, Title 25 of the District of Columbia Municipal Regulations

Existing and new facilities shall comply with the physical plant standards contained in § 2031 of this chapter. The hospital shall maintain all building materials and structural components so that total loads imposed do not stress materials and components more than one and one-half times

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the working stresses allowed in the building code for new buildings of similar structure, purpose, or location.

Interpretations: All dimension, sizes, and quantities; noted herein will be determined by rounding fractions to the nearest whole number.

Floor area is the space with ceilings at least seven feet in height and does not include areas such as enclosed storage, toilets, and bathing rooms, corridors and halls. The space beyond the first two feet of vestibules and alcoves less than five feet in width will not be included in the required floor area. In rooms with sloped ceilings, at least half of the ceiling shall be at least seven feet in height with areas less than five feet in height not included in the required floor area.

Dining Areas: If provided, dining areas for patients shall have an outside wall with windows for natural light and ventilation. In addition:

(a) (b)

(c)

(d)

Dining areas shall be furnished with tables and chairs that accommodate or conform to patient needs.

Dining areas shall have a floor area of fifteen (15) square feet per patient in existing facilities and twenty (20) square feet per patient in new construction.

Dining areas shall allow for group dining at the same time in either separate dining areas or a single dining area, or dining in two (2) shifts, or dining during open dining hours.

Dining areas shall not be used for sleeping, offices or corridors.

Activity Areas: If provided, activity areas shall have space for patient socialization and leisure time activities. In addition:

(a) Activity areas shall have furnishings to accommodate group and individual activities.

(b) Activity areas shall have a floor area of at least fifteen (15) square feet per patient residing in bedrooms and may be combined with dining areas.

(c) Activity areas shall not be used for sleeping, offices, or as a corridor.

(d) The hospital shall make activity areas available to all patients.

Bathing Rooms: A hospital shall provide a bathing room consisting of a tub and/or shower adjacent to each bedroom or provide a central bathing

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Toilet Rooms: The hospital shall provide toilet rooms with hand-washing sinks for patient use.

(a) Existing facilities shall have a toilet and sink adjoining each bedroom or shared toilet rooms may provide one fixture per four licensed beds.

(b) New construction and new facilities shall have a toilet and sink fixture provided adjoining each patient room.

Patient Rooms: The hospital shall provide patient rooms which allow for sleeping, afford privacy, provide access to furniture and belongings, and accommodate inpatient care and treatment.

Patient Rooms:

(a) Shall not be located in any garage, storage area, shed or similar detached buildings;

(b) Shall not be accessed through a bathroom, food preparation area, laundry or another bedroom;

(c) Shall be located on an outside wall with a window with a minimum glass size of 8 square feet per patient. The window shall provide an unobstructed view of at least ten (10) feet;

(d) Shall contain at least twenty-five (25) cubic feet of storage volume per patient in dressers, closets or wardrobes; and

(e) If they have multiple beds, shall allow for an accessible arrangement of furniture, which provides a minimum of three (3) feet between beds.

room on each floor with patient rooms. Tubs and showers regardless of location shall be equipped with hand grips or other assistive devices as needed or desired by the bathing patient.

(a)

(b)

In new construction a central bathing room shall open off the corridor and contain a toilet and sink or have an adjoining toilet room, and not open directly in food preparation or dining area.

Bathing Fixtures: Existing and new facilities shall have at least one bathing fixture per twenty (20) licensed beds. New construction shall have at least one bathing fixture per twelve (12) licensed beds.

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Existing or New Facility: Patient rooms in existing and new facilities shall have at least the following floor areas:

(a) Floor areas for single patient rooms shall be one hundred (100) square feet.

(b) Floor areas for multiple bed patient rooms shall be eighty (80) square feet per bed with maximum of four (4) beds.

New Construction: Patient rooms in new construction shall have at least the following floor areas.

(a) Floor areas for single patient rooms shall be one hundred and twenty (120) square feet.

(b) Floor areas for multiple bed patient rooms shall be one hundred (100) square feet per bed with a maximum of two (2) beds.

Isolation Rooms: The number and type of isolation rooms in a hospital shall be determined by the hospital and based upon an infection control risk assessment. In addition:

(a) Facilities shall make provisions for isolating patients with infectious diseases.

(b) A hospital shall have a minimum of one isolation room with an adjoining toilet room.

(c) In new construction, facilities shall equip isolation rooms with hand-washing and gown changing facilities at the entrance of the room.

Observation Areas: If the hospital provides medical observation, extended recovery or behavior intervention methods, the hospital shall provide one or more appropriately equipped rooms for patients needing close supervision. Each room shall:

(a) Have appropriate temperature control, ventilation and lighting;

(b) Be void of unsafe wall or ceiling fixtures and sharp edges;

(c) Have a way to observe the patient, such as an observation window or if necessary, flat wall mirrors so that all areas of the room are observable by staff from outside of the room;

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(d) Have a way to assure that the door cannot be held closed by the patient in the room which could deny staff immediate access to the room; and

(e) Be equipped to minimize the potential of the patient's escape, injury, suicide or hiding of restricted substances.

Critical Care Rooms: If monitored complex nursing care is provided, the hospital shall provide one or more rooms for patients needing the care. Each room shall be appropriately located and equipped to promote staff observation of patients. Rooms with a single occupant shall have a minimum floor area of no less than one hundred and thirty (130) square feet. Multiple bed locations shall contain at least one hundred and ten (110) square feet per bed with a minimum of four (4) feet between beds. The room shall include provision for life support, medical gas, sleeping, and convenient bathing and toileting facilities.

Bassinets: Each bassinet shall have a minimum floor area of forty (40) square feet with at least three (3) feet between bassinets.

Cubicles: Patient care and treatment cubicles shall have a minimum floor area of sixty (60) square feet with at least three (3) feet between bedsides and adjacent side walls.

Examination Rooms: Each examination room shall have a minimum floor area of eighty (80) square feet and a minimum of three (3) feet clear dimension around three (3) sides of the examination table or chair.

Treatment Rooms: Treatment room for procedures performed under topical, local, or regional anesthesia without pre-operative sedation shall have a minimum floor area of one hundred and twenty (120) square feet and a minimum of ten (10) feet clear dimension.

Procedure Rooms: Procedure rooms for invasive and minor surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs shall have a minimum floor area of two hundred (200) square feet and a minimum of fourteen (14) feet clear dimension.

Operating Rooms: Operating rooms for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a minimum floor area of three hundred (300) square feet and a minimum of sixteen (16) feet clear dimension.

Corridors: The hospital corridors shall be wide enough to allow passage and be equipped as needed by the patient with safety and assistive devices to minimize injury. All stairways and ramps shall have handrails.

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Doors: The hospital doors shall be wide enough to allow passage and be equipped for privacy, safety, and with assistive devices to minimize patient injury.

All patient room, toilet, and bathing room doors shall provide privacy yet not create seclusion or prohibit staff access for routine or emergency care.

(a) In new construction all toilet and bathing rooms used by patients with less than fifty (50) square feet of clear floor area shall not have doors that solely swing inward.

(b) Doors may prevent escape and create seclusion where therapeutically required, such as emergency protective custody, detoxification and psychiatric locations.

Outdoor Areas: Any outdoor area for patient usage provided by the hospital shall be equipped and situated to allow for patient safety and abilities.

Hand-washing Sinks: The hospital shall provide a hand-washing sink equipped with towels and a soap dispenser in all examination, treatment, isolation and procedure rooms and which shall also be available for every four care and treatment cubicle locations. Two scrub sinks shall be available near the entrance of each operating room.

Privacy: In multiple bed patient rooms, visual privacy, and window curtains shall be provided for each patient. In new facilities and new construction the curtain layout shall totally surround each care and treatment location which will not restrict access to the entrance to the room, lavatory, toilet, or enclosed storage facilities.

Finishes: A hospital shall provide the following special room finishes:

(a) Washable room finishes should be provided in procedure rooms, existing isolation rooms, sterile processing rooms, workroom, laundry, and food-preparation areas shall have smooth, non-adsorptive, surfaces which are not physically affected by routine housekeeping cleaning solutions and methods.

Acoustic lay-in ceilings, if used, shall be non-perforated.

(b) Scrubbable room finishes provided in operating rooms and new isolation rooms shall have smooth, non-adsorptive, non-perforated surfaces that are not physically affected by harsh germicidal cleaning solutions and methods.

BUILDING SYSTEMS

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Hospitals shall have building systems that are designed, installed and operated in such a manner as to provide for the safety, comfort, and well being of the patient.

Water and Sewer Systems: The hospital shall have and maintain an accessible, adequate, safe and potable supply of water. Where an authorized public water supply of satisfactory quantity, quality, and pressure is available, the hospital shall be connected to it and its supply used exclusively.

The collection, treatment, storage, and distribution potable water system of a hospital shall be constructed, maintained, and operated in accordance with all provisions of the Safe Drinking Water Act, approved December 16, 1974 (88 Stat. 1660; 42 U.S.C.S. §§ 300f et seq.).

The water distribution system shall be protected with anti-siphon devices, and air-gaps to prevent potable water system and equipment contamination.

Continuously circulated filtered and treated water systems shall be provided as required for the care and treatment equipment used in the hospital.

The hospital shall maintain a sanitary and functioning sewage system.

Hot Water System: The hot water system shall have the capacity to provide continuous hot water at temperatures as required by these regulations.

Heating and Cooling Systems: The hospital shall provide a heating and air conditioning system for the comfort of the patient and capable of maintaining the temperature in patient care and treatment areas as follows:

In existing and new facilities the systems shall be capable of producing a temperature of at least seventy degrees Fahrenheit (70°F) during heating conditions and a temperature that does not exceed eighty-five degrees Fahrenheit (85°F) during cooling conditions.

In new construction the systems shall be capable of producing a temperature of at least seventy-five degrees Fahrenheit (75°F) during heating conditions and a temperature that does not exceed eighty degrees Fahrenheit (80°F) during cooling conditions.

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In new construction and new facilities, central air distribution and return systems shall have the following percent dust spot rated filters:

(a) General areas: thirty (30) +%; and

(b) Care, treatment, and treatment processing areas: ninety (90) +%.

Surgical areas shall have heating and cooling systems that are capable of producing room temperatures at a range between sixty-eight (68°F) and seventy-three degrees Fahrenheit (73°F) and humidity at a range between thirty (30) and sixty percent (60%) relative humidity.

Airflow shall move from clean to soiled locations. In new construction, air movement shall be designed to reduce the potential of contamination of clean areas.

Floors in operating rooms, procedure rooms and other locations subject to wet cleaning methods or body fluids shall not have openings to the heating and cooling system.

Ventilation System: All hospitals shall provide exhaust and clean air to prevent the concentrations of contaminants which impair health or cause discomfort to patients and employees.

(a) Existing facilities shall have adequate ventilation.

(b) New construction and new facilities shall provide a mechanical exhaust ventilation system for windowless toilets, baths, laundry rooms, housekeeping rooms, kitchens and similar rooms at ten air changes per hour.

(c) New construction shall provide mechanical ventilation system(s) capable of providing air changes per hour (hereafter "ACH") as follows:

(A) Care and treatment areas: five (5) ACH;

(B) Procedure and airborne isolation areas: fifteen (15) ACH; and

(C) Operating rooms: twenty (20) ACH.

(d) Hospitals shall provide an emergency backup ventilation system for all patient rooms without operable windows.

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Electrical System: The hospital shall have an electrical system that has sufficient capacity to maintain the care and treatment services that are provided and that properly grounds care and treatment areas.

(a)

(b)

New construction and new facilities shall have ground fault circuit interrupters protected outlets in wet areas and within six (6) feet of sinks.

All facilities shall provide the minimum average illumination levels as follows:

- (1) General purpose areas: five (5) foot candles;
- (2) General corridors: ten (10) foot candles;
- (3) Personal care and dining areas: twenty (20) foot candles;
- (4) Reading and activity areas: thirty (30) foot candles;
- (5) Food preparation areas: forty (40) foot candles;
- (6) Hazardous work surfaces: fifty (50) foot candles;
- (7) Care and treatment locations: seventy (70) foot candles;
- (8) Examination task lighting: one hundred (100) foot candles;
- (9) Procedure task lighting: two hundred (200) foot candles;
- (10) Surgery task lighting: one thousand (1000) foot candles; and
- (11) Reduced night lighting in patient rooms and corridors.

Essential Power System: Facilities shall have an emergency power generator for all care and treatment locations which involve general anesthetics or electrical life support equipment, and in emergency procedure and treatment rooms.

(a)

(b)

Existing and new facilities shall maintain emergency power for essential care and treatment equipment and lighting, medical gas systems, and nurse call systems.

New construction shall maintain emergency power for essential care and treatment equipment and lighting, medical gas systems, ventilation and heating systems, and nurse call systems.

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(c) Facilities with electrical life support equipment shall maintain essential power systems with an on-site fuel source. The minimum fuel source capacity shall allow for non-interrupted system operation.

Call Systems: Call systems shall be operable from patient beds (except at psychiatric or mental hospital beds), procedure and operating rooms, and recovery bed and toilet locations. The system shall transmit a receivable (visual, audible, tactile, or other) signal to on-duty staff which readily notifies and directs the staff to the location where the call was activated. In addition:

(a)

(b)

In new construction the call system shall have a dedicated emergency call device which allows activation by a patient from treatment rooms and cubicles, and toilet and bathing fixtures.

In locations where patients are unable to activate the call, a dedicated staff assist or code call device shall promptly summon other staff for assistance.

Medical Gas System: The hospital shall safely provide medical gas and vacuum by means of portable equipment or building systems as required by patient receiving care and treatment. In addition:

(a) The installation, testing, and certification of nonflammable medical gas, clinical vacuum, and air systems shall comply with the requirements of the Life Safety Code (National Fire Protection Association 101).

(b) The hospital shall identify portable and system components, and periodically test and approve all medical gas piping, alarms, valves, and equipment for patient care and treatment. The hospital shall document such approvals for review and reference.

HOUSEKEEPING AND MAINTENANCE

Each hospital shall provide a safe, clean and comfortable environment for patients.

Housekeeping and Maintenance: The hospital shall provide the necessary housekeeping and maintenance to protect the health and safety of patients. In addition:

(a) The hospital's buildings and grounds shall be kept clean, safe and in good repair.

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Equipment, Fixtures and Furnishings: The hospital shall provide and maintain all equipment, fixtures and furnishings clean, safe and in good repair. In addition:

(a) Common areas and patient areas shall be furnished with beds, chairs, sofas, tables and storage that is comfortable and reflective of patient needs.

(b) The hospital shall provide equipment adequate to meet the care and treatment needs of patients.

(c) The hospital shall establish and implement a process designed for routine and preventative maintenance of equipment and furnishings to ensure that the equipment and furnishings are safe and function to meet the intended use.

Linens: The hospital shall provide each patient with an adequate supply of clean bed, bath and other linens necessary for care and treatment. Linens shall be in good repair. In addition:

(b)

(c)

(d)

All garbage and rubbish shall be disposed of in such a manner as to prevent the attraction of rodents, flies and all other insects and vermin. Garbage shall be disposed of in such a manner as to minimize the transmission of infectious diseases and minimize odor.

The hospital shall provide and maintain adequate lighting, environmental temperatures and sound levels in all areas that are conducive to the care and treatment provided.

The hospital shall maintain and equip the premises to prevent the entrance, harborage or breeding of rodents, flies and all other insects and vermin.

(a) (b)

The hospital shall establish and implement procedures for the storage and handling of soiled and clean linens.

When the hospital provides laundry services, water temperatures to laundry equipment shall exceed one hundred and sixty degrees Fahrenheit (160°F) or the laundry may be appropriately sanitized or disinfected by another acceptable method in accordance with manufacturer's instructions.

The hospital shall develop and implement policies and procedures to ensure that any facility-owned pet does not negatively affect patients. The policies and procedures shall include:

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- (a) An annual examination by a licensed veterinarian;
- (b) Vaccinations as recommended by the licensed veterinarian that include, at a minimum, current vaccination for rabies for dogs, cats and ferrets;
- (c) Provision of pet care necessary to prevent the acquisition and spread of fleas, ticks and other parasites; and
- (d) Responsibility for care and supervision of the pet by facility staff.

Environmental Safety: The hospital shall be responsible for maintaining the environment in a manner that minimizes accidents. In addition:

- (a)
- (b)
- (c)

The hospital shall maintain the environment to protect the health and safety of patients by keeping surfaces smooth and free of sharp edges, mold or dirt; keeping floors free of objects and slippery or uneven surfaces and keeping the environment free of other which may pose a potential risk.

The hospital shall maintain all doors, stairways, passageways, aisles, or other means of exit in a manner that provides safe and adequate access for care and treatment.

The hospital shall provide water for bathing and hand-washing at safe and comfortable temperatures to protect patients from potential for burns or scalds.

The hospital shall establish and implement policies and procedures to monitor and maintain water temperatures that accommodate patient preferences, but not to exceed the following temperatures:

- (a) Water temperature at patient hand-washing fixtures shall not exceed one hundred and twenty degrees Fahrenheit (120°F).
- (b) Water temperatures at patient bathing and therapy fixtures shall not exceed one hundred and ten degrees Fahrenheit (110°F).

The hospital shall establish and implement policies and procedures to ensure hazardous/poisonous materials are properly handled and stored to prevent accidental ingestion, inhalation, or consumption of the hazardous/poisonous materials by patients.

The hospital shall restrict access to mechanical equipment which may pose a danger to patients.

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Disaster Preparedness and Management: The hospital shall establish and implement procedures to ensure that patient care and treatment, safety and well-being are maintained during and following instances of natural disasters, disease outbreaks, or other similar situations, including:

- (a) The hospital shall establish plans to move patients to points of safety or provide other means of protection in case of fire, tornado, or other natural disasters or the threat of ingestion, absorption, or inhalation of hazardous materials;
- (b) The hospital shall ensure that food, water, medicine, and medical supplies, and other necessary items for care and treatment are available and obtainable from alternate sources;
- (c) The hospital shall ensure that plans are in place to move and house patients in points of safety when the building or a portion of the building is damaged to the point it is uninhabitable. The damage may be due to fire, tornadoes or other disasters; and
- (d) The hospital shall ensure that plans are in place to provide for the comfort, safety and well-being of patients in the event of electrical or gas outage, heating, cooling or sewage systems failure, or loss or contamination of water supply.

DEFINITIONS

When used in this chapter, the following terms and phrases shall have the meanings ascribed:

Abuse - any knowing, reckless, or intentional act or omission by a provider that causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, injury, death, or financial exploitation of a patient.

Act - the Health -Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, D.C. Law 5-48 (D.C. Official Code § 44-501 et seq.).

Administrator - the person who is responsible for day-to-day operation of the facility to include the Medical Director.

Anesthesiologist - a licensed physician who is certified by the American Board of Anesthesiology or who has training and experience in the field of anesthesiology, substantially equivalent to that required for certification.

Communicable disease - Communicable disease - any disease denominated a communicable disease, including without limitation any illness due to an infectious agent or its toxic product, which is transmitted directly or indirectly to a well person from an infected person, animal, or ectoparasite; or any illness due to an infectious agent or its

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toxic product which is transmitted through the agency of an intermediate host, vector, or by exposure within the immediate environment. Communicable disease also shall mean any disease occurring as an outbreak of illness or toxic conditions, regardless of etiology in an institution or other identifiable group of people.

Conversion - the act of limiting a license to either a restricted or provisional status. District or D.C - the District of Columbia.

Dentist - any licensed person who is authorized to practice dentistry in accordance with the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99.

Department - the District of Columbia Department of Health. Director - the Director of the Department of Health.

Emergency room - any area in the hospital set up for the reception and treatment of persons in need of emergency medical care.

Hospital - a facility that provides twenty-four 24-hour inpatient care, including diagnostic, therapeutic, elective surgery, and other health-related services, for a variety of physical or mental conditions, and may in addition provide outpatient services, particularly emergency care.

Hospital, general - a hospital that has the facilities and provides the services that are necessary for the general medical and surgical care of patients, including the provision of emergency care by an Emergency Department.

Hospital, private - a hospital not operated by an agency of the United States of the District of Columbia.

Hospital, special - a hospital that:

- (a) Defines a program of specialized services, such as obstetrics, mental health, orthopedy, long term acute care, rehabilitative services or pediatric services;
- (b) Admits only patients with medical or surgical needs within the defined program; and
- (c) Has the facilities for and provides those specialized services.

Idle space - Hospital area that is not used for patient services or any activity related to patient services and is either (1) inactive, (2) under renovation or (3) inactive in anticipation of renovation..

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Infant - a young person between the ages of thirty (30) days and one (1) year. Infectious disease - a disease caused by an communicable agent.

Internist - a licensed physician who is certified by the American Board of Internal Medicine or who has training and experience in internal medicine substantially equivalent to that required for that certification.

Joint Commission - an independent, not-for-profit organization that evaluates and accredits health-care facilities in the United States.

Laboratory - any area in the hospital set up for chemical, bacteriological, and histopathological examinations.

Medical record - a hospital record of a patient that provides identifying information about the patient and information about his or her medical condition, progress, and treatment.

Near miss - any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome

Newborn - any newly delivered infant who is up to twenty-nine days old..

Nurse - a person who is licensed and currently registered to practice nursing in accordance with the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99.

Nurse, private duty - a licensed professional or practical nurse who is engaged directly by the patient or his or her representative for the purpose of rendering nursing care to that patient.

Nursery - a room in a newborn patient care unit used as a patient room for newborn infants.

Obstetrician - a licensed physician who is certified in obstetrics by the American Board of Obstetrics and Gynecology, or who has training and experience in obstetrics substantially equivalent to that required for that certification.

Oral surgeon - a dentist who is a diplomat of the American Board of Oral Surgery, or a member of the American Society of Oral Surgery, or who has training and experience substantially equivalent to that required to be a diplomat or member.

Patient - a person who has been admitted to a hospital for the diagnosis, treatment, or care of physical or mental conditions.

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Patient room - a room set aside for the accommodation, care, and treatment of a patient or patients.

Pediatrician - a licensed physician who is certified by the American Board of Pediatrics, or who has training and experience in pediatrics substantially equivalent to that required for that certification.

Person - any individual, firm, partnership, corporation, company, or association; and including any administrators, guardians, trustees, directors, and agents.

Public Hospital - a hospital owned and operated by the government.

Physician - a person currently licensed pursuant to the Health Occupations Revision Act of 1985, effective March 25, 1986, D.C. Law 6-99, D.C. Official Code Section 3-1201.01 et seq., to practice medicine and surgery, or a person licensed in another jurisdiction whose application for a license or registration is pending in the District.

Provisional License- a license issued to a facility which is not in substantial compliance with all applicable laws and regulations, but which is taking ameliorative action in accordance with a mutually agreed upon timetable to achieve compliance.

Psychiatrist - a licensed physician who is certified in psychiatry by the American Board of Neurology and Psychiatry, or who has substantial training and experience in psychiatry equivalent to that required for that certification.

Qualified Health Professional - a person licensed pursuant to the Health Occupations Revision Act of 1985, effective March 25, 1986, D.C. Law 6-99, D.C. Official Code Section 3-1201.01 et seq., to practice a health occupation in the District, and who is authorized under the terms of that Act to perform the activity referred to in the particular regulation.

Regular license- a license which is issued for one year to a facility which is in compliance with all applicable laws and regulations.

Restricted license- a license which permits operation of a facility but prohibits the facility from accepting new residents and patients or from delivering services that it would otherwise be authorized to deliver, or both.

Sentinel event - an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

Substantial Compliance- meeting the majority of rules without jeopardizing health and safety.

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Surgeon - a physician who is certified by the American Board of Surgery or who has training and experience in surgery substantially equivalent to that required for that certification.

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PREAMBLE

The Division of Nursing, through its registered nurses, provides the primary Service delivered to patients at Washington Hospital Center: nursing care. To ensure that the professional nursing staff have the ability to provide nursing services in the safest, highest-quality manner possible, work has been underway for approximately two years to review and assess the nature, location and frequency of problems that impede the nursing process. That work was undertaken through a provision in the collective bargaining agreement between the Washington Hospital Center and Nurses United establishing a joint labor/management Committee on Quality Patient Care. Specific recommendations, organized around the issues of equipment and supplies, professional culture and collaboration, clinical practice, safe staffing, and the patient care process, follow. However, certain over-arching principles frame these recommendations. Included among them:

- Paramount to the success of these recommendations and our ultimate goals, is an organizational culture that embraces and demonstrates a philosophy that every individual should be valued and treated with respect and dignity.
- As providers of the primary service delivered in WHC, staff nurses should participate equally in decision-making that affects their professional practice and the safety and quality of patient care. Decision-making includes: the unit level, the department/division level, the administrative level and the Board level.
- Communication and collaboration among and between departments, staff and committees is paramount to insuring the best possible milieu for care. The organization should foster and enhance the ability for exchange of information that can enhance safety and quality of care and maximize satisfaction among the patients, their families, and the healthcare staff.
- As defined by the Code of Ethics for Nurses, registered nurses have a primary professional responsibility to advocate for, and protect, those for whom they provide care. Paramount to this responsibility is the capacity of the professional nurse to report concerns and conditions that can lead to patient and staff injury or illness without fear of retribution.

In conclusion, there will be a continuous evaluation and process by the QPCC to insure implementation of these recommendations as evidenced by resolution of the identified problems.

Guidelines for Perinatal Care

Fourth
Edition

American Academy
of Pediatrics



The American College
of Obstetricians
and Gynecologists



Table 2-1. Recommended Nurse/Patient Ratios for Perinatal Care Services

Nurse/Patient Ratio	Care Provided
Intrapartum	
1:2	Patients in labor
1:1	Patients in second stage of labor
1:1	Patients with medical or obstetric complications
1:2	Oxytocin induction or augmentation of labor
1:1	Coverage for initiating epidural anesthesia
1:1	Circulation for cesarean delivery
Antepartum/ postpartum	
1:6	Antepartum/postpartum patients without complications
1:2	Patients in postoperative recovery
1:3	Antepartum/postpartum patients with complications but in stable condition
1:4	Recently born infants and those requiring close observation
Newborns	
1:6-8*	Newborns requiring only routine care
1:3-4	Normal mother-newborn couplet care
1:3-4	Newborns requiring continuing care
1:2-3	Newborns requiring intermediate care
1:1-2	Newborns requiring intensive care
1:1	Newborns requiring multisystem support
1:1 or greater	Unstable newborns requiring complex critical care

* This ratio reflects traditional newborn nursery care. If couplet care or rooming-in is used, a professional nurse who is responsible for the mother should coordinate and administer neonatal care. If direct assignment of the nurse is also made to the nursery to cover the newborn's care, there may be double assigning (one nurse for the mother-neonate couplet and one for just the neonate if returned to the nursery). A nurse should be available at all times, but only one may be necessary, as most neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the nurse's direct supervision. Adequate staff are needed to respond to acute and emergency situations.

Establishing Criteria for 1:1 Staffing Ratios

R. Colette Hartigan, RN, BSN, MBA, CCRN
Critical Care Nurse, Vol. 20, No. 2, April 2000

Criteria for 24-Hour 1:1 Nursing Care

Stability Level I

- Patients with unstable cardiac rhythms that cause hemodynamic compromise and necessitate frequent assessments, pharmacological interventions, and/or mechanical termination of the rhythm and patients who require external cardiac pacing and/or placement of a transvenous pacemaker
- Patients who experience hypertensive or hypotensive crisis and require rapid stabilization of blood pressure
- Patients with symptomatic cardiac tamponade who require immediate intervention on the unit including drainage and stabilization
- Patients who experience inadequate myocardial perfusion who exhibit ongoing symptoms of chest discomfort resulting in decreased cardiac output and severe hemodynamic instability
- Patients who develop symptomatic bleeding and require immediate intervention
- Patients who experience cardiac arrest and remain severely compromised requiring ventilatory and pharmacological support with continuous adjustments
- Patients who exhibit symptoms of extreme dyspnea, acute anxiety, orthopnea, and diffuse pulmonary congestion who are highly complex and vulnerable in the acute phase of their illness
- Patients who require insertion of an intracranial pressure monitoring device (ventricular drain or Camino) and demand continuous intracranial pressure monitoring with frequent assessment and interventions
- Patients with an acute change in neurological status who require continuous nursing assessment and interventions
- Nonventilated patients exhibiting life-threatening airway compromise who require frequent treatments and continuous observation
- Patients in metabolic crisis with multisystem compromise who require continuous monitoring, assessment, and interventions
- Patients who must leave the critical care area for a procedure or test and require continuous nursing assessment and monitoring for the duration of the test

Highly Complex Level I

- Patients assigned to a research protocol who require initiation into the study that necessitates documentation every 15 minutes or more often
- Patients who require a diagnostic or therapeutic intervention in conjunction with conscious sedation and recovery
- Patients who are potential organ donors who require immediate, extensive preparation and/or management
- Patients who are severely compromised and require continuous arteriovenous hemofiltration

- Patients who require pressure control ventilation in the acute stage of acute respiratory distress or ventilated patients in the critical stage of acute lung injury with high-PEEP and high oxygen requirements

Vulnerability Level I

- Patients whose families require frequent interventions including complex teaching and help resolving ethical concerns; for example, families who require counseling because they are considering terminating life support measures and/or donating organs for transplantation
- Patients exhibiting emotional trauma who require intensive care, collaboration, and coordination with other support services, including but not limited to victims of sexual assault

Resiliency Level I

- Patients in the acute phase of their illness who exhibit signs of confusion, sensory overload, or psychosis and require continuous assessment and immediate pharmacological interventions
- Patients who require continuous intravenous sedation and/or neuromuscular blockade for control of anxiety in the acute phase of their illness and those who exhibit withdrawal symptoms as they are weaned from long-term sedation.

<http://www.aacn.org/wd/certifications/content/synpract8.pcms?pid=1&&menu=practice>



Progressive Care FACT SHEET

Background

In the early 1970s, advertisements were placed in Heart and Lung by major medical center recruiters for both critical care and progressive care nurses. Initially, progressive care units were used to house post myocardial infarction patients who needed cardiac monitoring but who did not require intensive care and observation. As the health care environment began to change, the acuity of patients admitted to the hospital steadily increased and with it the demand for critical care beds also increased. With an increased demand for and decreased availability of critical care beds, patients were often transferred from critical care units while still requiring an increased level of nursing care and vigilance. Patients who were admitted to critical care units five years ago are now routinely admitted to progressive care.

Progressive care is the term the American Association of Critical-Care Nurses (AACN) uses to collectively describe areas that are also referred to as Intermediate Care Units, Direct Observation Units, Step-down Units, Telemetry Units, or Transitional Care Units as well as to define a specific level of patient care. AACN recognizes the need to define and identify the special needs of progressive care nurses. In 2001, a task force and advisory panel were created to define the progressive care environment and patient populations served, as well as the core competencies and basic knowledge and skill requirements of progressive care nurses.

Definition

The American Association of Critical-Care Nurses recognizes progressive care as part of the continuum of critical care. AACN's vision is dedicated to creating a healthcare system driven by the needs of patients and families where critical care nurses make their optimal contribution. The AACN Synergy Model for Patient Care is the conceptual framework that actualizes the vision. It defines nursing practice based on the needs of the patient and the characteristics of the nurse to attain optimal patient outcomes.

Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require increased intensity of care and vigilance. Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

Progressive Care Patient Location

Using AACN's Synergy Model will assist in defining the progressive care patient. The Synergy Model identifies patients based on the characteristics and needs that they present and not on the location of the bed they occupy. As in critical care, the geographic domain of progressive care is expanding. Care provided to progressive care patients is not limited by geography but is based on the needs and required

interventions of the patient. While specific progressive care units can be identified, patients requiring progressive care nursing can be located throughout the hospital.

Progressive care can be very specialized, with care focused on a specific system such as cardiac, or more generalized, as in the care of patients with multi-system problems.

Educational Requirements

Progressive care nursing has expanded beyond the basic cardiac telemetry that marked its beginning and now encompasses many of the same technologies and therapies that were once limited to critical care units. To meet the changing needs of the patient, nurses caring for progressive care patients must demonstrate competencies that are influenced by ever changing technology. Progressive care nurses must demonstrate the following core competencies:

- Dysrhythmia monitoring techniques
- Basic & advanced life support
- Basic dysrhythmia interpretation and treatment
- Drug dosage calculation, continuous medication infusion administration, and patient monitoring for medication effects (i.e., non-titrated vasoactive agents, platelet inhibitors, anti-arrhythmic agents, and insulin)
- Patient monitoring using standardized procedures for pre, intra, and post procedures (i.e.; cardioversion, TEE, cardiac catheterization with PCI, bronchoscopy, EGD, PEG placement, chest tube insertion)
- Hemodynamic monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability
- Recognition of the signs and symptoms of cardiopulmonary emergencies and initiation of standardized interventions to stabilize the patient awaiting transfer to critical care
- Interpretation of ABGs and communication of findings
- Recognition of indications for and management of patients requiring non-invasive O2 delivery systems including oral airways, bipap, and nasal CPAP
- Assessment of the ventilated patient to assure delivery of the prescribed treatment and patient response
- Assessment and understanding of long term mechanical ventilation and weaning
- Recognition of the indications for and complications of enteral and parental nutrition
- Assessment, monitoring and management of patients requiring renal therapeutic interventions; For example hemodialysis, peritoneal dialysis, stents, continuous bladder irrigation, and urostomies
- Recognition of and evaluation of the family's need for enhanced involvement in care to facilitate the transition from hospital to home

According to the Synergy Model, stability, complexity, vulnerability, resiliency, predictability, resource availability, participation in care and participation in decision making are the patient characteristics that describe patient function. The nurse characteristics that typically represent comprehensive nursing practice include clinical judgment, advocacy, caring practices, collaboration, systems thinking, response to diversity, clinical inquiry and learning facilitator. The framework therefore takes into account the unpredictability of the progressive care patient, and based on the patient and family's needs the competencies of the progressive care nurse.

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