

**WEST VIRGINIA  
SECRETARY OF STATE**

**KEN HECHLER**

**ADMINISTRATIVE LAW DIVISION**

Form #3

Do Not Mark In this Box

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**Jan 7 3 32 PM '94**

**OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE**

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE  
AND  
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: Department of Health and Human Resources TITLE NUMBER: 64

CITE AUTHORITY §16-5B-8

AMENDMENT TO AN EXISTING RULE: YES  NO

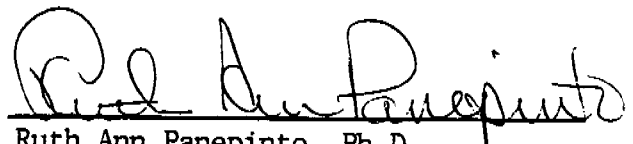
IF YES, SERIES NUMBER OF RULE BEING AMENDED: 12

TITLE OF RULE BEING AMENDED: Hospital Licensure

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: \_\_\_\_\_

TITLE OF RULE BEING PROPOSED: \_\_\_\_\_

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

  
Ruth Ann Panepinto, Ph.D.  
Secretary

27.90

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FISCAL NOTE FOR PROPOSED RULES

JAN 7 3 33 PM '94

Rule Title: Hospital Licensure

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

Type of Rule: X Legislative            Interpretive            Procedural

Agency Department of Health and Human Resources

Address Building 3, Capitol Complex

Charleston, W. Va. 25305

1. Effect of Proposed Rule

	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	\$	\$	\$ 0	\$ 0	\$ 0
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					

2. Explanation of above estimates.

The adoption of the proposed revisions of hospital licensure standards will neither increase or decrease the cost of the State licensure program.

3. Objectives of these rules:

The purpose of the proposed amendments to Hospital Licensure is to revise or delete certain outmoded hospital licensure standards which are creating problems due to their variance from current standards of good hospital practice. Additionally references to outdated State and national standards have been clarified and updated, and extensive stylistic revisions have been made for purposes of clarification, elimination of duplicated standards, and conformance with current Department procedures and legislative rule drafting standards.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific Groups of Citizens.

None.

C. Economic Impact on Citizens/Public at Large.

None.

Date November 19, 1993

Signature of Agency Head or Authorized Representative

A handwritten signature in cursive script, appearing to read "Ruth Ann Panepinto", written over a horizontal line.

Ruth Ann Panepinto, Ph.D., Secretary  
Department of Health and Human Resources

DATE: January 7, 1994  
TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE  
FROM: Department of Health and Human Resources  
LEGISLATIVE RULE TITLE: Hospital Licensure, 64 CSR 12

1. Authorizing statute(s) citation W.Va. Code §16-1-8

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2. a. Date filed in State Register with Notice of Hearing:  
November 18, 1993

b. What other notice, including advertising, did you give of the hearing?

Mailed Notice of Comment Period and proposed changes to various health care professional licensing boards and associations, hospitals, and local health departments.

c. Date of hearing(s): Public comment period ended December 20, 1993

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received \_\_\_\_\_

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

January 7, 1994

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f. Name and phone number of agency person to contact for additional information:

Kay Howard, 558-3223

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3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

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b. Date of hearing: \_\_\_\_\_

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

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d. Attach findings and determinations and reasons:

Attached \_\_\_\_\_

## RULE ABSTRACT

Agency: Department of Health and Human Resources

Rule Title: Hospital Licensure

CSR Title and Series: 64 CSR 12

Type: Legislative

Summary: The purpose of the proposed amendments to Hospital Licensure is to revise or delete certain outmoded hospital licensure standards which are creating problems due to their variance from current standards of good hospital practice. Additionally references to outdated State and national standards have been clarified and updated, and extensive stylistic revisions have been made for purposes of clarification, elimination of duplicated standards, and conformance with current Department procedures and legislative rule drafting standards.

The Department proposes substantive and major revisions to the rule are as follows:

1. A new Section 2.3 conforms with W. Va. Code §16-5B-1 regarding exemptions;
2. Former Section 4 was not consistent with the current rule-making procedures mandated by W. Va. Code §§29A-1-1 through 3 and has been deleted. Former Sections 5 and 6 have been revised for clarification and conformity with actual current administrative procedures and are now Sections 4, 5 and 6.
3. In Sections 3 and 7.3, criteria relative to consumers on hospital boards have been simplified in order to permit more individuals to be able to qualify as persons whose income is less than the national median income.
4. The requirement that verbal and telephone orders be given only to a registered professional nurse has been deleted. Section 10.3.1.h adopts the current federal and Joint Commission on the Accreditation of Health Care Organizations standard which permits individual hospitals to determine which licensed or certified personnel may receive verbal and telephone orders through policies and procedures set by the hospital's medical staff.
5. Section 11.11.4 adds a new set of requirements concerning the financial rights and responsibilities of hospitals and residents of extended care facilities operated by hospitals. These new standards limit the circumstances under which a resident may be discharged or transferred to another facility, require hospitals to provide protection against loss of resident funds administered by the hospital, and prohibit hospital employees from being named as committee or guardian for an extended care resident. These standards relate to financial matters and

have no impact on the reliance of hospitals on State law relating to advance directives regarding treatment or the 1993 Surrogate Health-Care Act related to selecting decision maker for an incapacitated adult who has no committee or guardian.

6. The requirement in Section 12.2 for a hospital to maintain an emergency service has been deleted, although the rule retains standards applicable if the service is provided. Small rural hospitals are no longer expected to maintain this type of service.

7. A recommendation that hospitals provide separate space for adjunct services such as EKG has been made mandatory in Section 13.4.1.

8. Provisions have been added to permit the use of health care personnel other than nurses to provide supportive nursing care services in emergency, cardiac and intensive care settings under the direction of a registered professional nurse.

For further information contact: John J. Jarrell, Program Administrator, or Lynda Kramer, Director, Office of Health Facility Licensure and Certification, Bureau of Public Health, Department of Health and Human Resources, Building 3, Capitol Complex, Charleston, West Virginia, 25305, telephone 558-0050 or the Office of Regulatory Development, Operations, Department of Health and Human Resources, telephone 558-3223.

11/19/93

**FILED**

**Jan 7 3 33 PM '94**

**OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE**

**[PROPOSED]  
TITLE 64**

**WEST VIRGINIA ADMINISTRATIVE RULES  
DIVISION OF HEALTH**

**HOSPITAL LICENSURE  
64 CSR 12**

**199\_**

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**For Filing with the Legislative Rule-Making Review Committee  
January 7, 1994**

[PROPOSED]  
WEST VIRGINIA ADMINISTRATIVE RULES  
DIVISION OF HEALTH  
HOSPITAL LICENSURE  
64 CSR 12

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[PROPOSED]  
TITLE 64  
WEST VIRGINIA ADMINISTRATIVE RULES  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

FILED

Jan 7 3 33 PM '94

SERIES 12  
HOSPITAL LICENSURE

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

§64-12-1. General.

1.1. ~~Scope - These legislative rules establish rules~~ This legislative rule establishes standards and procedures for the licensing of hospitals.

1.2. Authority - §16-5B-8.

1.3. Filing Date -

1.4. Effective Date -

1.5. ~~Supersession and Repeal of Former Regulations - This rule supersedes and repeals~~ amends and reenacts Hospital Licensure, West Virginia Department of Health Legislative Rules, Series 12, 1983 64 CSR 12, 1987.

§64-12-2. Application and Enforcement.

2.1. ~~Application - These legislative rules shall apply to every person, partnership, association, corporation or any local governmental unit or any division, department, board or agency thereof which shall operate or apply to operate a hospital as defined in these rules and in Chapter 16, Article 5B of the West Virginia Code of 1931, as amended, except as herein specified.~~ This rule applies to any person, partnership, association, corporation or local governmental unit or any division, department, board or agency thereof which establishes, maintains or operates a hospital or an extended care facility in connection with a hospital.

2.2. ~~Enforcement - The enforcement of these rules is vested with the West Virginia department of health.~~ This rule is enforced by the director of the division of health or his or her designee.

§64-12-3. Definitions.

(Note: In addition to changes in the text of various definitions, which are indicated by strike-through and underlining, the definitions have been rearranged in alphabetical order. Former Sections 7.2.2.a through j have been incorporated into the definition section.)

3.1. Applicable Hospital - means all nonprofit hospitals, A nonprofit hospital, whether governed by an in-state or out-of-state board of directors, and all hospitals or a hospital owned by a county, city or other political subdivision of the State of

West Virginia, except for existing nonprofit hospitals which are owned and have been were owned prior to March 9, 1983, by a corporation incorporated in another state.

~~3-1-~~ 3.2. Applicant - Shall-mean The person who submits an application for a license, or a renewal of a license, to operate a hospital, sanitarium or extended care facility operated in connection with a hospital.

~~3-3-~~ 3.3. Bed Capacity - Means The greatest number of beds the hospital is licensed to offer for patient care. No-hospital shall-admit-more-patients-than-the-number-of-beds-for-which-it-is-licensed-except-in-the-case-of-public-catastrophe-or-emergency, and-then-only-as-a-temporary-measure.

3.4. Board of Directors or Board - means The voting members of the governing authority of an applicable a hospital, or if a religious organization holds a hospital license, means the hospital board established by the religious organization.

3.5. Consumer Representative - means A member of an applicable-hospital's a Section 7.2.2 hospital's board of directors who-has-been-designated-as-such-by-the-board-by-virtue-of-qualifying-as-a-person-from-one-(1)-of-the-four-(4)-consumer-categories-and-who-is-not-a-member-of-management-of-the-applicable-hospital-nor-a-member-of-management-of-one-(1)-of-its-related-organizations; who is not a member of management of the hospital or one (1) of its related organizations, and who has been designated by the board as a person representing of one (1) of the following four (4) consumer categories: small businesses; organized labor; elderly persons; or persons whose income is less than the national median income.

3.6. Director - The director of the division of health of the department of health and human resources.

3.7. Elderly Persons - means-persons Individuals who are sixty (60) years of age or older.

~~3-6-~~ 3.8. Extended Care Facility - Means A hospital or a distinct-part unit thereof engaged in-providing-to-inpatients which provides skilled nursing and related services for long-term care patients (exclusive-of-tubercular-or-mentally-ill-persons) who require medical, nursing and rehabilitation other professional health care services.

3.9. Facility - Hospital or extended care facility.

3.10. Family - means A group of two (2) or more persons related by blood, marriage or adoption who reside together.

~~3-4-~~ 3.11. Hospital - Means Any institution, place, building or agency in which an accommodation of five (5) or more beds

is maintained, furnished or offered for the hospitalization of the sick or injured.

~~3-5- 3.12. Hospitalization - is defined as~~ The reception, in-house accommodation, and care of any person for a continuous period longer than twenty-four (24) hours, for the purpose of providing room, board, ~~nursing-service- and medical,~~ nursing and other professional health care services. ~~and other hospital-facilities-required-in-connection-with-diagnosis-and-treatment-of any-condition-or-infirmity-~~

~~3-7---License---Means-The document-issued-by-the-state-department-of-health--and--constitutes-the-authority-to-receive patients-and-perform-services-included-within-the-scope-of-these regulations-~~

3.13. Member of Management - means Any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such-action these actions, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

3.14. Organized Labor Members - means Members of organized labor unions covered by the National Labor Relations Act, the Railroad Labor Act or other federal labor acts.

~~3-2- 3.15. Person - Shall-include~~ Any individual, partnership, association, corporation, or any local governmental unit or any division, department, board, or agency thereof.

3.16. Persons Whose Income is Less than the National Median Income - means:--(1) Individuals whose gross family income, is ~~less-than-the-national-median-family-income,-or-(2)-individuals whose-gross-personal-income-is-less-than-the-national-median income-of-unrelated-individuals-~~ or gross individual income in the case of individuals not residing with a family member, is less than the national median family income. The director of health shall establish and periodically revise the national median family income figures-for-families-and-unrelated-individuals figure after consideration of Bureau of Census Current Population Reports, Consumer Income, Series P-60.

3.17. Principal Stockholder - means Any person who beneficially owns, holds or has the power to vote ten percent (10%) or more of any class of securities issued by a corporation.

3.18. Section 6a Hospital - Applicable hospital.

3.19. Small Business Representatives - means Officers, directors, general partners, sole owner or principal stockholders

of any activity subject to business taxation, which activity employs fewer than one hundred (100) full-time employees or which had gross annual receipts of less than four (4) million dollars, based on 1984 dollars, in its last fiscal year.

3.20. Swing Bed - A bed which is approved for dual use and reimbursement under the federal medicare program for both acute and extended care.

3.21. Unit Dose - The ordered amount of a drug dispensed by a pharmacist in a dosage form ready for administration to a particular person by the prescribed route at the prescribed time.

~~3-8- 3.22. Violations - Means Failure to comply with the licensing law or any provisions of these regulations this rule. A violation constitutes a misdemeanor as set forth in Section 11, Article 5B, Chapter 16, Code of West Virginia, 1931, as amended W.Va. Code §16-5B-11.~~

~~§64-12-4--Procedures-Governing-Adoption,-Amendment-and-Recision of-Regulations~~

~~The-state-department-of-health,-with-the-advice-and-counsel of-the-advisory-board,-shall-have-the-power-to-make,-enforce, modify,-amend-or-rescind-rules-and-regulations-governing-the operation-and-conduct-of-hospitals-and-other-related-institutions,-as-specified-in-Section-8,-Article-5B,-Chapter-16,-Code-of West-Virginia,-1931,-as-amended-~~

~~§64-12-5--Inspections-~~

~~5-1--Duly-authorized-representatives-of-the-state-department-of-health-shall-have-the-right-to-enter-upon-or-into-the premises-of-any-hospital-in-order-to-make-whatever-inspection-is deemed-necessary-in-accordance-with-the-licensing-authority-vested-in-the-department-~~

~~5-2--All-institutions-which-are-required-to-be-licensed under-the-provisions-of-Article-5B,-Chapter-16,-Code-of-West Virginia,-1931,-as-amended,-shall-comply-with-and-conform-to-all laws-of-the-state-of-West-Virginia,-and-all-rules-and-regulations which-provide-minimum-standards-for-the-prevention-of-fire-and for-the-protection-of-life-and-property-against-loss-or-damage-by fire-or-panic--A-certificate-of-approval-shall-be-obtained-from the--State--Fire--Marshal--by--any--institution--required--to--be licensed---Written-approval-of-the-institution-shall-be-filed with-the-state-department-of-health-and-a-copy-of-such-certificate-shall-be-posted-in-a-conspicuous-place-on-the-premises-of the-licensee-~~

~~§64-12-6--The-license-~~

~~6-1--Institutions-To-Be-Licensed---A-license-is-required-of~~

all-places-that-are-conducted-as-hospitals,-within-the-meaning-of-the-term-as-defined-in-Section-3,-of-these-regulations-and-in-Section-1,-Article-5B,-Chapter-16,-Code-of-West-Virginia,-1931,-as-amended,-provided-that-such-place-is-not-specifically-excluded-by-the-Code.

#### 6.2.--Institutions-Exempted-From-These-Regulations-

6.2.1.--Hospitals-operated-by-the-federal-government-or-the-state-government.

6.2.2.--Institutions-regularly-licensed-by-the-department-of-welfare,-such-as-child-caring-institutions,-day-nurseries,-child-care-centers-and-foster-boarding-homes.--However,-institutions-having-dual-functions,-one-(1)-of-which-is-clearly-subject-to-licensure-under-these-regulations,-are-not-exempt.

6.2.3.--Homes-or-institutions-regularly-licensed-by-the-West-Virginia-nursing-home-licensing-board.

6.2.4.--First-aid-stations-and-emergency-care-facilities-which-do-not-provide-accommodations-for-hospitalization.

#### 6.3.--Application-For-License.

6.3.1.--Applicants-for-license-shall-file-applications-with-the-bureau-of-hospitals-and-medical-facilities,-state-department-of-health-upon-forms-prescribed-by-the-department-and-shall-pay-an-annual-fee-as-required-in-Section-4,-Article-5B,-Chapter-16,-Code-of-West-Virginia-as-follows:--"Those-with-five-beds-but-less-than-50-beds-shall-pay-a-fee-of-\$20.00,-those-with-50-beds-or-more-and-less-than-100--beds-shall-pay-a-fee-of-\$30.00,-those-with-100-beds-or-more-and-less-than-200-beds-shall-pay-a-fee-of-\$40.00,-and-those-with-200-beds-or-more-shall-pay-a-fee-of-\$50.00."--No-such-fee-shall-be-refunded.

6.3.2.--Furnishing-of-an-application-form-is-in-no-way-a-guarantee-that-the-completed-application-will-be-acceptable-or-that-a-license-will-be-issued-by-the-state-department-of-health.

6.3.3.--Each-new-applicant-must-provide-at-least-two-(2)-letters-of-reference-from-reputable-citizens-with-whom-he-is-personally-acquainted-and-who-certify-to-his-character-and-qualifications.

6.3.4.--Each-application-for-license-shall-specify-the-maximum-number-of-beds-established-by-the-state-department-of-health-as-the-institution's-legal-bed-capacity.

6.3.5.--Every-hospital-shall-be-specifically-identified-as-such-by-an-appropriate-name,-which-shall-be-used-in-applying-for-the-license.--It-shall-not-be-changed-without-the-approval-of-the-state-department-of-health.

**6.4. -- Issuance of License:**

6.4.1. -- The license will be issued on a form prescribed by the state department of health and shall set forth the name, location, type of ownership, type of institution and number of beds for which the institution is licensed.

6.4.2. -- The license shall be posted in a conspicuous place on the licensed premises.

6.4.3. -- The license is not transferable or assignable. -- The state department of health shall be immediately notified of any change relative to the ownership, locations or operation of the institution, and an application for a new license shall be requested.

6.4.4. -- Each license is separate and distinct and shall be issued to a specific licensee for a specific location which is to be indicated on the license certificate. -- The institution shall be operated and conducted in the name of the licensee as indicated on the license certificate.

6.4.5. -- Only one (1) license shall be required for any person, partnership, association, corporation, or any local governmental unit or any division, department, board or agency thereof who operates any combination of a hospital, sanatorium or extended care facility operated in connection with a hospital, or more than one (1) thereof, at the same location.

**6.5. -- Expiration and Renewal of License:**

6.5.1. -- All licenses shall expire on the thirtieth of June following the date of their issuance unless continued pursuant to the provisions of Section 47-Article 5B, Chapter 16, Code of West Virginia, 1931, as amended.

6.5.2. -- Applications for the renewal of licenses will be mailed to each institution, and shall be completed and returned by the applicant, with the required license fee, to the state department of health, before April 30. -- The renewal of a license shall be contingent upon evidence of compliance with the licensing law and all minimum standards and regulations. -- Each applicant will be duly notified of any noncompliances and shall comply with the provisions of the law rules and regulations before the issuance of a license.

**6.6. -- Revocation and Reissuance of License:**

6.6.1. -- After an opportunity for a hearing, the state department of health may revoke the license of any institution found in violation of the licensing law or the rules and regulations issued pursuant thereto.

~~6-6-2---If-a-license-is-revoked,-a-new-application-for-a license-will-be-considered-by-the-state-department-of-health-when the-conditions-upon-which-revocation-was-based-have-been-corrected-and-evidence-of-this-fact-has-been-furnished-~~

~~6-6-3---Each-license-shall-be-returned-by-the-licensee-to the-state-department-of-health-immediately-upon-its-revocation, or-when-the-institution-voluntarily-ceases-operation-~~

§64-12-4. State Administrative Procedures.

4.1. License Required.

4.1.1. No person, partnership, association, corporation, or any local governmental unit or any division, department, board or agency thereof may establish, conduct or maintain in West Virginia any hospital or extended care facility operated in connection with a hospital without first obtaining a license: Provided, That only one (1) license is required for any person, partnership, association, corporation or any local governmental unit or any division, department, board or agency thereof who operates any hospital, extended care facility operated in connection with a hospital, or more than one thereof, at the same location.

4.1.2. A license is not transferable or assignable.

4.1.3. If the ownership of a facility with a valid unexpired license changes, the new owner shall immediately apply for a new license. The application of the new owner for a license has the effect of a valid license for three (3) months from the date the application is received by the director.

4.1.4. Any change in locations, the total or numbers of types of beds or other operation of the facility requires the issuance of a new license. The facility shall notify the director of any proposed change in the locations, the total or numbers of types of beds, or operation of the facility, and shall request an application form for a new license.

4.2. Application For License.

4.2.1. Applicants for a license shall complete and submit an application to the department on forms provided by the director and shall pay the annual fee as required by W.Va. Code §16-5B-4. The name used on the application forms shall be the legal name of the facility.

4.2.2. The application for license shall specify the facility's proposed total bed capacity and the numbers of beds categorized by service provided, including newborn, intensive care nursery and swing beds.

4.2.3. A section 6a hospital shall include a list of the

voting members of its board of directors who have been designated as consumer representatives and which of the consumer members are women, members of racial minorities, or handicapped in its application for licensure.

4.3. Issuance of License.

4.3.1. The director shall issue a license if:

4.3.1.1. The facility is in compliance with this rule and applicable sections of W. Va. Code §§16-5B-1 et seq.;

4.3.1.2. The facility is in compliance with the rules of the State fire commission;

4.3.1.3. Has submitted a complete application, with all required documentation;

4.3.1.4. In the case of a project reviewable under W. Va. Code §16-2D-1 et seq., the State health planning and development agency has issued a finding, after a final conformance review, that the completed project conforms to the terms of the certificate of need decision issued for the project; and

4.3.1.5. In the case of a section 6a hospital, the composition of the hospital's board of directors is in conformance with Section 7.3 of this rule or a plan of correction has been accepted, except, a license shall not be withheld for noncompliance with Section 7.3 of this rule in the case of the corporation defined in W.Va. Code §18-11C-1(d).

4.3.2. The director issues a separate license for each separate and distinct location of the hospital or extended care facility.

4.3.3. The license states the legal name of the facility to which it applies, the location of the facility, the maximum number of beds classified by type for which it is granted, and the dates of issuance and expiration of the license.

4.4. Expiration and Renewal of License.

4.4.1. All licenses expire on the thirtieth day of June following the date of their issuance unless continued pursuant to the provisions of W. Va. Code §16-5B-4.

4.4.2. Licensed hospitals and extended care facilities shall annually complete and return applications for licensure renewal with the required license fee to the director on or before April 30. The director mails licensure renewal forms to each licensed hospital and extended care facility.

4.4.3. A section 6a hospital shall include a list of the

voting members of its board of directors who have been designated as consumer representatives and which of the consumer members are women, members of racial minorities, or handicapped in its application for license renewal.

4.4.4. The director shall renew a license if:

4.4.4.1. The facility is in compliance with the provisions of this rule and W. Va. Code §§16-5B-1 et seq.;

4.4.4.2. The facility is in compliance with the rules of the State fire commission;

4.4.4.3. In the case of a project reviewable under W. Va. Code §16-2D-1 et seq., the State health planning and development agency has issued a finding, after a final conformance review, that the completed project conforms to the terms of the certificate of need decision issued for the project;

4.4.4.4. In the case of a section 6a hospital, the composition of the hospital's board of directors is in conformance with Section 7.3 of this rule or a plan of correction has been accepted; except, a license shall not be withheld for noncompliance with Section 7.3 of this rule in the case of the corporation defined in W.Va. Code §18-11C-1(d).

4.4.4.5. The facility has submitted the appropriate fee according to the provisions of W. Va. Code §16-5B-4.

4.5. Inspections.

4.5.1. The director has the right to enter upon or into the premises of any hospital or extended care facility in order to make inspections necessary to determine compliance with this rule.

4.5.2. The director shall notify a facility of any violations of this rule.

§64-12-5. Penalties.

5.1. After an opportunity for a hearing, the director may revoke the license of any hospital or extended care facility found in violation of this rule.

5.2. If the director revokes a license, the director shall consider a new application for a license when there is evidence that the conditions upon which revocation was based have been corrected.

5.3. A license shall be returned by the licensee to the director immediately upon its revocation, or when the hospital or extended care facility voluntarily ceases operation.

**§64-12-6. Miscellaneous Requirements.**

6.1. Every hospital shall be specifically identified as a hospital in its legal name, and it shall operate and conduct business in this name. Any word which suggests a type of facility other than a hospital shall not be used in the name of a hospital.

6.2. A hospital may not change its name without the written approval of the director. A hospital shall submit a written request for a change in its name. An approved name change is shown in the next license issued.

6.3. All hospitals and extended care facilities are required to comply with applicable rules of the State fire commission and the State air pollution control commission.

6.4. The hospital or extended care facility shall post its license in a conspicuous place on the licensed premises.

6.5. No hospital shall admit more patients than the number of beds for which it is licensed except in the case of public catastrophe or emergency, and then only as a temporary measure.

**§64-12-7. Administration of the Hospital.****7.1. Scope**

The governing body, owner or board of trustees is the highest authority responsible for the management and control of the entire institution including employment of a hospital administrator and appointment of medical staff. The administrator is responsible for the direction and control of the hospital operation in accordance with policies established by the governing authority. The medical staff is responsible for the quality of medical care provided and for submitting reports on the quality of this care to the governing board of the hospital at frequent intervals.

**7.2. Governing Authority.**

7.2.1. There shall be a governing authority legally and morally responsible for the management and control of the hospital. In the discharge of its duties, the governing authority places responsibility for the care of patients upon the medical staff. It is responsible for the establishment of policies.

a. The governing authority shall adopt and amend bylaws which shall require that-body it to:

- (1) Appoint members to the medical staff;
- (2) Approve the bylaws and regulations of the medical

staff;

(3) Define the committees of the governing authority and the functions and responsibilities thereof;

(4) Develop and maintain suitable formal liaison with the medical staff by means of a joint conference committee;

(5) Appoint a full-time qualified administrator and delegate to him or her executive authority and responsibility; and

(6) Provide for the proper control of all assets and funds, including annual audits thereof.

~~b. Minutes of all meetings of the governing authority and of its committees, including a record of attendance, shall be recorded, signed and retained in the hospital as a permanent record.~~

b. The governing authority shall record, sign and retain in the hospital as a permanent record minutes of all of its meetings and of its subcommittees, including a record of attendance.

c. The governing authority shall ~~be~~ is responsible for providing a safe physical plant equipped and staffed to maintain adequate facilities and services for hospital patients. [or just say "is responsible for ..."]

### 7.3. Consumers on Boards of Directors of Certain Hospitals.

~~7.2.2.~~ 7.3.1. The boards of directors of applicable section 6a hospitals shall designate at least forty percent (40%) of their voting members as consumer representatives with an equal portion of such the representatives in the four (4) consumer categories of small business representatives, organized labor members, elderly persons and persons whose income is less than the national median income, except if, when 0.40 is multiplied by the number of the voting members, the product, when rounded to the next higher whole number, is not a multiple of four (4), then the number of representatives in the consumer categories may be unequal, provided that the number of representatives in any consumer category is only one (1) consumer in excess of the number of consumers in any other consumer category.

~~As used in subsections 7.2.2 through 7.2.9:~~

(~~§§~~7.2.2.a through 7.2.2.j have been moved to §3, Definitions)

~~k. "Unrelated individuals" means persons fifteen (15) years old and over (other than inmates of institutions) who are not living with any person related to them by blood, marriage or adoption.~~

~~7.2.3. After the effective date of this rule all applicable hospitals shall include in their next application for hospital licensure a list of the voting members of its board of directors who have been designated as: (1) consumer representatives; and (2) such the members who are women; members of racial minorities; or who are handicapped.~~

7.3.2. No member of the board of directors of a section 6a hospital shall be designated by the hospital in more than one (1) consumer representative category. Within ninety (90) days of the effective date of these rules, all applicable hospitals shall either be in compliance with Section 7.2 of these rules or shall have on file with the department of health an accepted plan of correction for coming into compliance. Thereafter, (1) such information shall be provided annually to the department in the applicable hospital's license application, and (2) a license shall not be issued unless the composition of an applicable hospital's board of directors is in conformance with Section 7.2 of these rules or a plan of correction has been accepted; except, a license shall not be withheld for noncompliance with this regulation in the case of the corporation defined in West Virginia Code Chapter 10, Article 11C, Section 17, Subdivision (d) or in the case of Cabell County General Hospital as its board of directors exists under the authority of Chapter 157 of the Acts of the Legislature, regular session, 1945 and Chapter 166 of the Acts of the Legislature, regular session, 1947.

~~7.2.4.~~ 7.3.3. An applicable A section 6a hospital may change the designation of its consumer representatives from one (1) category to another by filing the change with the department of health director.

~~7.2.5.~~ 7.3.4. If a person designated as a consumer representative on an applicable a section 6a hospital's board of directors ceases to meet the definition of a consumer representative, then the person may retain his or her designation until the end of his or her term or until the next license application is submitted for the applicable hospital, whichever occurs first.

~~7.2.6-a.~~ 7.3.5. Each applicable section 6a hospital shall maintain a file containing affidavits by its consumer representatives as to their consumer category. The affidavits shall be in a form approved by the department of health director.

b: 7.3.6. If a hospital's designation of a consumer representative is selected for verification or is the subject of a complaint received by the department of health director, upon request from the department of health director, the consumer representative will be is required to provide the department director with whichever of the following which are is applicable to document his or her consumer designation:

(+) 7.3.6.1. For small business representatives, a copy of

the business financial statement, workers' compensation filing or other evidence of business size acceptable to the department-of health director;

(2) 7.3.6.2. For organized labor members, written verification of membership from the union;

(3) 7.3.6.3. For elderly persons, a birth certificate, driver's license copy or other evidence of age acceptable to the department director;

(4) 7.3.6.4. For persons whose income is less than the national median income, written verification by the Internal Revenue Service, as authorized by the board member, that the incomes of the persons are less than the established national median income, or copies of the signature pages of federal income tax returns, or an affidavit that the filing of such the returns with the federal government was not required.

e- 7.3.7. If the consumer representative designation of a board member of an-applicable a section 6a hospital is selected for verification or if the consumer representative designation of a board member of an-applicable a section 6a hospital is the subject of a complaint and if, upon request by the department-of health director, the consumer representative does not provide adequate documentation to justify such the designation, and if, after written notice to the applicable hospital, the board member has not been replaced before the then current license for the hospital is no longer in effect, the department director may-deem shall consider the hospital to be out of compliance with Section ~~7-2-2-of-these-rules~~ 7.3 of this rule.

~~7-2-7-~~ 7.3.8. Each applicable section 6a hospital shall also maintain a file which shall-contain contains the procedure established by the board of directors to assure the consideration of women, racial minorities and the handicapped in the selection of consumer representative board members and documentation that such the procedure has been followed, except no such file is required to be maintained by the corporation defined in West Virginia-Code-Chapter-18,-Article-11E,-Section-1,-Subdivision-(d) W.Va. Code §18-11C-1(d). or-by-Cabell-County-General-Hospital-as its-board-of-directors-exists-under-the-authority-of-Chapter-157 of-the-Acts-of-the-Legislature,-regular-session,-1945-and-Chapter 166-of-the-Acts-of-the-Legislature,-regular-session,-1947-

~~7-2-8-~~ 7.3.9. In no event shall a board of directors of an applicable a section 6a hospital be required to be composed of more consumer representatives than are necessary to achieve forty (40) percent (40%) of the voting members of the board, regardless of the number of hospitals for which the board is the governing authority.

~~7-2-9-~~ 7.3.10. To the extent that any provisions of the

charter or bylaws of an-applicable a section 6a hospital regarding board member qualifications are in conflict with the requirements of these-regulations this rule, such the provisions are null and void for purposes of complying with these-regulations this rule.

7-3- 7.4. Hospital Administrator - A hospital administrator qualified by education and experience shall be responsible at all times for directing, coordinating and supervising the administration of the hospital and for carrying out the policies of the governing authority and the rules and regulations of the medical staff. The administrator shall serve in an administrative liaison capacity between the medical staff and the governing authority.

#### S64-12-8. Physical Facilities.

8.1. General Requirement - The provisions of this-part-shall Section 8 of this rule apply to all hospitals coming-into-existence-after-the-effective-date-of-these-regulations which were constructed or alterations completed subsequent to 1969 and prior to the effective date of this rule. If the director determines that changes necessary for compliance with the-new-regulations this rule would create undue hardship, existing hospitals or construction in existence at the time this rule becomes effective may be governed by previously-established-requirements-that-have been-approved-by-the-state-department-of-health rules which were in effect at the time the hospital or construction was completed. Hospitals constructed prior to the effective date of this rule shall comply with those standards which were applicable at the time of construction: Provided, that compliance with the standards adopted in Section 8.3.1 of this rule are acceptable in lieu of compliance with the standards applicable at tthe time of construction for these hospitals.

#### 8.2. Site Selection.

8.2.1. The site of any hospital should be located in relation to the center of population, close to where patients live and where competent medical and surgical consultation is readily available and where employees can be recruited and retained. There shall be good drainage, approved-sewage-disposal,--safe water-supply, electricity, telephone, public transportation and other necessary facilities available on or near the site.

8.2.2. Local building codes and zoning restrictions shall be observed. Information as to zoning restrictions may be obtained from local civic authorities. Where local codes or regulations permit lower standards than required by these-regulations this rule, the standards contained herein in this rule shall govern.

8.2.3. Institutions shall be located in an environment

which is free from excessive noises of railroads, freight yards, traffic arteries, schools, playgrounds, airports, etc. The site shall not be exposed to smoke, foul odors or dust, or be subject to flooding.

8.2.4. Transportation shall be facilitated by roads which are kept passable at all times. There shall be walks and parking areas provided.

8.2.5. An inspection of the site for a proposed hospital shall be requested in writing and approval shall be obtained from the ~~state department of health~~ director before construction is started.

### 8.3. New Construction.

8.3.1. ~~For construction of new hospitals required to be licensed, the state department of health has adopted Appendix "A" of the public health service regulations, Part 53, Subpart N, general standards of construction and equipment, pertaining to the construction and modernization of hospital and medical facilities, as amended.~~ Hospitals constructed subsequent to the effective date of this rule shall comply with the General and Psychiatric Hospital sections, as applicable, of the 1992-93 edition of Guidelines for Construction and Equipment of Hospital and Medical Facilities.

8.3.2. ~~Drawings and outline specifications for any new hospital or buildings to be used as a part of or in conjunction with any institution required to be licensed under the provisions of Article 5B, Chapter 16, Code of West Virginia, as amended shall be presented in the schematic and preliminary stages to the state department of health for approval prior to the preparation and submission of final working drawings and specifications, and before construction is begun.~~ Complete construction drawings and specifications for any hospital construction project shall be submitted to the director for review prior to the beginning of work on the project. The drawings and specifications shall include architectural, structural and mechanical drawings and specifications and shall be prepared and signed by an architect registered to practice in West Virginia.

a. ~~Such drawings shall be signed by an architect registered in West Virginia;~~

b. ~~Drawn to a scale of not less than one-eighth inch (1/8") equals a foot; and~~

c. ~~Shall show, properly identified, the general arrangement and construction of the building and location of all fixed equipment.~~

### 8.4. Additions and Alterations, Conversions and Changes in

**Services Additions; Renovations.**

~~8.4.1. Additions and alterations to all hospitals and related institutions shall conform to the minimum standards for new construction.~~ Additions to and renovation or alteration of any hospital, which addition, alteration or renovation is begun after the effective date of this rule, shall comply with the General and Psychiatric Hospital sections, as applicable, of the 1992-93 edition of Guidelines for Construction and Equipment of Hospital and Medical Facilities.

~~8.4.2. Any institution required to be licensed shall, before making any structural changes to or any alteration in any building used or to be used as a part of or in conjunction with the licensed institution, including any changes in services, advise the state department of health in writing as to what is intended. Upon the department's request, there shall be submitted such plans, specifications or other information as may be required for approval before proceeding with the proposed changes.~~ Complete construction drawings and specifications for any hospital addition, alteration or renovation project shall be submitted to the director for review prior to the beginning of work on the project. The drawings and specifications shall include architectural, structural and mechanical drawings and specifications and shall be prepared and signed by an architect registered to practice in West Virginia.

~~8.4.3. Any existing building, or portions thereof, whether or not presently used in use as a hospital as of the effective date of this rule, shall, if converted for use as a specialized hospital within the meaning of these regulations this rule, be required to meet all standards as set forth for new construction shall comply with the General and Psychiatric Hospital sections, as applicable, of the 1992-93 edition of Guidelines for Construction and Equipment of Hospital and Medical Facilities.~~

**8.5. Walls, Ceilings and Floors.**

8.5.1. Walls and ceilings must shall be of a material which permits frequent washing, cleaning or painting.

8.5.2. Floors shall be smooth, nonabsorbent and constructed for easy and effective cleaning. Approved carpeting may be used in areas other than those requiring a smooth washable surface.

**8.6. Heating and Ventilation.**

8.6.1. Provision shall be made to provide adequate heating to insure the comfort and safety of patients and personnel.

8.6.2. The heating plant shall be capable of maintaining a temperature of seventy degrees Fahrenheit (70° F) in severe weather in all rooms used for patients.

8.6.3. Special attention shall be given to the ventilation of patients' quarters so as to supply fresh air and to prevent accumulation of objectionable odors, and:

a. Rooms which do not have outside windows, such as utility rooms, toilets, bedpan rooms, baths, sterilizer rooms, sterilizer equipment chambers and food storage rooms shall be provided with forced or suitable ventilation to change the air.

b. Kitchens and laundries which are located inside the hospital building shall be ventilated by exhaust systems which will discharge the air above the main roof, remote from any window or venting intake system.

c. Rooms used for the storage of combustible anesthetic agents, paints and other highly flammable materials shall be ventilated to the outside air with intake and discharge ducts.

~~d. Oxygen storage and oxygen manifold rooms shall comply with the regulations set forth in the latest edition of the National Fire Protection Association, No. 56.~~

8.6.4. No recirculation of air shall be permitted in operating rooms, delivery rooms, etc., and adjacent service areas. The ventilation system for such these areas shall be constructed to perform separately from any other ventilation system for the hospital.

#### 8.7. Windows, Doors, Corridors and Screens.

8.7.1. Each patient's room shall have at least one (1) window opening to the outside to permit ventilation and a source of natural light. The window area shall not be less than one-eighth (1/8) of the floor space.

8.7.2. Door widths at all patient rooms, treatment rooms, operating rooms, delivery rooms and any room where entrance of an assembled bed may be required shall be at least three feet, eight inches (3'8") to permit easy removal of the occupied bed.

8.7.3. No door shall swing into the corridor except janitor or toilet room doors. Bathroom doors shall open outward into patient rooms.

8.7.4. Corridors, stairways and elevators shall be of a width and design that will easily accommodate the removal of patients by bed, including beds with traction equipment. They shall be constructed and maintained in compliance with all safety regulations and requirements. Usage of these areas for purposes other than for which they were originally designed shall not be permitted at any time.

8.7.5. Handrails shall be installed in all corridors, ramps, inclines and passageways used by patients in those units of an extended care facility operated in connection with a hospi-

tal or in any hospital or hospital unit specializing in chronic or convalescent care.

8.7.6. Screens shall be provided for all exterior openings except that where doors to the exterior are self-closing or kept closed, screen doors are not required. Where provided, screen doors shall open outward and shall be self-closing. Window screens shall be designed and installed so as not to block exit in case of emergency. Window screens are not required in rooms that are fully air-conditioned and where windows are never opened.

§64-12-9. Operational Services.

9.1. Sanitation, Housekeeping and Maintenance.

9.1.1. ~~The water supply must be approved by the state department of health~~ shall comply with Public Water Systems, 64 CSR 3 and Cross Connection and Backflow Prevention Rules, 64 CSR 15. ~~There shall be an adequate supply of hot water available at all times.~~

9.1.2. ~~The Sewage disposal must be approved by the state department of health~~ shall comply with Sewage System Rules, 64 CSR 9.

9.1.3. Hospital housekeeping and maintenance services are required to be such that shall maintain safe, comfortable and sanitary living conditions for patients and employees. ~~are maintained constantly.~~

a. Accumulated waste material shall be removed daily or more frequently if necessary.

b. The grounds shall be kept in sanitary, safe and presentable condition.

c. The premises must shall be kept free from rodent and insect infestation.

d. There shall be sufficient supplies and equipment, properly stored and conveniently located, to permit frequent cleaning of floors, walls, woodwork, windows and screens and to facilitate all necessary building and ground maintenance.

e. Stairwells and corridors shall be kept free from obstruction at all times.

9.1.4. Toilet facilities shall be provided in reasonable ratio to the number of patients cared for in the institution. Conveniently located grab bars, ~~conveniently located,~~ shall be provided at commodes and bathing facilities. Toilet facilities shall be provided for the public.

9.1.5. All garbage shall be stored and disposed of in a

manner that will not permit the transmission of disease, create a nuisance or provide a breeding place for insects and rodents.

a. All garbage containers shall be watertight, nonabsorbent, rodent proof and have tight fitting covers.

b. ~~They must~~ Garbage containers shall be emptied at frequent intervals and those containers that do not use an auxiliary liner shall be thoroughly washed and sanitized before being used again.

9.1.6. ~~Adequate incineration facilities shall be provided so that infected dressings, surgical and obstetrical wastes and other similar materials can be handled and disposed of in a safe and sanitary manner.~~ The hospital shall comply with Infectious Medical Waste, 64 CSR 56.

~~a. Incinerators shall be constructed, operated and maintained in such a manner as not to create nuisances.~~

~~b. Ashes and noncombustible material shall be removed frequently and disposed of according to methods approved by the state department of health.~~

~~c. The use of heating plant fire boxes for incineration is not considered satisfactory.~~

## 9.2. Lighting.

9.2.1. All rooms and areas in the hospital shall be provided with sufficient artificial illumination to enable personnel to properly carry out procedures normally performed therein.

9.2.2. Emergency lighting shall be provided for exits, stairs, corridors, nurseries, emergency rooms, delivery rooms, operating rooms and other areas necessary for safe effective patient care. Emergency lighting shall be supplied by an automatic emergency generator or the equivalent and shall be checked periodically, preferably under load conditions, and the dates on which tested recorded in a permanent log.

9.3. Oxygen Systems - All hospitals shall have available provide oxygen and oxygen equipment required for the use of oxygen. ~~in accordance with recommendations of the national board of fire underwriters and national fire protection association.~~

## 9.4. Laundry.

9.4.1. The institution shall make provisions for the proper cleaning of linen and other washable goods with special provisions for handling and disinfecting contaminated linens. Hospitals maintaining and operating laundries shall provide ventilation for the elimination of steam and odors and proper insulation to prevent the transmission of noise to patient areas. The following are also required:

a. Soiled linen receiving, storing and sorting areas with handwashing facilities;

b. Washing, extracting, drying and ironing areas and equipment provided with all necessary safety appliances and sanitary requirements;

c. Storage area for laundry supplies;

d. Personnel toilets convenient to laundry.

9.4.2. If commercial laundry service is used, the following are required:

a. A soiled linen collection and storage area with handwashing facilities in the area;

b. A central clean linen storage room.

9.4.3. Each of the following classes of laundry shall be separately stored and washed: soiled diapers, newborn nursery linen, infected linen and all radioactive contaminated linen.

9.4.4. A supply of clean linen shall be provided sufficient for the hospital's capacity with particular attention given to assuring an adequate supply of clean linen during and after weekends, holidays and other periods when the laundry is not in operation.

9.5. Central Sterilization and Supply - Each hospital shall provide a central sterilizing and supply room to prepare, sterilize, store and dispense sufficient sterile supplies and equipment to all units of the hospital to insure that medical or surgical asepsis is maintained in carrying out diagnostic, treatment and personal care procedures. ~~according-to-categories-and-patients-being-admitted-to-inpatient-and-outpatient-units.~~

a. The hospital shall use an accepted method for determining adequate sterilization of supplies;

b. A cabinet, cupboard or other suitable enclosed space shall be provided for keeping sterile equipment and supplies in a convenient and orderly manner.

#### 9.6. General Storage.

9.6.1. If possible, all storage should be concentrated in one (1) area except mechanical maintenance items which may be in a separate area. Handwashing facilities should be in or convenient to work areas.

9.6.2. Separate storage rooms shall be provided for flammable materials and for oxygen gases.

#### \$64-12-10. Paramedical Services.

10.1. Pharmaceutical Service.

10.1.1. Hospitals operating and maintaining a pharmacy or dispensary in which drugs are compounded for internal use shall be under the supervision of a pharmacist registered as required by the pharmacy laws and regulations of the West Virginia board of pharmacy. Hospitals that do not maintain a pharmacy shall have a drug room under the supervision of a consulting registered pharmacist.

10.1.2. Medication Storage - All drugs shall be stored in proper containers and be plainly labeled. Poisons and medications for external use are to be kept in a separate compartment or section of the pharmacy or drug room.

a. All drugs on nursing units and hospital services shall be stored in a specially designated cabinet, closet or room, in or near each nurses' station, with one (1) or more sections for poisons and medications.

(1) The medicine cabinet shall have a compartment for the storing of medications for external use only.

(2) The medicine cabinet shall be well illuminated and have adequate space for the storing of medications and for their preparation and administration. It is to be provided with a lock and key; to be kept locked when not in use; and the key available only to authorized personnel.

10.1.3. Narcotics - Narcotics and controlled or dangerous drugs, ~~such as~~ which are required to conform with state and/or federal regulations shall be kept under double lock and accessible only to authorized personnel. Double locked boxes firmly attached to cabinets shall be used for storage of narcotics. Obsolete or surplus narcotics to be disposed of must shall be handled according to federal law.

10.1.4. Except for medication packaged for unit doses, all unused medications shall be discarded when orders have been discontinued or the patient has been discharged from the hospital, except that in the event the physician desires continuation of the medication, the patient may be permitted to take the medicine home if so ordered on the chart by the physician.

10.2. Blood Supply Service - Blood and blood substitutes shall be readily available to the hospital at all times for emergency administration. Arrangements shall be made to readily secure types of blood not ordinarily kept in the hospital. Blood shall be obtained, processed, stored and administered under the supervision of a pathologist or designated physician.

10.3. Medical Records and Reports.

10.3.1. A hospital shall maintain a medical records department under the supervision of a medical records ~~librarian~~ regis-

tered record administrator or other person qualified by training and experience. The medical records department shall be conveniently located and adequate in size and equipment to enable physicians to complete medical records.

a. Accurate and complete medical records shall be written kept for each patient admitted for care in the hospital and the record shall be retained in an easily accessible manner in the hospital. Whether or not an electronic system is used, the record system shall provide for authentication of record entries by the author and for record protection and security.

b. A complete medical record is one which includes patient identification, date, complaints, history of present illness, personal and family history, physical examination, doctor's orders including dietary orders, special examinations and consultations, clinical laboratory, x-ray and other examinations, provisional or working diagnosis, treatment and medications given, surgical reports including operative and anesthesia records, gross and microscopic pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary and autopsy findings, if performed.

c. A medical record for each newborn infant, separate from the mother's record, shall be kept.

d. A short form medical record may be used for inpatients staying patients who are in the hospital less than forty-eight (48) hours except in the case of maternity and newborn patients. The short form shall contain sufficient information for proper diagnosis and treatment.

e. Records, including records of patients treated in the emergency room or outpatient department, shall be preserved either in the original form or by microfilm or electronic data process.

f. All clinical information pertaining to patients shall be filed in the patient's medical record.

g. All orders for medication or treatment shall be in writing, signed by the physician in ink and filed in the patient's medical record. The use of signature stamps is acceptable.

h. There shall be maintained a system of nurses' clinical records and all doctors' orders shall be in writing and signed by the physician. Telephone or verbal orders shall be given to a registered professional nurse and shall be signed by the physician as soon as possible thereafter. Verbal and telephone orders shall be given to licensed or certified personnel that are authorized to receive these orders by the medical staff policies and procedures. Physicians shall countersign all verbal and telephone orders as determined by the medical staff bylaws.

i. All reports and entries in the patient's medical record

shall be typewritten or written in ink and signed by the person making the entry.

j. Only abbreviations approved by the medical staff shall be used in preparing medical records.

k. Final diagnosis diagnoses shall be included in the patient's medical record and shall be expressed in terminology of a recognized system of disease nomenclature.

l. Medical records shall be completed promptly, authenticated and signed by the physician or dentist within ~~fifteen-(15) days-but-not-more-than-forty-five-(45)~~ thirty (30) days following the discharge of the patient.

m. Medical records shall be indexed according to disease, operation and physician and indexing shall be kept up to date.

~~n.--Hospitals-using-automatic-data-processing-may-keep-in-dexes-on-punch-cards-or-reproduced-on-sheets-bound-in-books.~~

~~o. n. All-medical-records-of-services-to-outpatients-and-patients-treated-in-the-emergency-room-shall-be-maintained-in-the-files-of-the-medical-records-department. Records of services to outpatient and emergency room patients shall be maintained and shall be accessible to hospital staff as needed.~~

10.3.2. Births and Deaths Report - A complete list of all births, deaths and fetal deaths occurring within the month in licensed hospitals must shall be reported by the tenth of the following month on special-blanks-provided-for-the-purpose forms provided by or approved by the director or on a comparable computer printout approved by the director to the division of state registrar of vital statistics, state-department-of-health. All completed birth certificates should shall be sent to the county state registrar of vital statistics immediately-after-the-end-of-the-month within ten (10) days following the birth.

10.3.3. Communicable Disease Reports - Licensed-institutions must-report-each-case-of-communicable-disease-to-the-local-health officer-within-twenty-four-(24)-hours-after-the-disease-is-discovered.--Reporting-post-cards-furnished-by-the-state-department of-health-may-be-used-and-shall-be-signed-by-the-physician-who diagnoses-the-case. Licensed hospitals shall comply with Reportable Diseases, 64 CSR 7, AIDS-Related Medical Testing and Confidentiality, 64 CSR 64, and any other applicable rules regarding the reporting of diseases, infections or laboratory test results to the State.

~~10.3.4.--Venereal-Disease-Reports---Licensed-hospitals-shall report-every-previously-unreported-case-of-syphilis,-gonorrhea and-chancroid-within-forty-eight-(48)-hours-after-a-diagnosis-is made-or-treatment-started.--The-report-shall-be-made-to-the-state director-of-health-on-forms-supplied-by-the-state-department-of health.~~

a. ~~10.3.4. Information contained on medical records in licensed hospitals relative to venereal diseases shall be made available upon request to the state director of health. The hospital shall make medical record information relative to sexually transmitted diseases available to the director on request.~~

b. ~~Supervisors of all laboratories in licensed hospitals that perform serologic or other tests for syphilis shall make a report of all positive or reactive laboratory tests for syphilis as stated in Chapter 2, Article 4, Section 1 of the regulations of the West Virginia state board of health. These reports shall be submitted on the 1st and 15th of each month, except positive darkfield tests which shall be submitted within twenty-four (24) hours. These reports shall be made to the state director of health on forms supplied by the state department of health.~~

~~10.3.5. Annual Reports --- All institutions shall submit annual reports to the state department of health on forms which will be supplied for this purpose.~~

#### 10.4. Dietary.

10.4.1. The food service of the hospital shall be in full compliance with the West Virginia food service sanitation regulations, adopted by the West Virginia state board of health, effective April 10, 1965. comply with Food Service Sanitation Rules, 64 CSR 17.

10.4.2. Organization - There shall be an organized food service, planned, equipped and staffed to serve nutritionally adequate meals according to physicians' orders. A qualified dietitian or other person with suitable training shall be designated to serve as director of the dietary department on a full-time basis or in smaller hospitals on a regularly scheduled consulting basis. If the services of a qualified dietitian cannot be obtained, a person with a baccalaureate degree with major studies in food and nutrition shall be considered suitable to direct the food service.

a. Hospitals which employ a shared or consulting dietitian shall have the dietary department under the full-time direction of a person whose with training and experience in food service administration. ~~is acceptable to the department.~~ Provision shall be made for continued inservice training of the designated food service supervisor.

b. The dietary department shall maintain in its office a written plan of its policies, organization, management and daily operating procedure. The following records shall be maintained:

(1) The number of persons, by job description, employed full-time or part-time in the dietary department, the number of hours each employee works weekly; and

(2) A job description of each type of dietary department

position with verification that each employee has been familiarized with his or her duties and responsibilities.

c. Menus, planned at least one (1) week in advance for both therapeutic and general diets, shall be written and dated.

d. Menus shall be posted in appropriate places in the food preparation area and be available to administrative personnel.

e. Menus, as served, with all substitutions noted, shall be filed in the dietary department for at least four (4) weeks.

f. All therapeutic diets, including between meal nourishments, shall be prepared and served as prescribed by the attending physician. An up-to-date diet manual shall be used in planning therapeutic diets and shall be readily available to the medical and nursing staffs and dietary personnel.

g. Adequate personnel with ~~current food handlers permits~~ shall be employed to perform the functions of the dietary department.

h. There shall be procedures to control prevent the contamination of meals and other items prepared or served by the dietary department by dietary employees with respiratory ailments, infections and open lesions. ~~Health examinations for employees shall meet local, state and federal codes for food service personnel. Current health examination records of employees shall be on file.~~

i. There shall be an inservice training program designed to meet the needs of dietary employees, including training in proper handling of food and personal hygiene. ~~This is not a substitute for regular food handler training conferences conducted by the state department of health.~~

j. No personal belongings of personnel shall be stored in food preparation or serving areas or in the dishwashing and clean-dish storage areas.

k. Dietary personnel shall not be served food in preparation areas.

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

m. Adequate clean toilet facilities shall be provided for food handlers.

n. All food served shall be ~~from approved sources and shall meet the standards of quality as established by applicable laws and regulations. Food prepared outside the hospital shall be from sources that comply with existing laws and regulations.~~

comply with Food Service Sanitation Rules, 64 CSR 17, whether prepared inside or outside of the hospital. The hospital may contract with an outside food management company for dietary services if the outside company has a qualified dietitian who serves the hospital on a full-time or part-time consulting basis, and if the company complies with Food Service Sanitation Rules, 64 CSR 17, or, if located outside of this State, complies with the applicable rules and regulations of the authority having jurisdiction over the company.

o. Dry or staple food items shall be stored at least twelve inches (12") off the floor in well-ventilated rooms which are not subject to contamination by sewage or wastes, water backflow, or contamination contaminated water, leakage, rodents or vermin.

p. Potentially perishable foods shall be maintained at a temperature of forty-five degrees Fahrenheit (45° F) or below. Refrigerators and storerooms used for perishable foods shall be equipped with reliable thermometers.

q. All ice used in contact with food or drink shall be ~~obtained from a source meeting state department of health standards for drinking water.---it shall be stored, handled and dispensed in a sanitary manner.~~ comply with Public Water Systems, 64 CSR 3.

r. ~~Milk and milk products shall be obtained from a source and in a manner approved by the state department of health.~~ Milk shall be served to patients in the distributor's original individual containers or from approved bulk dispensers to be located in each patient area.

s. A sample of potentially hazardous foods from the menu of each meal shall be retained under adequate refrigeration for a period of at least twenty-four (24) hours after serving. By this method, proper samples of food are available for laboratory examination in the event of a food-borne disease outbreak.

t. Poisonous and toxic materials shall bear warning labels, be stored separately from food or equipment used in preparing and serving food and shall be used only in such ways that they will neither contaminate food nor be hazardous to employees.

u. Food being served or transported shall be protected from contamination and held at proper temperature in clean containers, cabinets or serving carts.

v. Garbage and refuse shall be placed in impervious containers equipped with tightly fitting covers. Containers shall be stored in a safe area or refrigerated space pending removal and shall be removed from the premises and sanitized daily.

~~w.---Hospitals contracting for food service with an outside food management company shall meet the requirements provided the company has a qualified dietitian who serves the hospital on a~~

~~full-time or part-time consulting basis and the company fulfills the minimum standards listed herein.~~

**§64-12-11. Patient Care Department.**

11.1. General Requirement - All patient care areas and units shall be segregated from areas used by the public or occupied by hospital service facilities. This includes administration, adjunct diagnostic treatment, dietary, laundry, etc.

11.2. Patient Care Unit.

11.2.1. Patient care unit means a designated area of the hospital that provides a bedroom or a grouping of bedrooms with supporting facilities and services to provide adequate nursing care and clinical management of inpatients and that is thereby planned, organized, operated and maintained to function as a separate distinct unit. All nursing units shall contain the facilities listed below. For the most part, these are the same for medical, surgical, pediatric, maternity, communicable and other nursing units. Any difference or special requirement for a particular service is noted.

a. Private and Multiple Bedrooms - There shall be provision for private bedrooms to meet the needs of patients and programs of the hospital. There should be no more than four (4) beds per patient bedroom. No bedrooms shall be located below ground level. There should be no more than approximately thirty-five (35) patient beds in a patient care unit. Larger units are permissible if additional facilities are provided.

b. Bedroom Size - Each one-bed room shall contain a minimum floor area of one hundred (100) square feet. Each multiple-bed room shall contain a minimum floor area of eighty (80) square feet per bed with three feet (3') between beds and two feet (2') from the walls at the sides of the beds. The area is to be taken in an unobstructed space contained in a square or rectangle.

~~c. Windows - Each patient room shall have a minimum window area equal to one-eighth (1/8) of the floor area. Privacy for the patient and control of light shall be provided at each window.~~

~~d. Entries - Each patient bedroom shall have direct entry from a corridor. Such entry shall have a door at least equal in fire resistance to one and three-fourths inches (1-3/4") thick solid-core wood. The door opening shall be at least three feet eight inches (3'8") in clear width (four feet (4') of clear width is recommended) and shall not swing into the corridor.~~

e. Lighting - Artificial light shall be provided and include: (1) general illumination; (2) other sources of sufficient illumination for reading and observations, examinations and

treatments; (3) night light controlled at the door of the bedroom bedroom; and (4) quiet-operating switches switches.

f. **Handwashing Facilities** - A lavatory complete with mixing faucet, blade controls, soap and sanitary hand-drying accommodations shall be provided in each patient bedroom. The lavatory may be installed within the toilet room in private rooms and two-bed rooms where the toilet serves only one (1) room. There shall be adequate handwashing facilities throughout existing institutions.

g. **Toilet Facilities** - Toilet facilities shall be provided immediately adjacent to private or multiple bedrooms in the ratio of one (1) toilet for not more than four (4) patient beds and shall include: (1) bedpan and urinal flushing equipment; (2) wastepaper receptacles with removable impervious liner; and (3) approved grab bars convenient for safety of patients.

h. **Bathing Facilities** - Patient bathing facilities shall be provided in the ratio of one (1) tub or shower for each ten (10) patients. Approved grab bars shall be sufficient to provide space for wheelchair movement.

11.2.2. **Patient Equipment** - Patient bedrooms shall have movable furniture and be equipped with the following for each patient:

- a. Adjustable beds bed with safety side rails;
- b. Cabinet or bedside table;
- c. Overbed table;
- d. Wastepaper receptacle with impervious disposable liner or disposable waste receptacle;
- e. Complete personal care equipment sanitized before each patient's use, and including water carafe, mouthwash cup, emesis basin, washbasin, bedpan and urinal;
- f. ~~Each-patient-shall-be-provided-with~~ Separate closet or locker; and
- g. ~~Each-patient-shall-be-furnished-with-an-adequate~~ Nurses' call system.

11.2.3. **Service Areas** - The following service areas shall be provided and located conveniently for patient care:

- a. Nurses' station, equipped with a nurses' call system from patients, a communication system with other departments of the hospital and to the outside. There shall be at least one (1)

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-----Not-required-in-existing-facilities.

nurses' station on each floor containing patient bedrooms.

- b. Medical record charting facilities.
- c. Medicine preparation area.
- d. Clean holding area.
- e. Soiled holding area.
- f. Janitor's closet.
- g. Stretcher and wheelchair storage area.

11.2.4. Nurses' Station - Nurses' station stations shall be adequately designed and equipped.

a. The medication preparation areas shall be equipped with: (1) cabinets with suitable locking devices to protect drugs stored therein in the cabinets; (2) a refrigerator equipped with thermometer and used exclusively for pharmaceutical storage; (3) counter work space; (4) a sink with approved handwashing facilities; and (5) antidote, incompatibility and metriapothecary conversion charts. Only medications, equipment and supplies for their preparation and administration shall be stored in the medication preparation area. Test reagents, general disinfectants, cleaning agents and other similar products shall not be stored in the medication preparation area.

11.2.5. Clean Holding (Utility) Room - The clean holding room shall be equipped with: (1) a counter sink with mixing faucet, blade controls, soap and sanitary hand-drying facilities; (2) a waste receptacle with cover (foot control recommended) and impervious disposable liner; and (3) cupboards or carts for supplies. There shall be a separate closed area in the clean holding supply area for clean linens and supplies on carts or in cabinets.

11.2.6. Soiled Holding (Utility) Room - The soiled holding rooms shall be equipped with: (1) a suitable counter sink with mixing faucet, blade controls, soap and sanitary handwashing facilities; (2) a waste receptacle with cover (foot control recommended) and impervious liners; (3) a soiled linen cart or hamper with impervious liners; (4) accommodations and provisions for enclosing soiled articles; (5) space for short-time holding of specimens awaiting delivery to the laboratory; and (6) adequate shelf and counter space.

11.2.7. Janitor's Closet - The janitor's closet closets in aggregate shall be equipped with: (1) a sink, preferably depressed or floor mounted with mixing faucet; (2) a hook strip for mop handles from which soiled mops have been removed; (3) shelving for cleaning materials; and (4) a waste receptacle with impervious liner. The area should be adequate to store mop buckets on a roller carriage, a wet and dry vacuum machine and a floor

scrubbing machine.

11.2.8. **Personnel Toilet Facilities** - Toilet facilities shall be provided for personnel on each patient care unit.

11.3. **Maternity Services.**

11.3.1. Maternity facilities, including accommodations for mothers and infants, and the delivery suite shall be a self-contained unit including the required facilities in Section 11.2 of this rule, and shall be segregated from all other parts of the hospital.

a. The administration of the obstetrical department shall be under the direction of a qualified, professional registered nurse currently registered in West Virginia. ~~Nurses caring for obstetrical patients are not to care for other types of patients.~~ Nurses providing services to non-obstetrical patients shall not subsequently provide care on the same shift to maternity patients.

b. Visiting rules shall be posted conspicuously.

11.3.2. **Labor-delivery Unit** - The labor-delivery unit, the maternity nursing unit and the nursery facilities should be planned in relation to each other so that prenatal, natal and postnatal processes are a continuous, safe and satisfying experience for mother and infant.

a. A designated special labor room is desired and one (1) labor bed for each ten (10) maternity beds is recommended. Rooms for labor shall have a lavatory with nonmanual controls, access to bedpan facilities and access to a toilet room which is under the supervision of nursing personnel. There shall be facilities for examination and preparation of patients as required by attending physicians.

b. One (1) delivery room is required and one (1) additional delivery room for each twenty (20) maternity beds is recommended. This room shall not be used for any other purpose, and it shall be used only for delivery of non-infected patients. Patients with any evidence of infection or possible infection shall be delivered in a separate, private room.

(1) There shall be a suitable delivery table equipped for operative deliveries and treatment for shock.

(2) The delivery room shall be furnished with suitable tables or stands for instruments and necessary supplies.

(3) An adequate supply of sterile utensils, linens, dressings, gloves and face masks shall be in readiness for all deliveries.

(4) Sterile equipment for administration of blood transfu-

sions and intravenous or subcutaneous therapeutic solutions shall be readily available.

(5) There shall be ready at all times equipment for general anesthesia, and a supply of drugs and anesthetics ordinarily needed for spinal and/or pudendal anesthesia.

(6) A heated bassinet or incubator shall be ready for the reception and care of the newborn infant in the delivery room.

(7) There shall be equipment for resuscitation as ordered by the physician and facilities for the administration of oxygen shall be available.

(8) ~~One (1) or two (2) drops of a one percent (1%) solution of silver nitrate~~ The contents of a single-use tube of an ophthalmic ointment containing one percent (1%) tetracycline or one-half of one percent (0.5%) erythromycin or the equivalent dosage of these medications or other appropriate medication approved by the director for the prevention of inflammation of eyes of the newborn shall be instilled in the eyes of the newborn baby immediately upon its birth.

(9) An acceptable means of identification for each infant shall be available in each delivery room and shall be applied at the time of delivery in the delivery room.

~~(10) --- All infant births shall be properly recorded in a delivery room record book in accordance with the rules and regulations of the state department of health.~~

11.3.3. Nursery Unit - A separate nursery unit shall be provided for the care of newborn infants. This nursery unit is not to be used for any other purpose. It shall be conveniently located with reference to the mothers' rooms and shall be preferably an outside room so located as to receive sunshine natural light some portion of the day.

a. Nurseries shall be of sufficient size to provide twenty-four (24) square feet of floor space per bassinet with at least twelve inches (12") between bassinets.

b. There shall be handwashing facilities with nonmanual controls in the nursery unit.

c. A viewing window shall be provided between each nursery and the corridor so that visitors may see the infants without entering the nursery.

d. There shall be provision for adequate control of atmospheric conditions in the nursery and heating shall be sufficient to maintain a temperature of seventy-five degrees Fahrenheit (75° F). There shall be a reliable room thermometer near the bassinets and approximately at bassinet level.

e. A separate bassinet for each infant shall be provided with suitable equipment.

f. Accurate scales shall be provided for each nursery.

g. Covered cans for waste shall be provided and emptied at frequent intervals.

h. One (1) rectal thermometer shall be provided for each infant and the thermometers shall be kept in an antiseptic solution in individual containers.

i. There shall be adequate space within or adjacent to the nursery unit for all equipment and supplies required to provide adequate and safe care to newborn infants.

j. Other essential equipment required includes incubators, resuscitators and oxygen apparatus.

#### 11.3.4. Formula. Room:

~~a.--This room is for the sole purpose of preparing the infant formula and shall have no direct access to the nursery or workroom.--The following shall be provided unless commercially prepared formula is used:~~

~~(1)--Work counter with built-in sink with gooseneck-type spout and knee or foot control;~~

~~(2)--Lavatory;~~

~~(3)--Hot plate;~~

~~(4)--Refrigerator;~~

~~(5)--Sterilizer (autoclave);~~

~~(6)--Bottle washer.~~

~~(b)--If Commercially prepared formula is to be used or other modifications are proposed in formula preparation and processing, the formula room shall include such the space and equipment as are necessary to accommodate formula processing and handling. shall be handled and prepared in a manner consistent with the requirements of Food Service Sanitation Rules, 64 CSR 17.~~

11.3.5. Isolation Facilities - Immediate segregation and isolation of all infants with communicable infections shall be provided. All equipment shall be kept completely separate for each infant.

a. Infants born outside the hospital shall be isolated for at least seventy-two (72) hours after admission.

#### 11.3.6. Clothing and Linen - Infant's clothing and diapers

shall be furnished by the hospital.

a. Nursery linen shall be washed separately from other hospital linen and care taken to avoid contamination of freshly laundered articles ~~and-autoclaved-before-use~~.

b. Infant's clothing and diapers shall be freshly laundered ~~and-autoclaved~~ before use.

11.3.7. Nursing Procedures - Each hospital shall establish definite nursing procedures for delivery room, nursery and antepartum and postpartum care of patients.

a. In order to insure uniformity of nursing practices within a hospital, ~~it-is-required-that~~ all nursing routines shall be in written form and available to all personnel in the maternity section.

b. Instructions for feeding and care of the infant shall be given to the mother in accordance with the physician's recommendations.

11.3.8. Noninfected gynecologic patients who do not have an elevated temperature may be admitted to the maternity service of the hospital provided the plan setting forth the hospital medical staff shall approve written policies, procedures and conditions for such the combined service. has-been-submitted-to and-approved-by-the-state-department-of-health. Infection control staff shall be involved in policy development. If these patients develop an elevated temperature, they shall be moved to another location within the hospital.

#### 11.4. Surgical Unit.

11.4.1. The surgical suite shall be a self-contained unit, under the direction of a surgical supervisor who is a qualified professional registered nurse, currently registered licensed in West Virginia, and shall be so located that traffic in and out can be controlled and there is no through traffic to any other part of the hospital. The surgical suite shall be separated physically from the delivery suite and emergency unit.

a. The surgical department shall be under the supervision of the chief of surgery who is shall be: duly licensed in West Virginia; competent in the practice of surgery; and practicing in the town or city in which the hospital is located; and ~~who-is~~ available at all times.

b. The term "competent" is intended to mean a surgeon holding a certificate from the American Board of Surgery, or a fellow of the American College of Surgeons or eligible for such membership, or a surgeon who has had two (2) years or more experience as the regular assistant in seventy-five percent (75%) or more of the operations of a major nature performed during such the two-year period by a senior surgeon who performs a large amount and

variety of major surgery in an approved hospital. Above The assistantship shall have been served within a five-year period immediately preceding the date of the hospital license application.

11.4.2. Operating rooms shall be provided with adequate standard equipment and supplies to insure safe surgical care.

a. Adequate provisions shall be made for the storage of sterile surgical supplies and instruments.

b. A room or area for an emergency supply of clean and sterile goods and equipment is required.

11.4.3. Emergency lighting shall be provided in the surgical suite and should be connected with an automatic transfer switch which will throw the circuit to the emergency circuit in case of current failure.

11.4.4. Separate scrub-up facilities with nonmanual controls readily accessible to each operating room are required.

11.4.5. Utility Areas - Clean and soiled utility rooms properly equipped are required.

a. Doctors' and nurses' dressing rooms are required with showers and lockers recommended.

b. A janitor's closet for the surgical unit is required.

11.4.6. An ungrounded electrical distribution system shall be provided. Conductive flooring, furniture, mattresses and pads, rubber tubing and parts, belting, plastics, sheeting, shoes, electrical wiring and equipment shall comply with the ~~national fire protection association, No. 56~~ rules of the State fire commission.

11.4.7. Heating and air-conditioning systems installed shall have provisions made to prevent the recirculation of air.

11.5. Recovery Room.

11.5.1. There should be adequate provisions for immediate postoperative care in a separate room.

11.5.2. Location - The recovery room should be located on the same floor and adjacent to the surgical suite.

11.5.3. Size and Equipment.

a. The size of the recovery room is dependent upon the maximum number of patients to be accommodated at one (1) time. It is suggested that in hospitals with one to four (1-4) operating rooms there be one (1) recovery bed for each operating room plus one (1) additional recovery bed; in hospitals having from

five to eight (5-8) operating rooms there be one (1) recovery bed for each operating room plus two (2) additional recovery beds; and in hospitals having from nine to twelve (9-12) operating rooms there be one (1) recovery bed for each operating room plus three (3) additional recovery beds.

b. For each bed, sufficient area should be allowed to permit space for bulky equipment and to afford access of personnel on all sides of the bed, including the head.

c. Beds should be arranged in ~~such-a-manner~~ so that all patients can be observed simultaneously.

d. Adequate utility facilities shall be provided in addition to a nurses' station, charting area, medication storage and preparation space and clinical sink.

e. Approved oxygen and suction outlets shall be provided for each patient.

f. Necessary items of equipment and adequate supplies shall be provided including space for proper storage.

g. There shall be a sufficient number of electrical outlets and emergency electrical power provided. Sufficient artificial lighting shall be provided.

h. Provisions for adequate control of atmospheric conditions shall be available. Cooling and heating shall be sufficient to maintain a comfortable average temperature.

i. An emergency call system and telephone shall be provided as a means of summoning physicians or additional nursing personnel when needed.

#### 11.5.4. Staffing.

a. The recovery room shall be under the direction of a registered professional registered nurse, experienced and trained in the care and management of post-operative surgical patients.

b. The number of nurses and other personnel required to staff the recovery room is dependent upon the number of patients in the unit at different times of the day, and the length of time the patients remain in the unit, and the availability of assistance in emergency situations.

(1) Usually one (1) nurse experienced in the post-operative care of surgical patients, with the assistance of a nurses' aide or orderly, can care for four (4) patients, if supplies and equipment are provided assembled ready for use from a central supply unit.

11.5.5. Records - A record for each patient while in the recovery room shall include the physicians' orders, respiration,

pulse and blood pressure readings, treatment and medications given and the patient's condition on admission and transfer. A special recovery record form may be used; however, the same clinical record forms as used on other hospital units may be used.

#### 11.6. Anesthesia Department.

11.6.1. There shall be an organized anesthesia department under the direct supervision of a physician duly licensed in West Virginia.

a. When anesthetics are administered under the supervision of a physician and not by him or her, the individual administering the anesthetic shall be specially trained in anesthetic techniques.

b. ~~Definite Safeguards in the use of various types of general anesthetics shall be established. in view of the known hazards in administration and handling, and shall conform to the latest requirements of national fire protection association, No. 56, code for the use of flammable anesthetics.~~

c. All equipment for the administration of anesthesia and oxygen shall be readily available and there shall be provided safe suction and resuscitation apparatus, all kept clean and in good repair.

11.7. Pediatrics Department - Institutions providing this pediatric care shall have proper facilities apart from the services for adult patients. There shall be proper facilities and procedures for the isolation of children with infectious, contagious or communicable diseases.

11.8. Provision for Contagious Disease Patients - Many institutions do not have specialized contagious disease departments, but they do find it necessary, from time to time, to care for patients with contagious disease. Occasionally, patients admitted for treatment of some other condition will later be found to have a contagious disease. There may also be contagious disease patients in the community for whom hospitalization is necessary for proper care and treatment. Therefore, all institutions shall make provision for isolation in the event that this becomes necessary, except for hospitals or alterations built before 1969. In planning new institutions, or additions to existing institutions, there shall be one (1) or more suitable rooms for this purpose in accordance with the size of the institution and the needs of the community. Rooms planned for isolation of patients shall have lavatory and toilet facilities. There shall be adequate facilities for sanitizing bedpans and other equipment used in the care of the patient. Such The units are most efficient when provided with a utility room equipped with a sink, drainboard and utensil sterilizer.

#### 11.9. Coronary Care Unit.

11.9.1. Definition - Coronary care unit means a specialized area of the hospital containing a grouping of single bedrooms or ~~enclosures accommodating not more than six (6) beds or less than two (2) beds~~ or single bed enclosures wherein constant, intensive visual observation and immediate emergency and prescribed non-emergency coronary care and treatment can be provided. When such a coronary care unit is provided, the requirements listed herein of Sections 11.9.1, 11.9.2 and 11.9.3 shall be observed:

a. The coronary care unit ~~should~~ shall be organized under the direction of a ~~specially-created~~ committee of the medical staff, preferably headed by a cardiologist. The ultimate authority in determining policies of admission, length of stay and discharge, and in instances where operational problems arise must shall be clearly delineated through policies developed cooperatively by administrative, nursing and medical staffs. Most importantly, a qualified physician must shall be available to the unit at all times. Essential to the effectiveness of the coronary care unit is the development of a highly skilled nursing staff.

b. The nursing service shall be under the supervision of a registered professional nurse qualified by training, experience and ability. At least a minimum of one (1) qualified, registered professional nurse with special training shall be on duty at all times to give direct patient care. ~~Additional nursing personnel shall be available consistent with the nursing care required by the patients.~~ Coronary care unit staff shall be under the supervision of a registered professional nurse and may include registered professional nurses, practical nurses and other health care personnel qualified by training and State law to provide emergency care services.

c. Adjunctly, the organization of a cardiac arrest team composed ideally of an internist, an anesthesiologist, a surgeon and appropriate auxiliary staff should be undertaken to provide immediate emergency care both within the unit and throughout the hospital on a twenty-four (24) hour basis.

d. A system shall be established for calling selected emergency personnel to the unit. The patient should have an intercom system to the nurses' station; the nurses' general monitoring console should also be linked by intercom to an adjacent nursing station (to summon additional aid when needed), to the nurses' and doctors' lounge and the family waiting room.

#### 11.9.2. Size and Equipment of the Coronary Care Unit.

a. The area of the coronary care unit shall be sufficient in size to allow movable equipment to be placed on either side of the bed(s). A separate enclosed space approximately eleven feet x by twelve feet (11' x 12') should be provided for individual patient areas to ensure an adequate working area in time of emergency. A minimum of at least eighty (80) square feet per bed in multiple bedrooms and one hundred (100) square feet in single

bedrooms is required. Space for storage of commonly used equipment, supplies and drugs shall be provided within the unit.

b. A nurses' station located and so arranged for direct surveillance of all patients in the unit should be provided.

c. A medication preparation room and a clean and a soiled utility room shall be provided in immediate proximity to the bedrooms or within the enclosure unit.

d. A lavatory complete with mixing faucets, blade controls, soap and sanitary hand-drying accommodations shall be provided in each room.

e. In addition to normal lighting, a bright light should be available for examinations and in time of emergency.

f. Bedside vacuum and oxygen outlets should be installed at each patient's bed.

g. Adequate air-conditioning should be provided to control temperature and humidity.

h. The selection of specialized equipment to be installed in the coronary care unit is to be determined by the committee of the medical staff. However, certain basic equipment is essential for satisfactory function of the unit, namely:

(1) Variable height, adjustable beds or carriages with safety sides and bedboards;

(2) Bedside cabinets;

(3) ~~Intravenous-rods-installed-in-ceilings,-walls-or-attached-to-beds~~ Provision for intravenous delivery systems;

(4) Electrocardiographic monitor with an alarm system, via chest or limb electrodes, and pacemaker equipment must shall be available for immediate activation. The electrocardiograph should be displayed instantly on a bedside oscilloscope or a slave oscilloscope shall be available for constant viewing by the nurse;

(5) External defibrillator;

(6) Respiratory resuscitative equipment;

(7) Oxygen administration equipment;

(8) Emergency call system at each bed.

11.9.3. Satisfactory provision should be made for adequate electrical circuits with necessary voltage for mounting and connecting equipment as well as safe and adequate uniform grounding of all circuits. Electrical interference problems must shall be

obviated. The electrical system shall be connected to the emergency power system.

11.10. Intensive Care Unit.

11.10.1. Definition - Intensive care unit means a specialized area of the hospital containing a grouping of single-bed rooms or enclosures wherein critically and seriously ill patients requiring highly skilled nursing care and close and frequent, if not constant, nursing observation are assigned.

11.10.2. Organization - The intensive care unit should be organized under the direction of a specially-created committee of the medical staff with written policies developed cooperatively by administrative, nursing, and the medical staffs concerning admission, types of patients, length of stay, discharge, records and other operational aspects.

11.10.3. Size and Equipment - Generally, the number of beds, staffing patterns, equipment and supply requirements, and the administrative and operational procedures of the intensive care unit depend upon patterns of medical practice, patient load, types of patients treated, staff requirements, physical arrangement, dietary services and housekeeping facilities of the hospital.

a. A minimum of at least eighty (80) square feet in multiple bedrooms and one hundred (100) square feet in single bedrooms is required. It is recommended that for each bed sufficient area should be allowed to permit space for special equipment and access of personnel on all sides of the bed.

b. Beds in the intensive care unit should be arranged to enable the nurse to observe all the patients closely and frequently from the nurses' station and work area.

c. Approved Oxygen and suction outlets shall be provided for each patient.

d. Sufficient artificial lighting, adequate number of electrical outlets and emergency electrical power shall be provided in addition to patients' call button.

e. Provision shall be made for an emergency call system and telephone as a means in summoning physicians or additional nursing personnel.

f. A nurses' station, toilet, charting area, medication storage and preparation area, clinical sink and adequate utility and storage space shall be provided within the unit for storage of bulky equipment.

g. Control of atmospheric conditions shall be provided to insure comfortable heating, cooling and humidity and assure an aseptic atmosphere within the unit. The ventilation requirements

and the need for temperature and humidity conditions within certain specific limits ~~will~~ shall be dictated by the type of clinical conditions treated.

h. It is recommended that a relatives' waiting room be provided near the intensive care unit with toilet facilities and telephone booth.

#### 11.10.4. Staffing.

a. The staffing pattern ~~will~~ shall depend on the type patients admitted, the degree or intensity of the illness, as well as the utilization of nonprofessional practical nurses and other health care personnel qualified by training and State law to provide intensive care services, and the size and physical arrangement of the unit.

b. ~~The nursing service~~ The intensive care unit staff shall be under the supervision and direction of an experienced registered professional nurse especially trained in caring for critically and seriously ill patients.

(1) The same complement of staff should be provided for the full twenty-four (24) hours.

~~(2) --- Generally, one (1) registered professional nurse and one (1) nonprofessional nurse per unit of six (6) patients for each shift are sufficient for proper patient care.~~

#### 11.11. Extended Care Unit.

11.11.1. General Requirement - The extended care unit shall be located in a segregated area of the hospital and shall include the usual complement of ancillary facilities required in the conventional care unit and meet the general rules and regulations for hospitals.

11.11.2. Special Requirements - Adequate space shall be provided for dining and recreation areas, special equipment storage, training toilets, showers and bath facilities. Handrails, drinking fountains, lavatories, thresholds and telephone alcoves shall be designed to meet the requirements of patients using crutches, walkers and wheelchairs.

11.11.3. Organization and Staffing - The extended care unit shall be organized under the direction of a ~~specialty-created~~ committee of the medical staff with written policies developed by professional personnel including at least one (1) registered professional nurse.

a. The nursing service shall be under the direction of a registered professional nurse responsible for meeting the nursing needs required to implement the policies developed.

b. A registered professional nurse shall be in charge of

the extended care unit on each tour of duty with sufficient other personnel to assure adequate patient care.

11.11.4. Financial Rights and Responsibilities.

a. The hospital shall inform each patient before, or at the time of admission, and periodically during their stay, of services available in the hospital and of any charges for those services, including any charges for services not covered under Medicare, Medicaid or by the hospital's per diem rate.

b. If emergency services provided are not included in the extended care per diem rate, the hospital shall inform the patient in writing at the time of admission or at the time the policy is adopted by the hospital.

c. No extended care resident shall be transferred from or discharged by a hospital except for medical reasons, for the resident's welfare or safety or the welfare or safety of other residents, for nonpayment for his or her stay, or upon the resident's consent or request.

d. An extended care resident whose cost of care is reimbursed under Titles XVIII or XIX of the Social Security Act shall be discharged for nonpayment only in accordance with the provisions of the Social Security Act and any related applicable rules and regulations.

e. Extended care residents or their representatives lawfully authorized to manage fiscal matters on behalf of the resident have the right to manage their own personal financial affairs.

f. A hospital which manages or holds personal funds for extended care patients shall do so only upon written prior authorization of the patient or his or her representative lawfully authorized to manage fiscal matters on behalf of the patient, and shall hold such funds separately and in trust. Patient funds shall not be commingled with hospital operating or other funds.

g. The hospital shall administer the funds on behalf of the resident in the manner directed by the depositor.

h. The hospital shall render a true and complete account upon request to the depositor and at least quarterly to the resident on forms designated by the director.

i. Upon termination of the deposit, the hospital shall account to the depositor for all funds received, expended and held on hand on forms specified by the director.

j. If the hospital manages or holds personal funds for extended care patients, it shall make provision for the protection, in the form of insurance or other means providing equivalent protection, of the funds from theft or other forms of loss in an amount equal to the hospital's average daily balance of

patient funds handled within the hospital's preceding fiscal year. Hospitals which have not handled patient funds in the preceding year may use an estimated daily balance, but shall update their estimate every three months based on actual experience until they have a full year on which to base an average.

k. When a hospital determines on the basis of medical judgment that a resident appears unable to manage his or her financial affairs, the administrator of the hospital shall notify the resident's next of kin to initiate guardianship or incompetency proceedings.

l. A hospital may initiate guardianship or incompetency proceedings on behalf of the resident if the resident has no family or if the family, once notified, fails to act.

m. An employee of the hospital, or a person having a financial interest in the hospital is prohibited from accepting appointment as guardian, committee or conservator of the estate of an extended care resident, or from accepting a power of attorney for an extended care resident unless the employee or person is related to the resident within the degree of consanguinity of second cousin.

n. An individual serving in a prohibited capacity under Subsection 11.11.4.m of this rule as of the effective date of this rule shall initiate proceedings within thirty (30) days of the effective date of this rule to have him or herself removed from the prohibited capacity and to have another qualified person appointed.

#### **§64-12-12. Outpatient Services.**

##### **12.1. Outpatient Department.**

12.1.1. Medical service for ambulatory patients shall be organized as a definite outpatient department of the hospital under the supervision and direction of a qualified administrative official of the hospital.

a. The outpatient department shall be easily accessible for any ambulatory patients receiving treatment.

b. The outpatient department shall be conveniently located to other hospital facilities such as x-ray, laboratory and physical therapy departments.

c. Adequate and properly arranged accommodations and facilities shall be provided for the physical comfort and convenience of patients, medical staff and personnel, in addition to the equipment necessary for efficient professional care of patients.

12.1.2. Personnel - The outpatient department shall be provided with sufficient personnel, physicians, nurses and clerical assistants to assure proper care of patients.

a. The medical staff of the outpatient department shall meet the same requirements and qualifications which apply to the attending medical staff of the hospital.

12.1.3. Records - Accurate and complete medical records, including social and scientific data, shall be written on all patients, and shall be filed and indexed in such-a-manner-as-to be a form readily available at any time for reference, restudy and statistical and chronological research.

## 12.2. Emergency Department Services.

12.2.1. ~~All general hospitals shall provide~~ If the hospital provides emergency services, it shall have an emergency room to be which is located within so as to permit easy access from automobiles and ambulances. ~~a. The emergency service of the hospital shall be under the direct control of the director of the outpatient department who is responsible for the efficient function of these services.~~ b. The emergency rooms service shall be of a size comparable to the need imposed upon it and shall be adequately equipped to provide whatever life-saving measures may be needed for patients admitted to this service.

12.2.2. ~~Personnel---There shall be available~~ Professional personnel at all times who are trained in emergency life-saving measures shall be available at all hours the emergency service is open. Also, Either a physician who is a member of the professional medical staff of the hospital shall be available at all times to the emergency department or the hospital shall make arrangements for physician availability. Emergency room staff shall be under the supervision of a registered professional nurse and may include registered professional nurses, practical nurses and other health care personnel qualified by training and State law to provide emergency care services.

12.2.3. Records-- Adequate and complete records shall be kept on all patients treated in the emergency department.

12.3. Dental Unit - In a general hospital with one hundred (100) or more beds, it is recommended that consideration be given to the inclusion of a separate dental unit under the supervision of a dental surgeon duly licensed in West Virginia. Standard dental equipment, including all necessary anesthetic and sterilization equipment, should be provided for the diagnosis and treatment of diseases of the teeth and their related structures, rehabilitation and replacement of defective teeth and oral surgery.

## §64-12-13. Adjunct Diagnostic and Treatment Departments.

### 13.1. ~~Adjunct Diagnostic and Treatment Departments:~~ General.

13.1.1. Those adjunct services which are to be used by patients should be located conveniently to inpatient areas and to

the outpatient reception point of the hospital. The ground or first floor is usually the most desirable place for adjunct services.

a. A waiting area or room for patients with space for patient reception and control shall be provided.

b. Toilets for ambulatory patients and the public are required.

### 13.2. Laboratory.

13.2.1. Laboratory facilities with adequate space, equipment and supplies shall be provided in accordance with services to be rendered. A minimum of two hundred (200) to two hundred twenty-five (225) square feet exclusive of washing and sterilizing area, depending upon arrangement, is recommended for minimum services.

a. Minimal services include at least routine chemical and hematological laboratory procedures. Additional space ~~will~~ shall be needed provided for pathological, bacteriological and serological services if these are provided.

b. Space must shall be provided for clean-up and sterilizing and for administrative activities. It is recommended that these be separate rooms.

c. Hospitals of twenty-five (25) beds or less ~~shall-not-be~~ are not required to provide their own laboratory facilities if there is an approved laboratory available for use and located reasonably near such the hospitals.

13.2.2. Personnel - It is desirable that the laboratory be under the supervision and direction of a physician licensed to practice medicine in the state of West Virginia and who preferably has received special training in pathology.

a. ~~If the laboratory director is not in-reality-full-time in the laboratory or readily available to the laboratory, there must-be-in-the-laboratory-at-all-other-times-during-its-working-hours-a-capable-assistant-to-the~~ the assistant laboratory director who has full authority and responsibility for the activities of the laboratory in the absence of the laboratory director shall be present in the laboratory during laboratory working house.

b. ~~Qualifications-of-director:~~ The laboratory director must shall have minimal qualifications as follows:

(1) He or she must shall be a college graduate with major work for his or her degree in one (1) or more of the biological or chemical sciences commonly employed in clinical laboratories; or

(2) If such a person is not available, the laboratory di-

rector may be a person who is, or is eligible to become a registered medical technologist with the Board of Registry of the American Society of Clinical Pathologists; or

(3) A high school graduate who has had five (5) years' experience under a qualified clinical pathologist. Two (2) years of this required experience must shall have occurred within the five (5) years immediately preceding such employment.

(4) The laboratory director must shall also have had at least three (3) years' experience performing clinical or public health laboratory analyses in two (2) or more of the various fields of clinical laboratory activity in a clinical or public health laboratory ~~acceptable to the state department of health~~. Each year of resident post-graduate study in fundamental medical sciences which has been satisfactorily completed in a college or university accredited for granting a post-graduate degree in one (1) or more of these sciences, or in an institution accredited for such the post-graduate training by the Council on Medical Education and Hospitals of the American Medical Association, may be substituted year for year for the required experience, up to a maximum of two (2) years.

c. Qualifications of The assistant to the laboratory director shall:

(1) Must Be a college graduate with major work for his or her degree in one (1) or more of the biologic or chemical sciences commonly employed in clinical laboratories, or the equivalent as described in paragraphs (1), (2) and (3) of the qualifications of the laboratory director, except that a high school graduate who has had four (4) years' experience under a qualified clinical pathologist may be ~~deemed to have satisfied~~ accepted as satisfying this requirement. Two (2) years of this required experience must shall have occurred within the five (5) years immediately preceding such employment by the hospital as the assistant laboratory director; and

(2) Must Have had at least one (1) year's experience or the equivalent, as described in paragraph (4) of the qualifications of the laboratory director.

d. Qualifications for Additional technical laboratory workers other than students or trainees Must shall be at least high school graduates with a minimum of one (1) year of technical training in one (1) or more of the sciences or procedures commonly employed in a clinical laboratory. Such The training must shall have been received in an accredited college or university, or in a laboratory approved for such this training by the Council of Medical Education and Hospitals of the American Medical Association, or in a laboratory directed by a qualified clinical pathologist, or in a nationally recognized public health laboratory.

~~e. --- Personnel Exempt from These Requirements --- Paragraphs a,~~

~~b, c, and d above do not apply to a person in a given laboratory who was employed at the time these regulations first became effective.~~

~~13.2.3.---Equipment---The following basic items, in good condition, are required in any laboratory:~~

~~a.---Laboratory sink;~~

~~b.---Cabinets for reagents, and small equipment;~~

~~c.---Microscope and lamp;~~

~~d.---Refrigerator of at least six (6) cubic feet capacity;~~

~~e.---Adequate gas and electric outlets;~~

~~f.---Adequate glassware and reagents;~~

~~g.---Adequate centrifuge;~~

~~h.---Adequate working tables;~~

~~i.---Adequate filing system;~~

~~j.---Current laboratory reference texts;~~

~~k.---Adequate colorimeter or spectrophotometer;~~

~~l.---Hot air sterilizer of at least 18" x 14" x 14" i.d. or equivalent;~~

~~m.---Bacteriological incubator, which for accuracy of temperature control should be have internal dimensions of at least 20" x 20" x 24" i.d., or the equivalent;~~

~~n.---Autoclave;~~

~~o.---Balance and weights of suitable accuracy;~~

~~p.---Still or demineralizer, properly operated.~~

~~If serological tests for syphilis are carried out, the following additional equipment, maintained in good condition, is required:~~

~~q.---Serologic shaker and/or rotator;~~

~~r.---Adequate water bath facilities.~~

13.2.3. The laboratory shall have equipment, instruments, reagents, materials and supplies appropriate to the type and volume of testing performed and adequate to maintain the quality and safety of all phases of testing and other laboratory operations.

~~13.2.4:--Reports---The-director-or-the-assistant-to-the-director-of-each-hospital-laboratory-shall-submit-to-the-state-department-of-health-an-annual-report-of-the-laboratory-facilities-and-personnel-on-forms-provided-by-the-state-department-of-health:~~

~~13.2.5:~~ 13.2.4. Nothing contained in or required by these regulations this rule and no action taken pursuant thereto to this rule shall be construed as constituting an approval by the ~~state-department-of-health~~ director of any laboratory for proficiency to perform any specific laboratory test or technique explicitly required by any public health law or regulation.

### 13.3. Radiology.

13.3.1. All hospitals shall have facilities for at least one (1) radiographic room with adjoining darkroom, toilet and office. Hospitals of one hundred fifty (150) beds and over should have at least one (1) additional radiographic room. The size of the radiological department ~~will~~ shall depend upon the volume and types of services offered.

13.3.2. The radiological department shall be under the supervision of a licensed physician or a competent, well-trained x-ray technician.

13.3.3. Requirements-- The following are minimum requirements for the x-ray service area:

a. One (1) radiographic room with adequate x-ray and fluoroscopic equipment;

b. Darkroom;

c. Office, viewing facilities and film filing for both active and inactive records. (May be one (1) room in a small radiology department.);

d. Dressing booths with adjoining toilet and lavatory for ambulatory patients;

e. Waiting space under the supervision of qualified personnel for stretcher and wheelchair patients and for outpatients, if served;

f. Utility area with sink and counter space;

g. Supply and equipment space;

h. Proper shielding of walls, floors and ceilings in area and shielded control areas for operators of x-ray equipment shall be provide by the institution. Plans for such this protection ~~must-be-approved-by-the-state-department-of-health~~ shall comply with Radiologic Health Regulations, 64 CSR 23.

13.3.4. Therapeutic x-ray and radiological isotopes may be provided with due consideration for the safety of patients and personnel being given to all aspects of the physical plant and equipment utilized in the radiology department.

#### 13.4. Other Services.

13.4.1. Examination and Treatment Rooms (BMR, EKG, etc.) - All hospitals shall have at least one (1) all-purpose room for examination, treatment, private conferences, etc., in the adjunct service area. Separate space shall be provided for each service provided. rooms-for-various-functions-are-recommended-where-patient-service-is-of-such-volume-as-to-require-them. A lavatory with nonmanual controls is required in such rooms any all-purpose room, and if there are multiple rooms, in at least one (1) of them.

13.4.2. Physical and Occupational Therapy - Space and equipment required ~~will~~ shall depend upon services provided. All hospitals admitting patients with diseases which lead to any incapacitation or disability should have facilities to provide inpatients with physical therapy, occupational therapy and speech therapy.

~~a.---in-hospitals-of-one-hundred-(100)-beds-and-over,--it-is-desirable-that-space-be-provided-for-electrotherapy,--hydrotherapy,--massage-and-exercise-~~

b. If physical therapy is provided in the institution, it must shall be under the supervision of a physician duly licensed in the state of West Virginia.

13.4.3. Morgue and Autopsy - In hospitals of fifty (50) or more beds, complete morgue and autopsy facilities are recommended. A morgue is not required in small hospitals if mortuary facilities are available to the hospital.

#### §64-12-14. Professional Standards.

##### 14.1. Medical Staff.

14.1.1. Medical Staff - Each hospital shall have an organized medical staff which includes fully licensed physicians and may include other licensed health care professionals who are privileged by law and by agreement with the hospital to attend patients, as defined in the hospital's governing and medical staff bylaws. The medical staff shall be accountable to the hospital's governing body for quality of medical care provided to hospital patients and for the ethical and professional conduct of its members while functioning in the hospital.

a. All hospitals which admit two (2) or more physicians to practice in the institution shall have an organized medical staff responsible to the governing authority for the fitness, adequacy and quality of medical care provided to patients in the hospi-

tal. Satisfactory evidence shall be maintained by the hospital of such the organization.

b. The term "staff" ~~is defined here as~~ refers to the group of physicians and other licensed health care professionals who are members in accordance with Section 14.1.1 of this rule and practice in the hospital. ~~inclusive of all groups, such as the active medical staff, the associate medical staff and the courtesy medical staff.~~

c. Membership - The medical staff shall be appointed by the governing body of the hospital in accordance with its bylaws, rules and regulations.

1. Each member of the medical staff shall be qualified for membership and the exercise of clinical privileges granted to him or her as evidenced by a current license to practice his or her profession in the State of West Virginia.

2. Clinical privileges of each medical staff member shall be delineated in writing.

3. Members of the medical staff ~~must~~ shall be legally, professionally and ethically qualified.

d. Rules and Regulations - The medical staff shall initiate and, with the approval of the governing board of the hospital, adopt rules, bylaws and regulations governing its professional organization and functional work. All medical staff members shall sign a document which specifies that the bylaws, rules and regulations have been read. These rules and regulations, and policies shall specifically provide:

(1) That staff meetings be held at least once each month unless the hospital medical staff has monthly meetings in each department, or unless monthly departmental quality improvement meetings occur in conjunction with bi-monthly departmental medical staff meetings. In the latter case cases, only quarterly meetings of the full medical staff are required;

(2) That the staff review and analyze at the ~~monthly staff meeting~~ these meetings their clinical experiences in the various departments of the hospital such as medicine, surgery, obstetrics and the other specialties. The clinical records of patients shall be the basis of such the review and analysis;

(3) ~~The medical staff shall provide in its bylaws, rules and regulations~~ For the performance of committee functions in at least the following areas: credentials, medical records, case and utilization review, quality assurance, hospital infections, casualties, pharmacy and therapeutic practices and such other committees as the hospital board may deem necessary;

(4) ~~There shall be~~ For a chief of staff with direct responsibility for the organization and administration of the medical

staff in accordance with the terms of the medical staff constitution, bylaws, rules and regulations; and

(5) For the chief of staff shall to be responsible for the functioning of the clinical organization of the hospital and shall-keep keeping, or cause causing to be kept, careful supervision over the clinical work in all departments of the hospital.

14.2. Nursing Department.

14.2.1. A department of nursing shall be organized to provide comprehensive, effective nursing care to each patient under the direction of a registered professional nurse designated by the governing authority of the hospital, currently licensed in West Virginia and with such the education and experience to enable him or her to properly execute his or her functions and responsibilities.

14.2.2. There should be a written departmental nursing department plan of administrative authority with delineation of responsibilities and duties of each category of nursing personnel. The following documents shall be maintained:

a. A statement of the policy and objectives of the nursing department.

b. Current job descriptions and specifications for each category of personnel subject to review at least annually.

14.2.3. The following records shall be available in the department hospital:

a. A list of all licensed nursing personnel, including private duty and per diem nurses, with each individual's current West Virginia license number;

b. Personnel records including employment application forms and verification of credentials and character references for each nursing department employee;

c. In the nursing department, the current nursing care policy and procedure manuals;

d. In the nursing department, minutes and records of attendance at all meetings;

e. In the nursing department, a list of the nursing department committees and other committees on which nursing is represented; and

f. In the nursing department, a master staffing plan for the current year.

14.2.4. There shall be an adequate number of registered professional nurses to meet the following minimum staff require-

ments:

a. Assistants to the director of nursing for evening and night services.

b. Supervisory personnel qualified by experience, education and ability for each specialty division of the nursing department, including but not limited to operating room, emergency, outpatient, maternity, newborn, pediatrics, intensive care, coronary care and medical and surgical services.

c. Staff personnel to provide direct nursing care as needed and to supervise nonprofessional personnel.

d. A registered professional nurse shall be on duty and immediately available for bedside care of any patient when needed on each shift, twenty-four (24) hours per day and seven (7) days a week.

e. Licensed Practical nurses as needed to supplement registered professional nurses in appropriate ratio to the registered professional nurses.

f. Auxiliary workers as needed to provide physical care and assist with simple nursing and clerical procedures not requiring professional judgment.

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

a. A written nursing care plan for each patient shall be kept current daily.

b. A copy of the current nursing care policy and procedure manual shall be available in each nursing unit.

c. Written nursing notes shall be maintained for each patient.

14.2.6. In order to assure well-established working relationships with other services of the hospital, both administrative and professional, a member of the nursing department, preferably a registered professional nurse, shall be represented on committees concerned with interdepartmental policies affecting nursing services and nursing care to patients.

14.2.7. Planned meetings shall be held monthly by the nursing department to discuss patient care, nursing service problems, administrative policies and to analyze the quality of nursing care rendered to patients.

14.2.8. Continuing planned educational activities shall be held for all nursing personnel. These activities shall include, but not be limited to, on-the-job training and development programs. Records of these program activities shall be maintained

including the methods used and an evaluation of their effectiveness.

**§64-12-15. Specialized Hospitals and Other Institutions.**

15.1. Tuberculosis Hospital - To be licensed as a tuberculosis hospital, an institution must shall be devoted exclusively to the care of tuberculosis patients, have on the staff professional personnel especially qualified in the diagnosis and treatment of tuberculosis and meet the requirements for a general hospital. Maternity services need not be provided if provision is made for adequate maternity care at some readily available licensed hospital.

15.2. Mental Hospital - To be licensed as a mental hospital, an institution must shall be devoted exclusively to the care of mental patients, have on the staff professional personnel especially qualified in the diagnosis and treatment of mental illness and have adequate facilities for the protection of the patients and staff against physical injury by patients becoming violent. The requirements for a general hospital must shall be met except that maternity facilities need not be provided if provision is made for adequate maternity care at some readily available licensed hospital.

15.3. Orthopedic Hospital - To be licensed as an orthopedic hospital, an institution must shall be devoted exclusively to the care of orthopedic patients, have on the staff professional personnel especially qualified in the diagnosis and treatment of orthopedic conditions and must shall meet the requirements for a general hospital except that maternity facilities need not be provided if provision is made for adequate maternity care at some readily available licensed hospital.

15.4. Chronic Disease or Long-Term Hospital - To be licensed as a chronic disease or convalescent long-term hospital, an institution must shall be devoted exclusively to the care of patients requiring hospitalization because of prolonged illness or who are not acutely ill and not in need of general acute hospital care but who do require continuing medical care, skilled nursing care and related medical services. It shall have an average length of inpatient stay greater than twenty-five (25) days. It must shall have a professional staff who are qualified in the diagnosis and treatment of chronic diseases, and it must shall meet the requirements for a general hospital except that maternity services are not to be provided.

**§64-12-16. Administrative Due Process.**

Those persons adversely affected by the enforcement of this rule desiring a contested case hearing to determine any rights, duties, interests or privileges shall do so in a manner prescribed in Rules of Procedure for Contested Case Hearings and Declaratory Rulings, 64 CSR 1.

§64-12-17. Severability.

The provisions of this rule are severable. If any provisions of this rule are held invalid, the remaining provisions remain in effect.

**Discussion of Public Comments Received  
Concerning Proposed Amendments to  
Hospital Licensure, 64 CSR 12**

The proposed amendments to this legislative rule revises or deletes certain outmoded hospital licensure standards which are creating problems due to their variance from current standards of good hospital practice. Additionally, references to outdated State and national standards have been clarified and updated, and extensive stylistic revisions have been made for purposes of clarification, elimination of duplicated standards, and conformance with current Department procedures and legislative rule drafting standards.

A public comment period was held, beginning November 18, 1993 and ending December 20, 1993. The Department received approximately 80 letters of comment, representing individuals, groups of individuals, hospitals, various professional associations and groups and the registered and practical nurse State licensing boards. These comments are summarized and discussed below. Copies of all comments received by or postmarked December 20 and a list of commenters are attached.

A few comments received and postmarked later than December 20 are not included; these late comments were not different in substance from comments received on time.

1. Comment: A number of commenters requested a public hearing in order to provide opportunity for discussion of the proposed rule and/or to comply with State law requiring a public hearing.

Response: The Department believes that it has complied with the State Administrative Procedures Act by providing extensive notice and opportunity for public review and written comment.

2. Comment: Section 3.1. Inquired which, if any, of the regulations apply to for profit hospitals. If they apply to both, 3.1 needs modified.

Response: The term "applicable hospital" is used only in the definition of "Section 6a Hospital," and is included for the purposes of Section 7.3 of the rule which, in accordance with W. Va. Code §16-5B-6a, relates to a requirement for consumer membership on the boards of directors of certain hospitals.

3. Comment: Section 3.8. The word "rehabilitation" could be replaced by the words "other professional healthcare" in the definition of "extended care facility."

Response: Agreed.

4. Comment: Section 3.12 fails to define the services, or identify the statutory authority under which such services may be

legally provided. The services which may serve as a basis for hospitalization should be clearly delineated.

Response: The Department sees no need to attempt to identify an exhaustive list of permissible services. As the commenter pointed out, Federal Medicare standards provide a list, and all hospitals in the State are certified for participation in Medicare.

5. Section 3.21. The Department has added a definition of unit dose in order to clarify a change to Section 10.1.4.

6. Section 7.2.1. The Department has added text to clarify that the hospital is responsible for compliance with the requirements of this rule.

7. Comment: Section 7.2.1(a)(4). Reference to a joint conference committee should be deleted since JCAHO (Joint Commission for the Accreditation of Health Care Organizations) no longer requires this. Membership on the board of trustees by the Chief of Staff and/or other physicians could fulfill the "formal liaison" requirement.

Response: Agreed.

8. Comment: Section 7.3.8. Appears to be discriminatory and smacks of "filling slots" or trying to "look good".

Response: This requirement is related to W. Va. Code §16-5B-6a.

9. Comment: Sections 8.3.2 and 8.4.2. A number of commenters requested that the rule specify a threshold amount before a hospital is required to submit architectural, structural and mechanical drawings and specifications. One suggestion was that projects requiring a certificate of need to be required to submit architectural drawings.

Response: The Department's concern is with the nature of and the compliance with applicable standards of proposed construction or alterations. It believes that it is important and a convenience to the hospital to predetermine these considerations prior to actual construction rather than after when correcting problems is apt to be problematic and costly. Certificate of need standards are cost-oriented. It is neither desirable or feasible to construct a set of standards sufficiently extensive to deal with the wide range of projects which might occur. Hospitals in doubt as to the applicability of these requirements, admittedly a cost issue, may request guidance from the Department in advance of actual expenditures for the various drawings and specifications requested.

10. Comment: Section 8.5.2. This section is too vague as

to the definition of an area requiring a smooth washable surface.

Response: See immediately below.

11. Comment: Section 8.6.4. Suggests adding "as allowed in the 1992-93 edition of Guidelines for Construction and Equipment of Hospital and Medical Facilities."

Response: The Department concurs but has added clarifying language to Section 8.1 of the rule to solve this problem.

12. Section 9.1.1. The Department has added the information that hospitals are required to comply with Cross Connection and Backflow Prevention rule, 64 CSR 15.

13. Comment: Section 9.1.5.b. The use of disposable can liners should be recognized.

Response: Agreed.

14. Comment: Section 10.3. No provision for electronic data or recognition of electronic capabilities has been made.

Response: The Department does not believe that the rule precludes the use of an electronic medical record system, but has added clarifying language to relevant sections.

15. Comment: Section 10.3.1. The word "librarian" is outdated. Use "registered record administrator."

Response: Agreed.

16. Comment: Section 10.3.1.d. No "short" form is acceptable. Suggested language - "A final progress note may be substituted for a discharge summary in the case of patients with problems of a minor nature which required less than a forty-eight hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetric deliveries."

Response: Section 10.3.1.d simply recognizes that the "complete record" required by Section 10.3.1.a and described by Section 10.3.1.b may not be needed or relevant for short-stay, maternity and newborn patients. The Department also notes that Federal standards for participation in Medicare require a discharge summary for all hospital patients.

17. Comment: Section 10.3.1.e. Should be more specific regarding the length of medical record retention. Medicare Conditions of Participate require a five year retention.

Response: There is no legal requirement in State law related to hospital record retention and the Department does not believe that it has the authority to attempt to set a minimum

length which would be applicable for liability purposes.

18. Comment: Section 10.3.1.g. Allow for an electronic signature or signature stamp.

Response: This would not be consistent with federal standards.

19. Comment: Section 10.3.1.h. The proposal to allow the medical staff of a hospital to determine which staff may receive verbal orders in place of the current requirement which limits the receiving of verbal (usually telephone) orders to registered professional nurses (RNs) attracted numerous negative comments from individual nurses, from the State Boards of Examiners for Registered Professional Nurses, and for Practical Nurses and others. The proposed amendment is supported by other affected professionals.

Response: The Department has studied this issue previously, although it has not actually proposed this specific revision to the Legislature. It is offered at this time as one of a set of proposals related to specific problems experienced. The Department does not endorse the extensive use of verbal orders. It recognizes, however, that there are circumstances in which verbal orders may be needed. Until relatively recently, federal standards for hospitals participating in Medicare and standards of the Joint Commission for the Accreditation of Health Care Organizations (formerly Joint Commission for the Accreditation of Hospitals) contained the same restriction. Both these national standards now permit individual hospitals to determine which procedures work best in the individual hospital setting. The issue has been raised as to whether in proposing the change the Department is attempting to define the practice of nursing. The Department would contend that permitting hospitals to make a determination regarding the receipt of verbal orders is no more a regulation of nursing than restricting the receipt of verbal orders to RNs. The Department does not interpret the Nurse Practice Act to limit the receipt of verbal orders to RNs, although clearly RNs may receive verbal orders. The RN is capable of and expected to be able to take verbal orders for all aspects of inpatient care; the receipt of verbal orders by other health care professionals would be limited to the specific area practice of the individual. For example, a pharmacist would have the requisite knowledge to discuss and clarify medications and a physical therapist would be expected to deal with verbal orders related to physical therapy. In actual practice there are some special areas of treatment within the hospital setting where Rns are not normally present. Additionally, the Department contends that individual hospitals have the knowledge and experience to determine what works best within their special circumstances and with their "mix" of health care professionals. The Department does not believe that allowing hospitals this latitude will endanger patient care and safety.

20. Comment: Section 10.3.1.j. A list of approved abbreviations is no longer required by JCAHO and has historically been proven to be ineffective.

Response: The Department believes that such a list is still useful and serves as insurance for better care and disagrees with the suggestion. The interpretation of an abbreviation is not always clear-cut.

21. Comment: Section 10.3.1(k). Does the requirement for final diagnoses inclusion in the patients' medical record include nursing diagnoses? Please change it.

Response: The commenter made no specific recommendation. The expectation for the medical record to serve as a recapitulation of events of the patient's treatment is consistent with commonly accepted standards of hospital practice.

22. Comment: Section 10.3.1.l. A number of commenters stated that medical records should be completed and signed within thirty days of discharge.

Response: Agreed.

23. Comment: Section 10.3.1.n. Hospitals should be able to decide the best location for record storage.

Response: Agreed, particularly in view of electronic record systems.

24. Sections 10.3.3 and 10.3.4. The Department has made minor clarifying changes to these two sections which relate to disease reports.

25. Comment: Section 11. Concerns were expressed that the rule appears to assume that each hospital will provide surgical, obstetrical and anesthesia services (Sections 11.3, 11.4, 11.5, 11.6, 11.7, 11.9, and 12.2), whereas services such as coronary care, pediatrics and emergency services are clearly described as optional.

Response: The provisions of the rule relating to specific service areas have been and will continue to be interpreted as non-applicable to facilities which do not providing these services.

26. Comment: Section 11.2.3(a). The regulation requiring a nurse's station equipped with a patient call system, a communication system to other departments and at least one nurse's station on each floor containing patient bedrooms is an outmoded requirement.

Response: The Department disagrees with the concept that

requiring a nurse's station to be located in a manner most proximately promoting nurse staff availability to each patient is outmoded.

27. Comment: Section 11.2.4. The regulation requiring that nurse's stations be adequately designed and equipped is outmoded.

Response: It is unclear exactly what the commenter is finds objectionable. The Department does not agree with the characterization of the requirement as outmoded.

28. Comment: Section 11.2.7. "The proposed rule's language makes it seem as though this equipment is required in each closet. Space for storage needs to be adequate for the equipment stored in each closet not all potential equipment that could find its way to a floor."

Response: Agreed.

29. Comment: Section 11.3.1.a. There are circumstances when nurses who care for obstetrical patients can care for other types of patients without compromising patient care and that hospitals should be able to use their beds and staff to the maximum extent possible if patient care is not jeopardized. Section 11.3.8, which allows patients other than obstetrical patients to be housed on the obstetrical unit, conflicts with Section 11.3.1.a.

Response: The department agrees and has provided alternative text. Section 11.3.1.a referred only to care and did not prohibit non-obstetrical patient admission to maternity services; nevertheless the proposed revision will also relieve the apparent conflict between the two items.

30. Comment: Section 11.3.3. Use of the word sunshine implies direct light from the sun. A better choice of words is "natural light".

Response: Agreed.

31. Comment: Section 11.3.8. There should be some recognized standard, perhaps from the Centers for Disease Control, with which the facility must comply when approving written policies. Such policies should be subject to approval not only by the medical staff, but by professional nursing personnel.

Response: The Department believes that individual hospitals have the necessary knowledge to develop adequate policies. Additional clarifying language has been added regarding the involvement of infection control staff and elevated temperatures.

32. Comment: Section 11.4.6. Should refer to national

fire protection association, No. 99, not No. 56.

Response: The Department inadvertently failed to delete this reference to NFPA 56 in the rule filed for public comment. All other such references were deleted and Section 6.3 of the rule defers to the rules of the State Fire Commission.

33. Comment: Several comments objects to numbers used in various sections relating to nurse/patient and other ratios. It was stated that the rule is inconsistent.

Response: The Department has made some changes, but feels that this comment is related to the issue of the use of staff other than nurses in certain areas of the hospital, which is discussed elsewhere in this document. The Department does propose to delate Section 11.10.4(b)(2) for the purpose of consistency.

34. Comment: Section 11.5.4(b). "Although no changes to this subsection have been proposed, the existing language is outdated and needs to be revised to reflect the current standard: to require registered professional nurses to fully staff the recovery room. The rule should include language which would prevent the recovery room from being dangerously isolated from other professional nursing staff, who should be available to provide assistance in the event of a patient emergency. There should be more than a single registered professional nurse assigned to the post-operative recovery area, or a registered professional nurse readily available from an immediately adjacent unit, in the event of a patient or other emergency."

Response: An extensive revision is beyond the scope of the present effort. The item has, however, been clarified regarding the availability of assistance in emergency settings.

35. Comment: Section 11.9.1. Many small hospitals combine the coronary care unit and intensive care unit, therefore, does not feel it is appropriate to place a limit on the number of coronary care beds that can be licensed.

Response: Agreed.

36. Comment: Section 11.9.1.a. Should be changed to clarify that a medical staff committee specific to and exclusively for a coronary care unit is not required.

Response: Agreed.

37. Comment: Sections 11.9.1.b, 11.10.4 and 12.2.2. These sections, applicable to the coronary care, intensive care and emergency services units respectively, received numerous negative comments from individual nurses, from the State Board of Examiners for Registered Professional Nurses, Board Practical Nurses

and others but also were favorably received by others.

Response: In each instance, the department proposes to permit, under the supervision of an RN, in addition to RNs and practical nurses "other health care personnel qualified by training and State law [emphasis added] to provide emergency care services." These proposed changes do not permit these individuals to provide nursing services generally. Appropriate and needed RN oversight of such individuals is mandated. The proposed revisions do not relieve the hospital of the responsibility for providing for patient care. They do, however, provide the hospital with the opportunity to utilize individuals highly skilled and trained in selected areas relevant for some aspects of the care typically needed in these settings. The hospital will need to establish a program to train such individuals to perform nurse aide tasks if these individuals perform tasks outside their area of expertise.

38. Comment: Section 11.10.2. clarify that a medical staff committee specific to and exclusively for an intensive care unit is not required.

Response: Agreed.

39. Comment: Sections 11.10.4.a and 11.10.4.b.(2). In place of "non professional" use "licensed".

Response: Not needed. State law requires practical nurses to be licensed.

40. Comment: Section 11.11.3. It is not necessary to have a specially created committee of the medical staff to oversee the operations of the extended care facility.

Response: Agreed.

41. Comment: Section 11.11.4.a. The rule should permit hospitals to charge patients for those items included in the admission contract, as well as any item specifically requested by the patients, such as barber\beautician services.

Response: Agreed. All of Section 11.11.4 was new. The West Virginia Health Care Association sponsored a thoughtful analysis, concurred with by the West Virginia Hospital Association, which offered several good points. Other commenters identified the same or similar points.

The intent of Section 11.11.4.a was and is to protect patients from unexpected expenses and to require that they be made aware of the potential for charges additional to the per diem. It has been reworded and clarified.

42. Comment: Section 11.11.4.b. Commenters stated that it

is not always practical to make a patient aware of the charges of various items prior to rendering a service. If the services are emergency services, it is very unlikely that there will be time for prior consent by either the patient or the financially responsible person. A literal interpretation could necessitate getting prior approval on every item of care rendered to a patient. Like most hospitals, this facility has several thousand different charges; it would be practically impossible for the hospital to estimate the charges for the emergency service.

Response: The department has revised this item.

43. Comment: Sections 11.11.4.c and d. The regulations should permit hospitals to transfer or discharge a patient if the patient's health has improved and the patient no longer requires the hospital's services and if the extended care unit ceases to operate. The proposed rule is too narrow.

Response: Improvement of health and no longer needing care would be classified as "medical reasons" for discharge or transfer. If the service is no longer offered, a transfer would seem to be indicated either for a medical reason or for reasons of the patient's welfare and safety. The Department believes that no change is necessary.

44. Comment: Section 11.11.4.f. Authorization by a patient's representative lawfully authorized to manage fiscal matters on behalf of the patient for a hospital should be permitted. Furthermore, hospitals should be permitted to maintain a single account for all patient accounts rather than individual accounts for each patient. It was also suggested that language be added providing for the transfer to the patient's use or account the full amount of any interest or benefit received from such assets.

Response: Clarifying language regarding a representative has been added although the Department believes that this would be the case under State law even if not specifically stated. The rule was not intended to preclude combining the funds of two or more patients in a single account, but rather to prevent the commingling of patient funds with hospital funds. Clarifying language has been added.

45. Comment: Section 11.11.4.j. The required amount of insurance which a hospital must maintain to protect the patient's funds is unclear. Maintaining insurance equal to the total patient funds handled throughout the year would be an unnecessarily high requirement. Insurance equal to the hospital's average daily balance of patient funds would be acceptable. Excessive insurance increases the cost of health care and does not protect funds.

Response: Agreed.

46. Comment: Section 11.11.4.k. Placing an affirmative duty on the hospital to determine a patient's capacity to manage his or her estate and requiring a committee in all cases places an unnecessary burden on the health care system.

Response: The rule has been reworded slightly to clarify that this is not intended to require such a determination in all instances. Nevertheless, the Department notes that the hospital has a responsibility and does not believe it is unreasonable to require notification of individuals who may be responsible for the patient's welfare. Usually, when the patient becomes incapable of making decisions about health care, an area in which the hospital already has a responsibility, the patient will also be incapable of managing his or her financial affairs.

47. Comment: Section 11.11.4.1. This section requires the hospital to initiate guardianship proceedings if the patient's family fails to do so. This section should state that the cost of the committee proceeding may be charged to the patient or the patient's estate.

Response: This rule is permissive, not mandatory and is simply a restatement of State law. A hospital may need to take such action in its own best interests. The Department does not have any regulatory authority over the disposition of charges for committee proceedings.

48. Comment: Sections 11.11.4.m and n. Prohibiting a hospital employee from serving as a patient's power of attorney when the patient selects that individual defeats the patient's expressed wishes and is in conflicts with the intent of Federal law. Employees should be permitted to remain the patient's fiduciary if they were appointed prior to the patient's admission to the facility. In the case of an employee serving as a patient's power of attorney, if another individual is not listed as a successor attorney under the power of attorney, it is likely that a committee will have to be appointed and that committee may well be a sheriff who never knew the patient. A stranger should not serve as the patient's financial decision-maker when the patient clearly stated that he or she wanted the employee to serve in that capacity. Again, exception should be made for appointments made prior to admission.

Response: The issue of surrogate health care decision making has evolved over a period of several years, culminating in 1993 with the passage of the general Health Care Surrogate Act, W. Va. Code §16-30B. Unfortunately there is at the present time no similar law dealing with the problem of safeguarding the financial interests of individuals who become temporarily or permanently incapable of managing their own funds and who have not executed a durable or other power of attorney which specifies procedures for the selection of an individual to represent them. A commission appointed by the Department has been working on a

proposal for legislation which is intended to be before the 1994 Legislative Session. The Department is concerned about the potential for conflict of interest in the instance of an employee of the hospital having control over the use of the patient's funds by his or her employer but is aware that the county sheriff is not necessarily the best person to take this role. The Department defers to the Legislators' judgment on this issue. The items in question can be retained or deleted.

49. Comment: Section 12.2.1.a. Not all hospitals have outpatient directors. The position to whom the emergency director reports should be a decision made by the hospital. It is not always appropriate for the emergency service to be under the direct control of the director of the outpatient department.

Response: Agreed. Section 12.2.1.1 has been deleted.

50. Comment: Section 12.2.2. Add "licensed" before "practical nurse".

Response: Not needed. State law requires practical nurses to be licensed.

51. Comment: Section 13.2.2. "We disagree with the licensure law attempting to establish minimum levels and types of education and experience to hospital personnel. We also disagree with the licensure law establishing a chain of command for management or a minimum level of management."

Response: The proposed revision does not essentially modify the existing requirements which have not been problematic. The requirement is comparable to current federal laboratory standards.

52. Comment: Section 13.2.3. Why is a hot air sterilizer in addition to an autoclave needed. The balance and weight requirement is obsolete and is not necessary. 13.2.3.k could be replaced with "adequate equipment, maintained in good condition to accurately perform all tests reported by the laboratory."

Response: The Department proposes an alternative revision of this item which should solve the issues raised above as well as certain other outdated provisions.

53. Comment: Section 13.4.1. "Non-manual controls should only be required if dictated by good infection control practices."

Response: The Department agrees in principle although not in the exact language.

54. Comment: Section 13.4.2.a. "It is our understanding that hospitals in the future will be of 100-200 bed capacity."

For reasons of maximum efficiency and medical effectiveness, our physical therapy department feels that the requirements for adequate space for electrotherapy, hydrotherapy, massage, and exercise specified in this rule, be maintained."

Response: See Section 13.4.1. At the present time this rule applies to small and large hospitals.

55. Comment: Section 14.1.1.d.(1), (2) and (3). One commenter stated that JCAHO no longer requires monthly departmental meetings of the medical staff and is promoting a quarterly review instead. Another commenter noted that monthly meetings at the departmental level would be unduly burdensome to small rural primary care hospitals and also suggested that the rule clarify that in the case of this type of facility that the committee functions identified in subsection xx could be performed by designated staff in conjunction with the larger hospital with which the rural primary care hospital is affiliated.

Response: The Department does not believe that the requirement for monthly review of clinical experience is unduly burdensome in many instances. Clinical record review by whatever format determined to be appropriate by the medical staff and the governing body may well be the only formalized mechanism by which quality assessment and improvement of clinical services will occur in some instances. Language has been added to recognize some acceptable alternatives, however. Although the numbers inpatients in small rural hospitals may be low compared to other hospitals, the overall combination of outpatient and inpatient services rendered in small rural hospital outpatient services may in fact be quite large when compared to the number of staff available.

Separate committees are not required by the rule. It has been common practice over the years for hospitals to utilize "committee-of-the-whole" approaches. One person committees are also options, particularly for very small hospitals.

56. Comment: Section 14.2. "The highly prescriptive approach causes a redundancy in record keeping and a lack of flexibility in developing alternative patient care modalities."

Response: The comment is very general and does not offer specific suggestions. The Department believes that the requirement for documentation of nursing care is reasonable and is no more prescriptive than requirements for other departments and services.

57. Comment: Section 14.2.3. A number of commenters objected to keeping personnel records in the nursing department.

Response: The Department agrees that these records do not need to be kept in the nursing department and proposes additional

changes in Section 14.2.3 to correct the problem.

58. Comment: Section 14.2.4. Disagrees with establishing a minimum staffing requirement and chain of command. Disagrees with terms "appropriate" and "immediately available", etc. "These terms leave the hospital open to whatever opinion an evaluator may apply."

Response: This is not a new requirement and has not been problematic. Patient outcomes will determine the degree of adequacy and appropriateness.

59. Comment: Section 15.4. Suggested modifying this section by adding long-term care and adding a limit of twenty-five days and other wording to specifications for licensure as chronic disease hospital.

Response: Agreed.

## HOSPITAL LICENSURE COMMENTS

Pamela L. Alderman, RN, MSN, Assistant Professor of Nursing,  
Director of Allied Health - Southern WV Community College  
Carol Banal, RN, CCRN  
Debra Bell, RN  
Bluefield Regional Medical Center, Director, Medical Records/QA  
- Margaret T. Millsap  
Kathleen A. Bonnett, RN, C, MS  
Gene Brewer  
Suzanne Brewer, RN, PCC  
Cheryl Rae Brumfield, RN, MSN, CNA (and 4 other RN's)  
Rachel G. Byrd  
Ann Carter, RN, CCRN  
Cindy Cornett, RN  
Davis Memorial Hospital, Director of Nursing Service  
- Diana H. Patella, RN  
Davis Memorial Hospital, Director of Human Resources  
- Dale A. Biesecker  
Davis Memorial Hospital, Chief Executive Officer  
- Robert L. Hammer, II  
Lillian S. Dick, RN  
Joyce Diederich, RN, BSN, CCRN  
Natalie Eddy, RN, MSN, FNP-C  
April Edwards, RN  
Yvonne Everman, RN, CCRN  
Trudy Forster, RN  
Mary M. Frohme, RN, C  
Patsy M. George, RN  
Grant Healthcare Management, Inc.  
Tammy Harbour, RN, CCRN  
Highland Hospital  
Michael W. Holt, PA-C  
Joyce A. Hummel, RN  
Lesia M. Hurst, EMT-P  
Suzanne M. Kolas, RN, BSN  
Shelia Kyle, M.S.N., R.N., C.  
Barbara W. Law, RN, BSN, MSN, CCRN, CS  
Brian J. Loshbough, MS, RN, C-FNP  
Irene Louda, BSN, MHA, CEN, CNA, RN  
Marshall University, Director, BSN Program -  
Judith Sortet, Ed.D., RN  
Emily McDowell, RN-CS, FNP  
Mary G. McKinley, RN, MSN, CCRN  
Monongalia General Hospital  
Ruth J. Moore, R.N., Ed.D.  
Mountain View Regional Rehabilitation Hospital  
M. Elizabeth Naranch, ASSW, Social Worker, Long Term Care  
NovaCare Southern Hills Regional Rehabilitation Hospital  
Martha L. Packer, RN

Peterson Rehabilitation Hospital & Geriatric Center,  
 Administrator/Director of Nursing  
 - Elizabeth J. Sproull, RNC, M.Ed.  
 Carol Porter, RN  
 Preston Memorial Hospital, Director of Nursing, Helen C. Nikirk  
 Sandra K. Prunty, MSN, RN, CS, FNP  
 Mary C. Ramsburg, BSN, RN  
 Susan Reasor, RN, CCRN  
 Laura Skidmore Rhodes, RN, MSN  
 Martha Richardson, RN, C, BSN  
 Lorraine Ritz, RN  
 Catherine A. Robinson, RN, MS, CEN, CCRN  
 Jody Ross, RN  
 Mary Rust, MSN, RN  
 Janice M. Smith, MSN, RNC  
 Sara E. Smith, RN, MSN, CNAA, Associate Administrator/Director  
 of Nursing - Ohio Valley Medical Center  
 St. Joseph's Hospital, President & Chief Executive Officer  
 St. Joseph's Hospital, Director  
 Compensation & Benefits - Adele Watson  
 St. Joseph's Hospital, Director, Medical Records  
 - Jill Z. Choi, RRA  
 St. Joseph's Hospital, Vice President  
 - Rosalie Vlahutin, RN, MPH  
 Sandra A. Strom, RN  
 Summersville Memorial Hospital (SMH)  
 Laura Taylor, RN  
 Margaret Tebay, RN  
 United Hospital Center  
 George D. Velianoff, R.N., D.N.S. (GV)  
 Weirton Medical Center, President & Chief Executive Officer  
 - Donald Muhlenthaler FACHE  
 Paula Weisal, RN  
 Wheeling Hospital Physician Assistant Surgical House Staff  
 (10 individuals)  
 Terri L. Wilkinson, RN  
 WV Association of Physician Assistants  
 WV Board of Examiners for Registered Professional Nurses  
 WV Health Care Association  
 WV Hospital Association  
 WV Organization of Nurse Executives  
 WV Society for Respiratory Care, Inc.  
 WV State Board of Examiners for Licensed Practical Nurses  
 WV University Hospitals, Director  
 Pharmaceutical Services - Kenneth G. Jozefczyk, M.S., RPh



## WEST VIRGINIA UNIVERSITY HOSPITALS

December 10, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305  
ATTN: Kay Howard

**RE: Amendment of Hospital Licensure Rules (64 CSR 12), revision #4 (Verbal and Telephone Orders).**

Dear Ms. Howard:

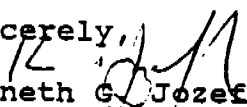
The purpose of this letter is to support the proposed change in the Hospital Licensure Rules concerning verbal and telephone orders. This move is positive in terms of patient care. Although it affects Respiratory Therapists, Physical Therapists and other health professionals, I feel especially qualified to comment on its impact relative to Hospital Pharmacists.

In the hospital setting, verbal or telephone orders should always be minimized. They do, however, have a place. Consider the example of a prescription for a miscalculated dose of medication for a pediatric patient. In the hospital setting, this dose is hopefully identified by the pharmacist. The pharmacist contacts and consults with the physician and an appropriate dosage change is made. Under the current West Virginia Hospital Licensure Rules, a third party (ie., a nurse) must be added to the process in order to facilitate the order change. While verbal orders in themselves can be dangerous, the addition of multiple players in the process adds to the potential for error. The best way to handle this situation is for the pharmacist to transcribe the physician's order change directly in the patient's medical record.

The above example is one of many which I could share with you. This rule change is not about crossing over professional bounds or professional turf. It is about providing good, safe patient care.

Thank you for the opportunity to comment on this matter. If I can be of further information, do not hesitate to contact me.

Sincerely,

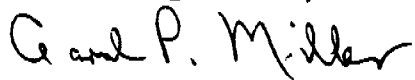
  
Kenneth G. Jozefczyk, M.S., RPh  
Director  
Pharmaceutical Services

/kj

Kay Howard  
December 7, 1993  
Page 2

patient. No other health care provider is required by law to be responsible for such a comprehensive range of activities. The licensed practical nurse is to perform selected nursing acts not requiring the substantial specialized skill, judgment and knowledge required in professional nursing. In view of the definitions of both registered professional nursing and licensed practical nursing, utilization of a licensed practical nurse to take verbal and telephone orders in patients whose conditions are unstable and fluctuating may be beyond the legal scope of practice based on the substantial knowledge necessary to evaluate the physicians orders with respect to the total clinical picture for a given patient.

Sincerely Yours,



Carol P. Miller, R.N., Chairperson

CPM/nrw



Postmarked  
12/18/93

# Southern West Virginia Community College

Dr. Harry J. Boyer  
President

December 17, 1993

Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3 Room 265  
Charleston, West Virginia 25305

Dear Ms. Howard,

It has come to my attention the Regulatory Development Committee is considering changes regarding verbal/telephone orders by the physician. Currently only a licensed registered professional nurse may accept a telephone order. This is to protect the client, as well as the physician and the institution. Other hospital personnel are not qualified to carry out this function.

If this rule is changed by the Regulatory Development Committee many people will be in jeopardy. Licensed practical nurses and certified nursing assistants are not trained, either theory or clinically, for this duty. Changes in the rule will greatly jeopardize the care of the clients in the health care setting.

I am also distressed to learn the committee is considering the use of EMS personnel in the ICU/CCU and other areas of the hospital. EMS personnel are trained to administer care to the client in the field, not in the hospital setting. The scope of practice is different for this level of health care provider.

**Logan Campus**  
P.O. Box 2900  
Logan, WV 25601  
Phone: (304) 792-4300

**Williamson Campus**  
Armory Drive  
Williamson, WV 25661  
Phone: (304) 235-2800

**Boone County Center**  
P.O. Box 398  
Madison, WV 25130  
Phone: (304) 369-6840

**Wyoming County Center**  
P.O. Box 338  
Pineville, WV 24871  
Phone: (304) 732-8340

As the Director of Allied Health and a Registered Professional Nurse who practices on a part time basis in the Emergency Department I believe I am qualified to verbalize my opinion. Several paramedics and EMS personnel have entered the Registered Nursing program at Southern. Their first reaction is the differences in the knowledge base and level of function between the health care providers. They realize they are not prepared to care for clients in the hospital and acute care settings.

It is my hope the committee will not change the rules for verbal orders or use of EMS personnel in the acute care setting. Please do not compromise the quality of care the clients are currently receiving.

Sincerely,



Pamela L. Alderman, RN, MSN  
Assistant Professor of Nursing  
Director of Allied Health

POSTMARKED

12/17/93

CAROL BANAL

73704 PLEASANT VIEW DRIVE • ADENA, OHIO 43901

RECEIVED

DEC 21 1993

REGULATORY DEVELOPMENTS  
SECTION

December 17, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, W.V. 25305

Dear Ms. Noward,

I am a Registered Nurse here in Ohio but licensed and employed in West Virginia at the Ohio Valley Medical Center in Wheeling. I am writing in response to the new licensure rules filed in the office of the Secretary of State.

I am concerned about several issues. I believe there should have been a public meeting which I could have attended and been given an opportunity to express my concerns. I firmly believe that Registered Nurses must be involved in drafting rules that directly affect our practice.

The proposed rule concerning our orders will place nurses in a difficult situation. Our nurse practice act allows us to take orders from a physician or dentist. If the proposed rule is passed, which rule will

we follow? I also believe this rule would jeopardize patient care by creating confusion & unclear communication about who's taking the order & who's carrying it out.

I am also concerned about the proposed change that allows other health care persons to provide emergency services. Nursing care needs to be performed by licensed qualified nurses to protect and adequately serve the public. I believe the proposed change could open a door for hospitals to hire persons without adequate knowledge & skills and therefore jeopardize safe care. What is safe and expected in the field is not the standard by which hospital care is judged.

In closing, I would appreciate knowing if there is a public hearing prior to the rules being changed so I can further discuss my concerns.

Yours truly,  
Carol Banal RN CCRN

Postmarked  
12/16/93

RECEIVED

DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

December 16, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

I am a registered nurse practicing in Ohio County. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons:

A rule allowing verbal or telephone orders to a variety of licensed or certified personnel will create many conflicts. According to the nurse practice act, nurses will still only be able to take orders from physicians or dentists. Orders taken by other personnel will have to be verified and that will require additional phone calls and delays in patient care. I do not think this requirement should change. The Registered Nurse is responsible in all hospitals and many home health agencies for coordinating care with all other departments and agencies. The R.N. is in the best position to protect the patient from problems caused by conflicts in orders. All orders should come through the R.N. directly from the doctor or dentist. Also, verbal and telephone orders are dangerous at best, because of the chance of error. The people giving and receiving these orders should be limited.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, some institutions may use this to decrease the number of Registered Nurses and hire personnel who can not perform patient care requiring the substantial specialized judgement and skill based on knowledge and application of principles of nursing. Those trained to provide emergency services are excellent at providing pre-hospital care but cannot take the place of the R.N. in the hospital.

I would like to request that a public hearing be held on these rules and the other proposed rules. These issues have the potential to have a grave impact on the health care of the citizens of West Virginia.

Very truly yours,

*Debra Bell, R.N.*

Debra Bell, R.N.  
68 Greenwood Ave.  
Wheeling, WV 26003

Postmarked  
12/26/93

**BLUEFIELD REGIONAL  
MEDICAL CENTER**  
*Touching Lives With Technology*

**RECEIVED**  
DEC 21 1993  
**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Ms. Howard:

In response to the proposed amendments to the hospital licensure rules, we have the following comments:

**MEDICAL RECORDS**

Page 22 - #j - This rule is no longer required by JCAHO and has historically been proven to be ineffective in that abbreviations utilized by staff members are made in conjunction with a particular case or type of patient and are most often self explanatory.

**MATERNITY SERVICES**

Page 30 - 11.3.1.A - While we understand the meaning of this rule, we feel a more efficient utilization of OB staff could be realized without patient compromise with appropriate Infection Control policies and procedures. OB staff could be utilized on other patient care units for general nursing care, excluding medication administration, treatments etc.

**MEDICAL STAFF**

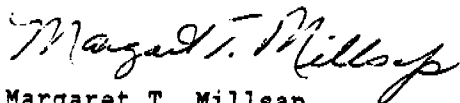
Page 50 - #1 - JCAHO no longer requires monthly departmental meetings of the medical staff, rather they are promoting a quarterly review of quality assessment activities so that an adequate amount of data can be collected and reported to allow for conclusions to be drawn and actions taken where appropriate. We do not see the need for quarterly medical staff meetings of the full medical staff, as in most institutions the Medical Staff Executive Committee meets on a monthly basis and by bylaws has the power to take necessary actions. Presently we require an annual meeting of the full medical staff.

**BLUEFIELD REGIONAL  
MEDICAL CENTER**  
*Touching Lives With Technology*

Kay Howard - Page 2.

Upon review of the rules, we also noted there was no provision for electronic data or recognition of electronic capabilities under the Medical Records Section. Thank you for allowing us to comment on the proposed rules. Should you have any questions concerning the comments, please do not hesitate to contact me.

Sincerely,



Margaret T. Millsap  
Director, Medical Records/QA

cc: Robert Harman, Chair - Health Care Policies Committee  
West Virginia Hospital Association

Postmarked  
12/15/93

**RECEIVED**

DEC 22 1993

**REGULATORY DEVELOPMENT  
SECTION**

Route 4, Box 393  
Proctorville, OH 45669  
December 14, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Gentlemen and/or Ladies:

I am a Registered Nurse practicing in West Virginia (Cabell Co.). I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filled, the rules are not beneficial to patient care in West Virginia for the following reasons:

Passage of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the Code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Yours truly,

*Kathleen A. Bonnett*

Kathleen A. Bonnett, RN, C., MS

Department of Health and Human Resources  
Regulatory Development  
Attention: Kay Howard  
State Capitol Complex  
Bldg 3, Rm 265  
Charleston WV 25305

**RECEIVED**

DEC 20 1993

**REGULATORY DEVELOPMENT  
SECTION**

I would like to express my views concerning the proposed amendment to W.Va. Code §16-5B-8.

It is my observation that non-licensed health care personnel, specifically, State and National Registry Paramedics are aptly trained and qualified to perform supportive roles in hospital emergency rooms. The nature of their training and experience makes them ideal supplements to the traditional emergency room staff.

I have always viewed the emergency department's role in patient care much the same as how I view Emergency Medical Services in the field setting: rapid assessment and initial treatment of the patient and, upon stabilization, transfer to the appropriate department or ward for continued treatment and support.

I do take exception to the concept of using personnel other than nurses in specialized care units such as ICU or CCU. The mission of such units exceeds the specialization of paramedics and non-licensed health care personnel.

I have witnessed paramedics working along side registered nurses in the emergency room, under the supervision of the physician. The quality of care was of the highest degree. The same patients treated by an all licensed staff would not have received better care. Use of paramedics in the emergency room as supportive staff not only maintains a high level of quality care, but with the added benefit of cost effectiveness in providing quality care to the general public.

I fully support any measures to allow for the use of health care professionals other than licensed personnel, specifically paramedics, in the emergency room setting.

Sincerely



Gene Brewer

Gene Brewer  
Rt 1 Box 212  
Princeton WV 24740

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DEC 20 1993

**REGULATORY DEVELOPMENT  
SECTION**

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305  
ATTN, Kay Howard

I feel that the use of paramedics in the emergency care setting in no way deters from the quality of care that one might receive. Paramedics working under the direction of the physician are more than qualified to work in this setting. However I feel the cardiac and intensive care unit setting is beyond a paramedics scope of training. I do not feel that a registered nurse is qualified to supervise supportive health care personnel in the cardiac or intensive care units.

*Susanne Brewer RN PCC*  
Susanne Brewer RN PCC

PostMARKED

12/18/93

1408 Tenth Street  
Vienna, WV 26105

Dec. 17, 1993

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Kay Howard,

I am writing this letter in response to the proposed rule changes for hospital Licensure. My colleagues and I have a number of concerns regarding the changes. I feel that the proposed changes will have a negative impact on nursing care. A negative impact on nursing care means a negative impact on the patients/citizens of West Virginia. The premise that the rules need to be changed "due to their variance from current standards of good hospital practice" does not appear to be true. Also, if in fact, the purpose is to "revise or delete certain outmoded" standards, there are additional revisions that should be made. Our concerns are as follows:

Page 22 - 10.3.h. Verbal and telephone orders shall be given to licensed or certified personnel that are authorized to receive these orders by the medical staff policies and procedures. Physicians shall countersign all verbal and telephone orders as determined by the medical staff bylaws. \*\*This change presents several concerns. This revision is in direct conflict with the WV nurse practice act. Allowing other personnel to take verbal or telephone orders jeopardizes the continuity of patient care. It facilitates increased fragmentation of care and this is not in the best interest of the hospitalized patient.

Page 23 - 10.3.1. Medical records shall be completed promptly, authenticated and signed by the physician or dentist within forty-five (45) days following discharge of the patient. \*\*In this day of modern information systems and emphasis on increased productivity, why would this number not be decreased? It would seem that 45 days is inconsistent with the word "promptly".

Page 36 - 11.5.4.b. "one nurse experienced in the post-operative care of surgical patients, with the assistance of a nurses' aide or orderly can care for four patients". \*\*This ratio is one that is outdated and should be revised. Currently at our institution, the ratio is two patients for each RN. Aides/orderlies are used primarily for transport.

Page 37 - 11.9.1.b. ...other health care personnel qualified by training and State law to provide emergency care services. Emergency care is only a small portion of critical care, nursing care is provided in the coronary care unit and those working in that area need to be "trained in NURSING care". The service of emergency care personnel is needed outside the hospital setting. It seems that the current wording (Additional nursing personnel shall be available consistent with the nursing care required by the patients.) is adequate and reflects "good hospital practice".

Page 40 - 11.10.4.a. - "and other health care personnel qualified by training and State law to provide intensive care services" \*\*Who are these "other" personnel? Are we looking at another level of provider? Most hospitals recognize the need for all RN staff in both intensive care and coronary care to provide the necessary care for the patients. This change does not represent "good hospital practice".

We urge you to reconsider the proposed changes in light of their impact on the citizens of West Virginia. Again, we feel that these proposed changes will have a negative impact on nursing care. A negative impact on nursing care means a negative impact for the patient.

Thank you for your careful consideration of these comments.

Sincerely,

*Cheryl Brumfield, RN*  
Cheryl Rae Brumfield, RN, MSN, CNA

*Lilia Underwood RN, BSN, CDE*  
*Linda Wilman RN, BSN, M.S.*  
*Sheesa O. Conway RN, MSN*  
*Andrea E. Harman, RN, BSN.*

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DEC 16 1993

December 15, 1993

REGULATORY DEVELOPMENT  
SECTION

Rachel Byrd  
924 Chappell Road  
Charleston, WV 25304

Ruth Ann Panepinto, Ph.D.  
Secretary  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Dr. Panepinto:

I am writing in regards to Department of Health and Human Services Legislative rule changes being proposed for the Hospital Licensure document. I am in opposition to the proposed changes. I feel strongly the proposed rule should be dropped. Revisions to hospital licensure could then be drafted with input from nursing and other involved parties. Among my concerns, the proposed rule does not accurately reflect the objectives stated. The change in verbal orders does not address practice parameters nor risk management. The defined staffing levels are archaic and misleading.

Thank you for your assistance.

rgb

Sincerely,



Rachel G. Byrd

PostMARKED

12/17/93

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Registered Nurse practicing in an Open Heart Recovery Room unit. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

*Ann Carter RN, CCRN*

Ann Carter, RN, CCRN



St. Mary's Hospital

Huntington, West Virginia 25702

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12/20/93

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DEC 22 1993

238 Washington Ave.  
Wheeling, WV 26003  
December 18, 1993

REGULATORY DEVELOPMENT  
SECTION

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Sir:

I am a registered nurse practicing in West Virginia. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons:

Passage of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the Code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules. As a staff nurse, I am responsible for the total care of a patient. It is my responsibility to know the whole patient and make decisions regarding the patient's well being. To allow others who are not qualified to make such decisions, may not be in the best interests of the patient and might produce a dangerous situation.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

*Cindy Cornett RN*

Cindy Cornett, RN

**RECEIVED****DAVIS MEMORIAL HOSPITAL**

DEC 20 1993

ELKINS, WEST VIRGINIA  
26241**REGULATORY DEVELOPMENT  
SECTION**

December 20, 1993

ROBERT L. HAMMER  
Chief Executive OfficerTELEPHONE  
636-3300Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Attention: Kay Howard

TO WHOM IT MAY CONCERN:

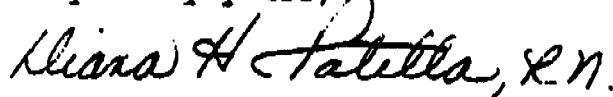
As Director of Nursing Service at Davis Memorial Hospital, I am writing to protest the proposed amendment to the law governing hospital licensure, 64 CSR 12, Article 14.2.3.b.

This article would appear to require hospital nursing departments to maintain separate, "Personnel records, including application forms and verification of credentials and character references for each nursing department employee". Essentially this would mandate the maintenance of duplicate personnel records in both the nursing department and personnel or human resources department of a hospital.

This represents an unnecessary and costly duplication of records and could also compromise the confidentiality implicit in the maintenance of such records. The logistical difficulties could also result in problems with the accuracy and completeness of these personnel records.

The records cited in this proposed amendment are routinely maintained within the personnel function of any hospital, and are readily available for inspection in a timely manner by anyone having a legal right to do so. This legislation is unnecessary, burdensome, costly and counter-productive at a time when Health Care cost containment is a state and national goal.

Very truly yours,

Diana H. Patella, R.N.  
Director of Nursing Servicecc: Delegate William Proudfoot  
Delegate Joe Martin

bcc: D. Parker Haddix, Assistant CEO

Postmarked  
12/17/93

# DAVIS MEMORIAL HOSPITAL RECEIVED

ELKINS, WEST VIRGINIA  
26241

DEC 21 1993

ROBERT L. HAMMER  
Chief Executive Officer

**REGULATORY DEVELOPMENT  
SECTION** TELEPHONE  
636-3300

December 16, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305  
Attention: Kay Howard

To Whom It May Concern:

As Director of Human Resources of Davis Memorial Hospital, and an officer of West Virginia Hospital Human Resource Administrators, I am writing to protest the proposed amendment to the law governing hospital licensure, 64 CSR 12, Article 14.2.3.b.

This article would appear to require hospital nursing departments to maintain separate, "Personnel records, including application forms and verification of credentials and character references for each nursing department employee." Essentially this would mandate the maintenance of duplicate personnel records in both the nursing department and personnel or human resources department of a hospital.

This represents an unnecessary and costly duplication of records and could also compromise the confidentiality implicit in the maintenance of such records. The logistical difficulties could also result in problems with the accuracy and completeness of these personnel records.

The records cited in this proposed amendment are routinely maintained within the personnel function of any hospital, and are readily available for inspection in a timely manner by anyone having a legal right to do so. This legislation is unnecessary, burdensome, costly and counter-productive at a time when Health Care cost containment is a state and national goal.

Very truly yours,



Dale A. Biesecker  
Director of Human Resources

cc: Delegate William Proudfoot  
Delegate Joe Martin

DAVIS MEMORIAL HOSPITAL  
P.O. Box 1484  
Elkins, West Virginia 26241-1484

Postmarked  
12/20/93

# Davis Memorial Hospital

P.O. Box 1484 Elkins, West Virginia 26241

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ROBERT L. HAMMER  
Chief Executive Officer

December 15, 1993

DEC 2 304-836-3300  
1993

REGULATORY DEVELOPMENT  
SECTION

Kay Howard  
Regulatory Development  
State Capital Complex  
Building 3, Room 265  
Charleston, WV 25305

RE: West Virginia Code 16-5B-8

Dear Ms. Howard:


The following comments address our position on the proposed legislative rule amending the current hospital licensure rule referenced above.

Davis Memorial Hospital supports the proposed amendment that would allow telephone orders to be given to licensed or certified persons that are authorized to receive these orders by medical staff policies and procedures. The capabilities provided by the amendment would streamline and expedite the carrying out of physician orders. We believe this would improve the quality and timeliness of patient care, as well as provide opportunities for cost containment.

Likewise, we support the proposed amendment that would allow paramedics to be included on the staff of emergency rooms. The resource of highly trained and multi-skilled emergency care personnel, represented by paramedics, is vital to rural hospital emergency departments where the shortages of other health care personnel is a reality. The capabilities provided by this amendment would allow rural hospitals to staff the emergency department with the best blend of health care personnel to assure high quality, cost effective care to their patients.

Thank you for the opportunity to comment on these issues.

Sincerely,



Robert L. Hammer, II  
Chief Executive Officer

RLH/bes



St. Mary's Hospital School of Nursing  
2900 First Avenue / Huntington, West Virginia 25702 / (304) 526-1415

December 14, 1993

**RECEIVED**

DEC 16 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

**REGULATORY DEVELOPMENT  
SECTION**

Dear Sir/Madam:

I am a registered nurse practicing in West Virginia. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons:

Passage of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the Code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgement and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

*Lillian S. Dick*

\* Lillian S. Dick, RN

LSD/cjp

Postmarked  
12/17/93

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DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Registered Nurse practicing in an Operating Room Pre-op Assessment area. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

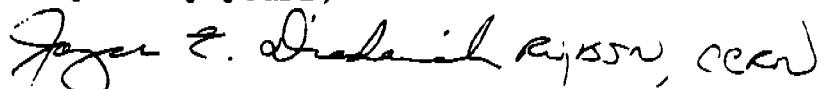
As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,



Joyce Diederich RN, BSN, CCRN



**St. Mary's Hospital**

Huntington, West Virginia 25702

Postmarked  
12/17/93

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

Regulatory Development  
State Capitol Complex  
Building 3, Room 266  
Charleston, West Virginia 25305

Dear Regulatory Development:

I am a registered nurse practicing in intensive care. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons:

Passage of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the Code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Sincerely,

*Natalie J. Eddy, RN, MSN, FAAP-C*

*Mike & Natalie Eddy  
124 Nelson Court  
Barboursville, WV 25504*

POSTMARKED

12/18/93

December 17, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston WV 25305

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

Dear Ms. Howard:

I am a Registered nurse from Ohio however I work in Wheeling, West Virginia. I am writing regarding the Hospital license rules filed in the office of the Secretary of State.

Several issues concern me. I believe that the R.N. should have participation in drafting rules that affect practice and that on occasion via public meeting is needed to express these concerns.

The proposed verbal rule will place the R.N. in a difficult position. This does not support the R.N. as the coordinator of the patient.

Also the proposed change allowing emergency services to be provided by other health care professionals concerns me. Nursing care needs delivered by licensed qualified nurses to protect the public. Anything less will jeopardize patient safety.

Would you please let me know if there is a public hearing prior of the rules being changed so I could further discuss my concerns.

Very truly yours,

Paul Edwards R.N.  
52181 Skyline Dr  
Shadyside Ohio 43947

Postmarked  
12/17/93

**RECEIVED**

DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Registered Nurse practicing in an Open Heart Recovery Room unit. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

*Yvonne Everman RN, CCRN*

Yvonne Everman, RN, CCRN



**St. Mary's Hospital**

Huntington, West Virginia 25702

**RECEIVED**

DEC 20 1993

December 17, 1993

**REGULATORY DEVELOPMENT  
SECTION**

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

Attention Kay Howard

Dear Ms. Howard:

I am a registered nurse practicing in West Virginia. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons:

Passage of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the Code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to this enactment.

Sincerely,

*Trudy Forster*

Trudy Forster, R.N.

Trudy Forster, R.N.  
1534 Marshall Street  
Benwood, WV 26031

Postmarked

12/18/93

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

Mary M. Frohme  
123 Springdale Ave.  
Wheeling, WV 26003  
December 17, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305  
Attention: Kay Howard

Dear Ms. Howard:

I am writing in response to the hospital licensure rules filed in the office of the Secretary of State. As a Registered Nurse working in Wheeling, West Virginia, I am concerned about several issues.

I believe there should have been a public meeting that I could have attended and personally expressed my concerns. Registered Nurses should be involved in the drafting of rules that directly affect their practice.

Since I am able to take orders only from a physician or dentist, the proposed rule regarding verbal orders will place me in a difficult position. I believe the safety of patient care will be in jeopardy due to the confusion of who's taking the order and who's carrying it out.

I am also concerned about the proposed change that allows other health care personnel to provide emergency services. Nursing care needs to be performed by licensed qualified nurses to protect and safeguard the public.

If there is to be a public hearing prior to the rules being changed, I would appreciate being informed so I could further discuss my concerns.

Very truly yours,



Mary M. Frohme, R.N., C.

POSTMARKED  
12/17/93

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 245  
Charleston, West Virginia  
attention: Kay Howard

Dear Ms. Howard,

I am a registered nurse in Wheeling West Virginia. I am writing to you because of concerns I have regarding the hospital licensure rules filed in the office of the Secretary of State.

I have concerns regarding two issues. The proposed rule regarding verbal orders will cause confusion and perhaps unsafe patient care. As a nurse I am only permitted to carry out orders given to me by a physician or dentist. Who will carry out the other verbal orders? How can I be sure that all necessary information has been communicated both to and from the ordering physician regarding my patient?

The second issue I am concerned

about is in regard to emergency services. I feel strongly that the proposed rule may allow hospitals to hire persons without adequate knowledge to provide care. Nursing care must be provided by qualified licensed nurses to protect the public.

I believe a public hearing should be held so that concerns could be expressed. Please notify me if any such meeting takes place. Nurses need to have a voice when rules are drafted which effect their practice!

very truly yours,

Patsy M George, RN  
125 Mt View Drive  
Wheeling, WV.  
26003

**GRANT HEALTHCARE MANAGEMENT, INC.**

---

Regulatory Development  
State Capital Complex  
Building 3, 265  
Charleston WV. 25305  
**ATTENTION: KAY HOWARD**

**RECEIVED**

DEC 20 1993

**REGULATORY DEVELOPMENT  
SECTION**

**RE: COMMENTS ON PROPOSED RULE AMENDMENT  
- 64 CSR 12 HOSPITAL LICENSURE**

Dear Ms. Howard,

Please accept the following suggested wording for <sup>s</sup>64-12-15.4: My rationale for such is discussed below.

15.4 Chronic Disease or Long-Term Hospital - To be licensed as a chronic disease or ~~encompassed~~ long-term hospital, an institution ~~must~~ shall be devoted exclusively to the care of patients requiring hospitalization because of prolonged illness or who are not acutely ill and not in need of general acute hospital care but who do require continuing medical care, skilled nursing care, and related medical services. It shall have an average length of inpatient stay greater than 25 days. It ~~must~~ shall have a professional staff who are qualified in the diagnosis and treatment of chronic diseases, and it ~~must~~ shall meet the requirements for a general hospital except that maternity services are no to be provided.

**RATIONALE:**

The medicare or over age 65 segment of the population is increasing at a faster rate than other population segments. With this the disproportionate share of health care expenditures are made on this population. This is further exacerbated by the co-morbidity that often exists with elderly patients. Yet these patients continue to receive the care needed albeit in an acute care setting. A hospital which is structured to provide its services in the "sub-acute" setting can more economically deliver this care.

Currently there are one hundred fifteen (115) hospitals listed by the American Hospital Association as a "Long Term Hospital". This hospital licensure classification will help to illuminate the nuances associated with an acute care hospital.

Thank you for your support. Please call me at (304) 487-2829 if I may provide additional information.

Sincerely,



Scott M. Pittman  
**PRESIDENT**

Postmarked  
12/17/93

**RECEIVED**

DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Registered Nurse practicing in an Open Heart Recovery Room unit. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

*Tammy Harbour RN CCRN*

Tammy Harbour, RN, CCRN



**St. Mary's Hospital**

Huntington, West Virginia 25702

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DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION

David M. McWatters, III  
Administrator



Robert M. Dixon  
President

December 17, 1993

Kay Howard  
West Virginia Department of Health and Human Resources  
Regulatory Department  
Building 3, Room 265  
Charleston, West Virginia  
35305

Dear Ms. Howard:

Please share with the appropriate persons the concerns of Highland Hospital regarding the proposed amendments to W.Va. Code Hospital Licensure, 64 CSR 12, specific to the maintenance of nursing personnel records within the Nursing Department (14.2.3). Such a requirement would result in unnecessary and costly duplication and would not, in fact, contribute in any manner toward further insuring quality patient care. All of the documentation referenced is maintained in the Personnel Office and is available to appropriate nursing supervisory staff. In addition, master staffing plans and other relevant program information is available through the Director of Nursing.

Thank you in advance for this consideration.

Sincerely,

A handwritten signature in cursive script that reads "Frances Clendenen".

Frances Clendenen  
Assistant Administrator-Personnel

WEST VIRGINIA  
STATE BOARD OF EXAMINERS  
FOR LICENSED PRACTICAL NURSES

RECEIVED

DEC 20 1993

TELEPHONE  
(304) 558-3572

REGULATORY DEVELOPMENT  
SECTION

FAX  
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NANCY R. WILSON, R.N.  
EXECUTIVE SECRETARY

LANETTE L. ANDERSON, J.D., R.N.  
ASSISTANT EXECUTIVE SECRETARY



101 DEE DRIVE  
CHARLESTON, WEST VIRGINIA 25311-1688

December 7, 1993

Kay Howard, Regulatory Development  
Department of Health and Human Resources  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

Dear Ms. Howard:

We appreciate the opportunity to review the proposed revisions to Legislative Rules, Series 12, Hospital Licensure.

The following comments are offered for consideration at this time. The first is that the legal title, "licensed practical nurse" should appear in all sections of the rules where "practical nurse" now appears. Those specific sections are 11.9.1.b., 11.10.4.a., 11.10.4.b.2. and 12.2.2. Section 11.9.1.b. also contains the statement that coronary care unit staff may include "health care personnel qualified by training and State law to provide emergency care services". The question arose regarding why training in emergency care services is required rather than training in coronary care services. When describing acceptable staff for intensive care units and the emergency departments staff must be qualified in intensive care and emergency services respectively.

The final comment relates to 10.3.1.h., verbal and telephone orders. The possibility exists that licensed practical nurses might be authorized to accept verbal and telephone orders in the acute care setting. The nature and complexity of the illnesses of hospitalized patients requires substantial specialized judgement and skill in evaluating medical orders and their impact on patient outcomes. The registered professional nurse is legally responsible for observation of symptoms and reactions and the accurate recording of the facts and for understanding of cause and effect of medication and treatments to safeguard life and health of a

achieved by qualified supervisors from the department providing the services. These supervisors are not necessarily nurses. This in no way demeans the qualifications or skills of the nursing staff, but merely addresses the complexity of patient care and the existence of other highly qualified professionals working in the field of health care today. We support the concept of close interaction of all members of the health care team in the provision of patient care today and in the future.

3. Since the proposed changes to the rule make the recommendation mandatory that hospitals provide separate space for adjunct services such as EKG in section 13.4.1, and since services such as laboratory, radiology, physical and occupational therapy are also addressed in the rule, we suggest that respiratory care and cardiopulmonary services be addressed. An addition to section 13 such as the following would seem to be appropriate and consistent with the rest of the section:

" Respiratory Care and Cardiopulmonary Services - Space and equipment required shall depend upon services provided. All hospitals admitting patients with cardiopulmonary diseases should have facilities to provide inpatients with respiratory care or cardiopulmonary services."

" If respiratory care or cardiopulmonary services are provided in the institution, they shall be under the direction of a physician licensed in the state of West Virginia and should be under the supervision of a competent, well-trained respiratory therapist or technician."

Sincerely,

A handwritten signature in cursive script, appearing to read "Chris R. Clark".

Chris R. Clark, BS, RRT  
President

# West Virginia Society for Respiratory Care, Inc.

*the West Virginia Affiliate of the AARC*

1502 Mount Vernon Road Charleston WV 25314

**RECEIVED**

DEC 20 1993

**REGULATORY DEVELOPMENT  
SECTION**

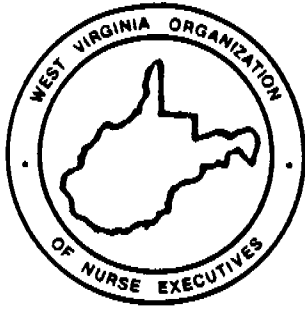
December 18, 1993

Ms. Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Ms. Howard,

This letter is in response to the proposed amendments to Hospital Licensure, 64 CSR 12 and contains our comments and suggestions pertaining to same.

1. The West Virginia Society for Respiratory Care supports the change to section 10.3.1.h which deletes the requirement that verbal and telephone orders be given to a registered professional nurse. We believe that this change is consistent with good medical practice and will provide better communications and patient care. We do suggest that the word "nurses" be deleted from the first sentence of this section since the clinical records are the records of the institution and are used by all members of the health care team, not nurses alone.
2. We also support the intent of the proposed changes in sections 11.9.1.b, 11.10.4.a, and 12.2.2. which have been added to permit the use of health care personnel other than nurses to provide care in emergency, cardiac, and intensive care settings. However, it is of some concern to us that these other health care personnel will be required to be supervised by a registered professional nurse. Many health care personnel work under the supervision of physicians or other health care professionals, not necessarily under nursing supervision. Nurses may also work under the supervision of other health care professionals. We therefore suggest that the language pertaining to "supervision by a registered professional" be deleted. As an alternative, individual hospitals could determine who shall be permitted to supervise the health care personnel assigned to these areas. Another alternative would be to replace the phrase "supervision of a registered professional nurse" with "supervision of a person qualified by training". We are making these suggestions because, in certain instances, the person best qualified to supervise aspects of patient care may or may not be a nurse. For example, one department of the hospital may be providing services and personnel for all three areas mentioned. The supervision of these personnel may be better



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REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

Dear Ms. Howard:

The West Virginia Organization of Nurse Executives has reviewed the proposed amendments to hospital licensure rules by the Department of Health and Human Services. As proposed, the rules do not meet the objectives stated in revising or deleting outmoded hospital licensure standards. Both federal and JCAHO regulations are misquoted. The proposed rules instead create problems they are purported to solve.

Specifically, the change in the requirement on verbal orders is problematic. The nurse may only take orders from a physician or licensed dentist according to the nurse practice act. This proposed change would negatively impact the quality of care and create risk management issues, especially if the medical staff are allowed to set the criteria. The standards for nurse staffing in the patient care areas identified are confusing and outmoded. In addition, the proposed addition of other health care personnel in the emergency and intensive care areas already takes place and the revision proposal only adds to the inconsistency of the rules. Restrictions for construction projects as stated are also problematic.

We are gravely concerned that the proposed rules were developed without collaboration from nursing which is impacted the most by the proposals. We believe the proposed rules will negatively impact patient care. We request a public hearing so full deliberation of the issues may be discussed. We are anxious to assist in the development of a modern, appropriate set of hospital licensure rules.

Sincerely,

Lorraine Ritz, M.S.N., R.N., CNA  
President  
West Virginia Organization of Nurse Executives  
41 Delwood Avenue  
Wheeling, West Virginia 26003

Postmarked - copy FAXED 12/20/93  
12/20/93



600 D Street, Second Level  
South Charleston, West Virginia 25303  
(304)744-9842 FAX (304)744-9889

December 20, 1993

Ms. Kay Howard, Director  
Office of Regulatory Services  
State Capitol Complex  
Bldg. 3, 5th Floor  
Charleston, West Virginia 25305

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DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

Dear Kay:

The West Virginia Hospital Association, on behalf of its 63 member hospitals appreciates the opportunity to provide comment on proposed legislative rule 16-5B-8.

We respectfully submit the following comments:

64-12-10.3 Medical Records and Reports

Subsection H has been amended to read as follows:

There shall be maintained a system of nurses' clinical records and all doctors orders shall be in writing and signed by the physician. Verbal and telephone orders shall be given to licensed or certified personnel that are authorized to receive these orders by the medical staff policies and procedures. Physicians shall countersign all verbal and telephone orders as determined by the medical staff bylaws.

Basically, the Hospital Association supports the additional flexibility in terms of verbal and telephone orders. I believe that this brings the state in line with Medicare regulations. We would recommend one modification. The modification we are recommending is that certified personnel be changed to registered personnel.

64-12-12.2.2 Emergency Department

The West Virginia Hospital Association supports the proposed amendment. Again, this allows the hospital more flexibility in terms of addressing emergency medical service needs in the community, while at the same time, ensuring cost-effectiveness and quality.

64-12-8.3 New Construction and 64-12-8.4 Additions Renovations

The proposed amendments require that a hospital proposing either new construction or renovation has to:

Complete construction drawings and specifications for any hospital construction project shall be submitted to the director for review prior to the beginning of work on the project. The drawings and specifications shall include

Ms. Kay Howard, Director  
Page 2

architectural, structural and mechanical drawings and specifications and shall be prepared and signed by an architect registered to practice in West Virginia.

We have significant concerns with this proposed amendment. Specifically, there is not a definition or a threshold for a hospital construction project or a hospital renovation project. If this remains as open-ended as it appears to be, it could significantly increase the cost of hospital renovation and construction projects. We would suggest that there needs to be a threshold amount before a hospital is required to submit architectural, structural and mechanical drawings and specifications. One option would be projects requiring a certificate of need be required to submit architectural drawings.

#### 64-11.11.4B Financial Rights and Responsibilities

The proposed rule reads as follows:

If emergency services provided are not included in the extended care admission contract, the hospital shall, when feasible, obtain the prior written consent of the extended care resident or other financially responsible person or agency, stating the amount of the applicable charges.

If the services are emergency services, it is very unlikely that there will be time for prior consent by either the patient or the financially responsible person. In addition, it would be practically impossible for the hospital to estimate the charges for the emergency service.

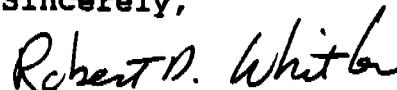
In terms of the other proposed regulations impacting hospitals extended care facilities, Patrick Kelly, on behalf of the West Virginia Health Care Association has submitted a number of comments. We have reviewed those comments and are supportive of his recommendations.

#### 64.14.2.3 Nursing Department

The proposed regulations require that nursing personnel records be available in the nursing department. This is a duplication and will require hospitals to have duplicate personnel records.

Again, the Hospital Association appreciates the opportunity to comment on this rule for Hospital Licensure.

Sincerely,



Robert D. Whitler, Vice President  
Public Policy Development

Ms. Kay Howard  
December 13, 1993  
Page 4

maker, when the resident clearly stated that he or she wanted the employee to serve in that capacity. Again, exception should be made for appointments made prior to admission.

Very truly yours,

  
Patrick D. Kelly

PDK/kjy

cc: Ed Foss  
Kay Cottrill

Ms. Kay Howard

Page 3

of patient funds handled within the hospital's fiscal year" (emphasis added) before the end of the fiscal year. Potentially, every hospital will be out of compliance with this regulation.

Additionally, the word "patient" should be removed and the word "resident" inserted.

WVCSR § 64-12-11.11.4.k - The proposed regulation appears to require hospitals to take affirmative steps to determine whether or not a resident is capable of managing his or her own financial affairs and to notify a resident's next of kin to initiate proceedings. Is it the intent of this regulation to place an affirmative duty on the hospital to initiate such a determination? Is there a presumption that if a resident has been determined to be incapacitated for purposes of health care decision-making that the hospital must make an additional determination of whether or not the resident is able to manage his or her financial affairs? Furthermore, does a hospital have to initiate guardianship proceedings when a resident, who is incapable of managing his financial affairs, has no assets and is only receiving \$30.00 from Medicaid per month? By placing an affirmative duty on the hospital to determine the resident's capacity to manage his or her estate and requiring a committee in all cases, the proposed regulation places an unnecessary burden on the health care system.

WVCSR § 64-12-11.11.4.l - The proposed regulation requires the hospital to initiate guardianship proceedings if the resident's family fails to do so. The rule fails to state who will pay for the committee proceedings. If it is the responsibility of the hospital to pay for the proceedings, few families will ever spend their own money to initiate the proceedings themselves. This will result in an unnecessary financial burden to the hospital and, in the end, result in a cost shift to other patients of the hospital. At a minimum, a provision should be placed in this regulation stating that the cost of the committee proceeding may be charged to the resident or the resident's estate.

WVCSR § 64-12-11.11.4.m - The proposed regulation generally prohibits hospital employees from serving as guardian, committee, conservator or power of attorney of a resident's estate. Employees who have been appointed the resident's guardian, committee, conservator or power of attorney prior to the resident's admission to the facility should not be removed from that capacity. Prohibiting a hospital employee to serve as a resident's power of attorney when the resident selected that individual as his power of attorney defeats the resident's expressed wishes and violates the general intent of OBRA. Employees should be permitted to remain the resident's fiduciary if they were appointed prior to the resident's admission to the facility.

WVCSR § 64-12-11.11.4.n - The proposed regulation requires individuals serving in a prohibited capacity - guardian, committee, conservator or power of attorney - to withdraw from that position within thirty days. In the case of an employee serving as a resident's power of attorney, if another individual is not listed as a successor attorney under the power of attorney, it is likely that a committee will have to be appointed and that committee may well be a sheriff who never knew the resident. A stranger should not serve as the resident's financial decision-

Ms. Kay Howard  
December 13, 1993  
Page 2

consent to the charges for the services. If the services are emergency services, it is unlikely that a resident or a financially responsible person will be able to provide any type of consent and it is even more unlikely that the hospital will be able to estimate the cost of the services. This is an unworkable rule and opens the door for residents to refuse to pay for legitimate emergency services provided by the hospital. This proposed regulation should be replaced with the statement that facilities which do not include emergency services in the extended care admission contract must provide a statement in the contract to that effect.

WVCSR § 64-12-11.11.4c and d - The proposed regulations narrowly limit the circumstances under which a hospital is permitted to transfer and discharge extended care residents. The regulations should also permit hospitals to transfer or discharge residents if the resident's health has improved and the resident no longer requires the hospital's services and if the extended care unit ceases to operate.

WVCSR § 64-12-11.11.4.f - The proposed regulation requires hospitals to obtain the resident's written authorization to hold or manage funds. The regulation should also allow hospitals to manage and hold personal funds upon the written authorization of the resident's representative who is lawfully authorized to manage fiscal matters on behalf of the resident. Furthermore, hospitals should be permitted to maintain a single account for all resident accounts rather than individual accounts for each resident. The regulations should read as follows:

A hospital which manages or holds personal funds for extended care residents shall do so only upon written prior authorization of the resident or his or her representative lawfully authorized to manage fiscal matters on behalf of the resident, and shall hold such funds separately and in trust. The hospital may place all residents' funds in a single account, but must separately account for the funds of each resident in a manner consistent with generally accepted accounting principles.

Alternatively, the regulation should be deleted entirely because this issue is sufficiently addressed by federal law.

WVCSR § 64-12-11.11.4.j - The proposed regulation applies to the amount of insurance which a hospital must maintain to protect the residents' funds. The required amount of insurance is unclear. The regulation states that the amount of insurance must be "equal to at least the total amount of patient fund handled within the hospital's fiscal year". Does this regulation require the hospital to maintain insurance equal to the total patient funds which it handled throughout the year? If so, this is an unnecessarily high requirement. Insurance equal to the hospital's average daily balance of patient funds is more acceptable. Requiring excessive insurance only increases the cost of health care and does not protect funds.

Furthermore, under the proposed regulation, a hospital would not be able to calculate the total amount of patient funds handled within the hospital's fiscal year until the end of the hospital's fiscal year. There is absolutely no way that a hospital can calculate "the total amount

# STEPTOE & JOHNSON

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WRITER'S DIRECT DIAL NUMBER

December 13, 1993

(304) 353-8119

Ms. Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Re: Proposed Hospital Licensure Regulations  
WVCSR § 64-12-1 et al.

Dear Ms. Howard:

On behalf of the West Virginia Health Care Association, I am submitting the following comments to the proposed Hospital Licensure Regulations, WVCSR § 64-12-1 et al.

WVCSR § 64-12-11.11.4.a - The proposed regulation states that "residents shall be liable only for charges which have been included in the admission contract". This language is too limiting because residents often request extra services to be performed while they are at the facility, such as barber/beautician services. The regulation should permit hospitals to charge residents for those items included in the admission contract, as well as any item specifically requested by the residents.

In the alternative, the regulation should mirror the OBRA requirement of tag F 160 and state that "The facility must inform each resident before, or at the time of admission, and periodically during their stay of services available in the facility and of any charges for those services including any charges for services not covered under Medicare, Medicaid or by the facility's per diem rate."

WVCSR § 64-12-11.11.4.b - The proposed regulation states that, if emergency services are not included in the extended care admission contract, "the hospital shall . . . obtain the prior written consent of the extended care resident or other financially responsible person or agency, stating the amount of the applicable charges". The sentence is unclear as to whether the hospital is to obtain prior written consent for the treatment of the resident in an emergency situation, or

In fact, the proposed rule would delete reference to some standards without providing alternative, objective standards, and would permit practices that are not consistent with either Medicare conditions of participation or Joint Commission on Accreditation of Hospital Organizations standards.

The proposed rule was drafted without consultation with organized professional nursing, despite the fact that standards for hospital licensing which relate to nursing practice must be deferred to the agencies governing licensed nurses. The rule should be reviewed and revised with the participation of registered professional nurses in the State representing nursing leadership in the administration of organized nursing services.

The proposed rule attempts to alter the professional nursing standards significantly, and the regulation of nursing practice is not a function of an agency charged with the licensing of health care facilities. The rule would also endanger practical and professional nursing education in the State of West Virginia. If facilities create and/or employ unlicensed health care providers to deliver skilled health care services, there may not be sufficient professional nursing personnel in facilities to serve as preceptors and resources to nursing students during clinical rotations. It would handicap nursing education in the State, at a time when West Virginia is finally seeing resolution of a prior shortage of registered professional nurses.

In summary, the West Virginia Board of Examiners for Registered Professional Nurses finds that the proposed rule does not accomplish its stated purpose of updating outmoded language and requirements, but instead seeks to regulate professional and practical nursing practice in contravention of the laws governing nursing licensure. The Board further finds that the "substantive and major revisions" are far broader and farther reaching than predicted by the rule abstract, and present serious hazards to public health.

Based upon these findings, the Board requests that a public hearing be held on the proposed rule, to ensure that any potential amendments have been fully publicized and examined, and subjected to thorough review and debate, in the interest of protecting the health and safety of the citizens of West Virginia.

trust, and shall transfer to the resident's use or account the full amount of any interest or benefit received from such assets.

## 12.2. Emergency Department.

12.2.2. ~~Personnel~~ ~~There shall be available~~ Professional personnel at all times who are trained in emergency life-saving measures shall be available at all hours the emergency service is open. Also, Either a physician who is a member of the professional medical staff of the hospital shall be available at all times to the emergency department or the hospital shall make arrangements for physician availability. Emergency room staff shall be under the supervision of a registered professional nurse and may include registered professional nurses, practical nurses and other health care personnel qualified by training and State law to provide emergency care services.

*This proposed amendment authorizes that the staffing of hospital emergency departments "may" include "registered professional nurses, [licensed] practical nurses and other health care personnel qualified by training and State law to provide emergency care services."*

*Staffing in the hospital emergency department must include registered professional nurses if professional nursing care is to be provided. Under West Virginia Code, a license is required to practice registered professional nursing and licensed practical nursing.*

*In addition to State professional licensure requirements, hospitals which receive Medicare funds and provide emergency services are required to have "adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility." 42 CFR §482.55(b)(2). There is no language in the Medicare regulation which recognizes providers other than medical and nursing personnel.*

*The proposed rule exceeds the agency's statutory authority, by attempting to authorize persons not holding valid nursing licenses to provide professional nursing services. The agency must defer to the laws and agencies which regulate nursing practice in this state in establishing standards for nursing practice.*

The proposed rule also needs to refer to licensed practical nurse throughout.

The proposed rule has a stated purpose "to revise or delete certain outmoded hospital licensure standards which are creating problems due to their variance from current standards of good hospital practice . . . references to outdated State and national standards have been clarified and updated . . ."

*professional nursing care must be defined by the two state licensing boards charged with the regulation of nursing practice.*

*An agency cannot promulgate a legislative rule which is in conflict with statutory law. The proposed rule conflicts with the laws governing registered professional nurses and licensed practical nurses. This principle has recently been recognized in an Alabama case, in which the Alabama State Committee of Public Health was found to have exceeded its statutory authority when it promulgated a rule defining an "emergency department paramedic". (Alabama State Board of Nursing, et al. v. Carole Samuelson, et al., CV-92-2275 and CV-92-2477, 15th Jud. Circ.)*

#### **11.10. Intensive Care Unit.**

##### **11.10.4. Staffing**

a. The staffing pattern ~~will~~ shall depend on the type patients admitted, the degree or intensity of the illness, as well as the utilization of ~~nonprofessional practical nurses and other health care personnel qualified by training and State law to provide intensive care services~~, and the size and physical arrangement of the unit.

*As noted above, the agency does not have the statutory authority to regulate the practice of professional or practical nursing, or to create a new category of health care provider by rule. The Legislature has already established that licensure is required to practice nursing in West Virginia, and the agency must defer to the nurse licensing boards on issues related to nursing practice.*

b.(2) Generally, one (1) registered professional nurse and one (1) ~~nonprofessional practical~~ nurse per unit of six (6) patients for each shift are sufficient for proper patient care.

*While no change is proposed to this subsection, it should be modified to reflect current standards for nursing care. The existing language should be amended to add that, "under no circumstances will there be less than one registered professional nurse per three (3) intensive care patients; complex and/or critically ill patients may often require more than the minimum level of nurse staffing to provide adequate care."*

##### **11.11.4 Financial Rights and Responsibilities.**

*This section should include language providing that the "hospital which manages or holds personal funds for extended care residents shall do so only upon written prior authorization of the resident, and shall hold such funds separately and in*

## 11.5. Recovery Room.

11.5.4(a) The recovery room shall be under the direction of a registered professional registered nurse . . .

*Second "registered" should be deleted.*

11.5.4(b)(1) Usually one (1) nurse experienced in the post-operative care of surgical patients, with the assistance of a nurses' aide or orderly, can care for four (4) patients, if supplies and equipment are provided assembled for use from a central supply unit.

*Although no changes to this subsection have been proposed, the existing language is outdated and needs to be revised to reflect the current standard: to require registered professional nurses to fully staff the Recovery Room.*

*The rule should include language which would prevent the Recovery Room from being dangerously isolated from other professional nursing staff, who should be available to provide assistance in the event of a patient emergency.*

*There should be more than a single registered professional nurse assigned to the post-operative recovery area, or a registered professional nurse readily available from an immediately adjacent unit, in the event of a patient or other emergency.*

## 11.9. Coronary Care Unit.

11.9.1(b) The nursing service shall be under the supervision of a registered professional nurse qualified by training, experience and ability. At least a minimum of one (1) qualified, registered professional nurse with special training shall be on duty at all times to give direct patient care. ~~Additional nursing personnel shall be available consistent with the nursing care required by the patients.~~ Coronary care unit staff shall be under the supervision of a registered professional nurse and may include registered professional nurse, practical nurses and other health care personnel qualified by training and State law to provide emergency care services.

*This proposed amendment would delete the requirement which provides that "additional nursing personnel shall be available consistent with the nursing care required by the patients." Hospitals should not be relieved of the responsibility of providing sufficient nursing care as "required by the patients".*

*The proposed amendment also calls for staffing to include "personnel qualified by training and State law to provide emergency care services", who shall be "under the supervision of a registered professional nurse". This clearly demonstrates that the care to be provided is professional nursing care, and standards for*

(ii) Signed or initialed by the prescribing practitioner as soon as possible; and

(iii) Used infrequently.

42 CFR §482.23 Condition of participation: Nursing services. (emphasis added).

*The federal guidelines address the acceptance of verbal orders under the section dealing with the provision of nursing services within a facility. The acceptance of verbal orders is clearly a nursing function. The proposed amendment should not permit medical staff to authorize other health care providers to perform the nursing service of accepting verbal orders.*

*The guidelines also recognize the potential hazard which exists with each and every verbal order, and call for such orders to be used infrequently. The proposed rule fails to recognize the major clinical significance of ordering new therapies, medications, treatments or other care for hospitalized patients, and thus fails to provide adequate safeguards.*

*The federal guidelines require that nursing services must be organized under the department of nursing. Medical staff does not establish the standards for nursing practice in a hospital or other facility; these standards must be developed by professional nursing personnel, consistent with the laws governing nursing practice.*

### 11.3. Maternity Services.

11.3.8. Noninfected gynecologic patients may be admitted to the maternity service of the hospital provided ~~the plan setting forth the~~ the hospital medical staff shall approve written policies, procedures and conditions for such ~~the combined service. has been submitted to and approved by the state department of health.~~

*The proposed amendment removes the requirement that the state department of health approve the policies, procedures and conditions for a combined gynecologic and maternity unit, but fails to set forth any other guideline for such policies. There should be some recognized standard, perhaps from the Centers for Disease Control, with which the facility must comply when approving written policies. Such policies should be subject to approval not only by the medical staff, but by professional nursing personnel.*

*The standards which must be met by hospitals which receive Medicare funding are set forth in 42 CFR Part 482. Subpart C, Basic Hospital Functions, enumerates various services which must be provided: medical staff, nursing services, medical record services, pharmaceutical services, radiological services, laboratory services, food and dietetic services, and utilization review. Optional Hospital Services are found under Subpart D: surgical services, anesthesia services, nuclear medicine services, outpatient services, emergency services, rehabilitation services, and respiratory care services.*

*The services which may serve as a basis for hospitalization should be clearly delineated in this proposed rule.*

### **10.3. Medical Records and Reports.**

10.3.1(h) There shall be maintained a system of nurses' clinical records and all doctors' orders shall be in writing and signed by the physician. ~~Telephone or verbal orders shall be given to a registered professional nurse and shall be signed by the physician as soon as possible thereafter.~~ Verbal and telephone orders shall be given to licensed or certified personnel that are authorized to received these orders by the medical staff policies and procedures. Physicians shall countersign all verbal and telephone orders as determined by the medical staff bylaws.

*The proposed amendment to this section would permit a hospital's medical staff to determine who may accept verbal or telephone orders. The proposal exceeds the scope of the Department's rule making authority. The Department, and its licensed hospitals, are not authorized under the law to regulate professional or practical nursing practice, nor to delegate the regulation of nursing practice to the medical staffs of individual hospitals. The West Virginia Code requires licensure to practice professional and practical nursing, and a legislative rule may not be promulgated in contravention of statute.*

*In addition to State law, federal guidelines applicable to hospitals which receive Medicare funds address the subject of verbal orders:*

*All orders for drugs and biologicals must be in writing and signed by the practitioner or practitioners responsible for the care of the patient as specified under § 482.12(c). When telephone or oral orders must be used, they must be -*

*(i) Accepted only by personnel that are authorized to do so by the medical staff policies and procedures, consistent with Federal and State law.*

## REVIEW OF PROPOSED LEGISLATIVE RULE - 64 CSR 12

The Board has reviewed proposed revisions to 64 CSR 12, and notes serious problems with the rule which pose risks to the public health and safety. These comments address both general concerns about the effect of the rule on health care in this State, as well as specific issues which present problems or hazards.

### General comments:

The proposed rule offers numerous amendments which would effectively regulate professional and practical nursing practice, rather than hospital licensure. The West Virginia Board of Examiners for Registered Professional Nurses and the West Virginia Board of Examiners for Licensed Practical Nurses are charged with the regulation of nursing practice in this state, and a rule governing hospital licensure must defer to these agencies on issues of professional and practical nursing practice.

The proposed rule moves hospital licensing standards away from specific criteria and permits institutions to make their own rules. In many instances, institutional policy-making is deferred to the facility's medical staff. This paternalistic approach fails to recognize the other professions that provide hospital based care, and charges physicians with the responsibility for setting standards of hospital practice for numerous non-physician practitioners.

Health care reform has come to the forefront of public concerns, and the State's own Health Care Planning Commission has recommended more stringent regulation of health care to protect the citizens of West Virginia. The proposed rule would grant health care facilities alarming latitude in self-regulation, and has the effect of "de-regulating" many critical aspects of health care. Such a proposal, which seeks to circumvent other licensing and regulatory statutes, is dangerous and not in the public interest.

### Specific concerns:

#### §64-12-3. Definitions.

**3.12. Hospitalization -** ~~Is defined as~~ The reception, in-house accommodation, and care of any person for a continuous period longer than twenty-four (24) hours, for the purpose of providing room, board, ~~nursing service,~~ and medical, nursing and other professional health care services. ~~and other hospital facilities required in connection with diagnosis and treatment of any condition or infirmity.~~

*The section states that hospitalization is for the purpose of providing medical, nursing, and "other professional health care services", while failing to define the services, or identify the statutory authority under which such services may be legally provided.*

Page Two  
Hospital Licensure  
December 17, 1993

structure of today's hospital, and

- (g) were written without the valuable input of the many resources (including organized nursing administration) available in West Virginia and nationally on the topic of hospital regulation and standards.

Please see additional comments as attached.

The Board respectfully calls for a public hearing on the matter before us. The public's interest will be better served through public dialogue, information sharing, and collaborative efforts of all interested and affected parties.

As professional nursing practice is an integral part of hospital function, the Board and its staff wish to offer our expertise on the regulation of nursing practice as a resource to your regulatory development staff for the purpose of achieving current, measurable, enforceable and defensible standards for hospital licensure in an era of health care reform.

Again, thank you for the opportunity to respond with comments to the proposed hospital licensure rule.

Sincerely,



Janet H. Fairchild M.S., R.N.  
Executive Secretary

JHF/f

Attachment

Janet H. Fairchild, M.S., R.N.  
Executive Secretary



TELEPHONE:  
(304) 558-3596  
(304) 558-3728  
FAX (304) 558-3666

STATE OF WEST VIRGINIA  
BOARD OF EXAMINERS FOR REGISTERED PROFESSIONAL NURSES  
101 Dee Drive  
Charleston, WV 25311-1620

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Attn: Kay Howard

RE: 64CSR12 as Proposed

Dear Ms. Howard,

Thank you for the opportunity to respond to the proposed Legislative Rule 64CSR12 titled Hospital Licensure as filed November 18, 1993 with the Secretary of State's Office.

The Board opposes the proposed rule as it has been submitted in that the rule:

- (a) would endanger public safety and the welfare of patients;
- (b) does not achieve the stated purpose of updating outmoded regulations;
- (c) exceeds statutory authority by attempting to authorize persons not holding valid nursing licenses to provide professional nursing services;
- (d) repeatedly and inappropriately retains outmoded, paternalistic regulations that direct licensed physicians to regulate, determine standards and set policy on hospital issues that are not directly related to the practice of medicine;
- (e) does not establish standards for hospital licensure that are measurable, enforceable, or defensible;
- (f) does not take into consideration the multitude of standards currently available for the governance and

210 Sturmer Street • Belington, WV 26250

**RECEIVED**

DEC 20 1993

**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

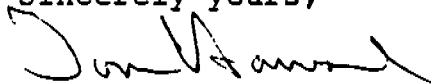
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305  
Attn: Kay Howard

Dear Ms. Howard,

The West Virginia Association of Physician Assistants would like to express its' support for the proposed Hospital Licensure rule changes (64 CSR 12). In particular, the changes proposed in Section 10.3.1.h which would permit licensed physician assistants to receive verbal and telephone orders will make hospital and rural emergency room physician assistants more effective. Under the present system, when a physician assistant evaluates a patient on behalf of his or her supervising physician, he or she must then go find a nurse before a physician order may be written. This procedure is cumbersome and adds nothing to effective patient care. Physician assistants are baccalaureate and masters level educated health care providers who have received training in order writing. They are certainly capable of safely carrying out the order writing provisions of the proposed regulations.

Thank you for your consideration.

Sincerely yours,



Tom Harward, PA-C  
Legislative Chairman  
\*West Va. Association of Physician Assistants  
Belington Clinic  
210 Sturmer St.  
Belington, WV 26250

**RECEIVED**

DEC 16 1993

To: Ruth Ann Panepinto, Ph.D.

**REGULATORY DEVELOPMENT  
SECTION**

I am a registered professional nurse practicing in Kanawha County in a large, tertiary-care facility. I am responding to the hospital licensure rules filed in the office of the Secretary of State.

The rules I am opposing are specifically: page 22, section 10.3 h., page 37, section 11.9.b., page 40, section 11.10.4.a. and b., and page 43, section 12.2.2. Passage of these rules do not coincide with the West Virginia Nurse Practice Act and will make it difficult, if not impossible, to deliver safe, legal, and competent patient care. I would like to request a public hearing to hear discussion and hopefully resolution of the issues at hand. Allowing "other health care personnel" (noting the word professional isn't included in the title) into these areas will not assist the health care industry and/or the nursing profession to increase the quality of care. It may save costs in the beginning, but in the long run we will all pay. These "other" personnel do not have the education and/or training to coordinate all of the patient's care: it's more than administering a medication or reading an EKG strip.

Thank you for your time in reviewing my concerns.

Terri L. Wilkinson, RN

Regulatory Development Section

Page 2

If Physician treatment orders can only be given to a registered nurse, then the scope and effectiveness of all other members of the health care team is hampered and ultimately the patient is deprived of the best quality care that the team is capable of providing. With today's nursing shortages the nurse is stressed enough to attempt to give each patient the personal nursing care that they deserve without further taking precious time away from the patient to receive a verbal or telephone order from a physician. The order could have readily been given to another qualified allied health professional who is in actuality more knowledgeable in the specific treatment ordered by the physician. Furthermore, the inability of these qualified allied health professionals to fulfill their expectations as a true team member is forcing the out-of-state migration of many of these health care givers to other states which will allow them to participate to their potential. Once again, our patients, the citizens of West Virginia, are the ones who are deprived of the quality health care that is available and they deserve.

We appreciate your support for the proposed amendment as adopted by the West Virginia Board of Health.

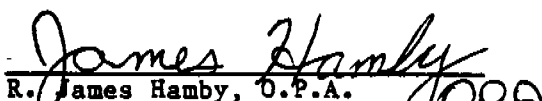
  
David A. Blowers, P.A.-C


Sincerely,

  
Laura Miller, P.A.-C PA-C

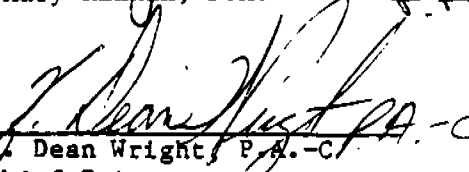
  
Tonda Stauffer, P.A.-C

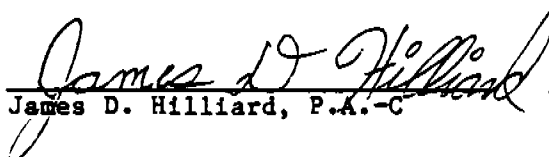
  
Wesley L. Mayle, P.A.-C PA-C


  
R. James Hamby, O.P.A. O.P.A.

  
Mary Rankin, P.A. PA

  
Buford Vita, P.A.-C

  
K. Dean Wright, P.A.-C PA-C  
Chief P.A.

  
James D. Hilliard, P.A.-C

  
Rodney Stoner, P.A. PA

RECEIVED

December 15, 1993

DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION

Regulatory Development Section  
Department of Health and Human Resources  
Building 3  
Capitol Complex  
Charleston, WV 25305

Dear Sirs:

We, the Physician Assistant Surgical House Staff at Wheeling Hospital, are writing to show our support for the proposed amendment adopted by the West Virginia Board of Health which authorizes individual hospitals to determine which licensed or certified personnel may receive verbal and telephone orders as authorized by their medical staff policies and procedures. This amendment deletes the current restrictive language that permits such orders to be given only to a registered nurse.

As everyone is aware, health care technology has expanded rapidly over the past few decades. It has become apparent that the traditional Physician/nurse health care delivery method is not adequate to allow the patients to benefit from this new technology. New allied health professionals of multiple disciplines with their own technological skills have evolved to work as a member of the health care delivery team to aid the physician in delivering the best patient care. Only with a team approach with the Physician coordinating the patient's care, can the patient most benefit from our advanced medical technology.

That the team approach is necessary to deliver modern technology to the patient most efficiently has been well established and can be best expressed by a quote from the late Dr. Hu C. Myers of Philippi, West Virginia and the founder of the Alderson-Broadus College Physician Assistant Program. He stated, "The rapid and spectacular advances in medicine, as evidenced in the past few decades, inevitably will slow or cease unless there are enough educated, trained and dedicated people in fields allied to medicine to aid the physician effectively in the conveyance of these advanced techniques to patients".

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12/20/93

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117 South Park Street  
Wheeling, WV 26003  
December 18, 1993

DEC 22 1993

REGULATORY DEVELOPMENTS  
SECTION

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Sir:

I am a registered nurse practicing in West Virginia. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons:

Passage of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the Code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,



Paula Weisal, RN

Postmarked  
12/17/93



December 17, 1993

**RECEIVED**

DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

Regulatory Development  
State Capitol Complex  
Building 3; Room 265  
Charleston WV 25305

Attn.: Kay Howard

Thank you for the opportunity to comment on the proposed amendments to the Hospital Licensure rules. [CRS Title and Series: 64 CSR 12]

*10.3.1.h. ... Verbal and telephone orders shall be given to licensed or certified personnel that are authorized to receive these orders by the medical staff policies and procedures. Physicians shall countersign all verbal and telephone orders as determined by the medical staff bylaws.*

The Weirton Medical Center strongly believes this is a hospital decision and not an issue for medical staff bylaws.

*12.2.1.b. The emergency service of the hospital shall be under the direct control of the director of the outpatient department.*

We do not believe this may always be appropriate.

If you have any questions or would like further discussion, please contact me [797.6136] at your convenience.

Very truly yours,


WEIRTON MEDICAL CENTER, INC.

Donald Muhenthaler FACHE  
President & Chief Executive Officer

DC.RN.dfk

I could go on, however, I believe I have made my points. I would encourage you to delay these amendments and call a group of nurses together through the West Virginia Nurses Association, West Virginia Organization of Nurse Executives, West Virginia Board of Nurses to help you amend the rules so that they ARE reflective of "good hospital practices" and that will not adversely affect the citizens of West Virginia. I would be pleased to help you in this endeavor. If, however, you choose to continue with these amendments, I will have no choice but to adamantly, publicly, and politically oppose your actions.

In the interest of excellence in health care, I am sincerely,

A handwritten signature in cursive script, appearing to read "George D. Velianoff".

George D. Velianoff, R.N., D.N.S.

Section 10.3.1. h. This change is unwise and has the potential to create enormous errors and litigation within the hospital setting. Research has proven that any intermediary process between the originator and implementor of activities creates error, re-work and in some cases extremely fatal consequences to the patient. Research has proven that an adequate number of RNs and the better the collaboration between RNs and physicians has lead to better patient outcomes, decreased mortality and morbidity as well as decreased costs. Further, you state that there shall be "maintained a system of nurses' clinical records.." yet, you are determining how that system should work without input from state nursing groups, associations, committees. In the revision you propose, you give authority to the Medical staff to determine who can "take verbal orders" rather than allowing the hospital that decision. Also, regardless of who can "give" orders, the state practice act for nursing does not allow those orders to be carried out by the nurse. I believe you have amended this section without clearly researching the issue and I can not support an amendment that is obviously not in the best interest of patients. Giving an order to a certified nursing assistant who has no formal education regarding the implications, interactions, or appropriateness of that order in relation to the patient treatment plan and condition is negligent and inappropriate. Yet, the changes requested will set this scenario to happen.

Section 10.3.1.k. Since you claim to be making revisions to "update outmoded practices", does this statement also include NURSING diagnoses? Why not try changing that to make the rules more in line with "good hospital practice"?

Section 11.2.3.a. and 11.2.4. Again, an outdated rule that has not been proposed to be changed yet, much more outdated and deviant from "good hospital practice" than the sections proposed to be amended.

Sections 11.4.1, 11.5.4. a and b., 11.6, 11.9.1.b, 11.10.4.a,b,2., 11.11.3. All of these sections refer to staffing of the areas. You are inconsistent with your recommendations and statements between all these sections. To change only some of the sections is inconsistent. Further, you make no recommendations for anesthesia staffing yet you do state recommendations for ICU,CCU etc. The statement that "staffing, under the direct supervision of a registered professional nurse will be dependent on the number of patients, their severity, acuity, degree or intensity of their illness" would be sufficient. To delineate who should staff the areas is taking that right away from those that have the systems and the expertise to make those decisions. In addition, why have you not recommended staffing for radiology areas in the rules if you are to be consistent?



Charleston Area  
Medical Center

Corporate Professional Nursing

3101 MacCorkle Avenue, SE  
Charleston, West Virginia 25304  
(304) 348-4343

December 6, 1993

Ruth Ann Panepinto, Ph.D.  
Secretary  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305  
ATTN: Kay Howard

Dear Dr. Panepinto:

I am writing in regards to the Department of Health and Human Services Legislative Rule changes being proposed for the Hospital Licensure document. I am in opposition to the proposed changes and would like to state my reasons. In addition, I would like to request a formal public hearing on the rules.

The purpose of the proposed amendments to the Hospital Licensure is stated as being "to revise or delete certain outmoded standards which are creating problems due to their variance from ... good hospital practice." This is difficult to believe since there exists several antiquated and much more problematic issues in the Hospital Licensure Administrative Rules that are not being addressed, changed, or identified. Further, it is difficult to believe the identified amendments are "creating problems" since no one I know of in the State of West Virginia has verbalized problems, except to the extent of several attempts at changing the rules as you are proposing which does create problems. In addition, I believe the changes you are proposing lower standards, create an environment proven to be conducive to errors, not in accordance with the intent of the JCAHO standards as you suggest, and an attempt to resolve political issues at the expense and negligence of the consumers of hospital services, the citizens of West Virginia. Your statements on the Fiscal Note for Proposed Rules, number 4, are not accurate. The potential for the changes being proposed to have fiscal impact to the citizens and government is great and question your research and analysis of this issue.

The areas I would like to make specific comments on are Sections 64-12-10.3.1 h,k, 64-12-11.2.4 a, 64-12-11.5.4 b(1), 64-11.9.1 b, 64-12-11.10.4 a, (2), 64-12-12.2.2, 64-12-14.2 through 14.2.8

Ruth Ann Panepinto, Ph.D.  
Secretary  
Department of Human Resources  
Page 3

and limited services which will be provided by Webster County Memorial Hospital as a RPCH facility. If multiple departments are not required by a RPCH facility then the proposed rule is certainly more acceptable as the RPCH does provide for quality improvement/quality assurance functions but not through a traditional committee approach as a large comprehensive medical facility would. A single individual (the medical director referred to above), is designated to have responsibility in association with allied health professionals and other hospital employees. Given the low expected patient volume, the requirement that the staff as a whole meet and review clinical experience and/or outcomes on a monthly basis (Rule 14.7.1(d)(a)) appear unduly burdensome to such facilities.

The requirement under Rule 14.1(d)(3) that requires committees for the "performance of committee functions in at least the following areas: credentials, medical records, case and utilization review, quality assurance, hospital infections, casualties, pharmacy and therapeutic practices," appears to be written for interpretation to mean that separate committees would be required. Given that Webster County Memorial Hospital does not anticipate more than three or possibly four physicians at any one time and receives oversight from its affiliate facility, United Hospital Center in Clarksburg, with respect to many of these functions, it would be desirable to clarify the rules and establish that the listed functions can be performed by "designated employees of the RPCH, rather than by a committee of the medical staff in the first instance." It is very likely that utilization review, quality assurance, hospital infection, casualties and all other functions above related to clinical care will be in the first instance reviewed by the medical director after initial gathering of required data and material has been done by non-physician clerical personnel.

The North Central West Virginia Rural Health Network, composed of United Hospital Center and Webster County Memorial Hospital have expended considerable effort in attempting to "create" a Rural Primary Care Hospital (RPCH) in Webster Springs. One of the goals of that Federal program was to lessen the burden imposed on failing small rural hospitals which already have difficulty in meeting many regulatory requirements as their particular circumstances deteriorate, financially as well as operationally and strategically. We would be happy to discuss these comments with you or to assist your department in drafting any potential revisions which would taken into consideration the specific and special needs of RPCH facilities.

Sincerely,



David F. Bailey

Director, Physician Services, United Hospital Center  
Coordinator, North Central West Virginia Rural Health Network

DFB:dp

Ruth Ann Panepinto, Ph.D.  
Secretary  
Department of Human Resources  
Page 2

indicating that no RPCH is required to provide services other than those approved under the EACH/RPCH program.

It appears the proposed regulations continue the requirements from pre-existing regulations with respect to the number and organization of departments throughout a "hospital." These appear to be unduly burdensome with respect to the following requirements as it applies to RPCH facilities.

The existing rules currently state the following departments exists:

- Surgical - A Department of Surgery with a "Chief of Surgery" (Rule 11.4)
- An Anesthesia Department organized under a medical doctor (Rule 11.6.1)
- Emergency Services Department (if such services are provided), under the direction of a Director of the Outpatient Department (Rule 12.2.1); and an Outpatient Department (Rule 12.2)

A general exemption for RPCH facilities so designated under this program concerning services not permitted or allowed under the federal statute will eliminate the need for excessive departmental obligations and/or requirements which would otherwise be imposed on a small rural facility which has a physician staff of only two to four physicians.

Under the designation documents submitted to the state of West Virginia Office of Rural Policy, Webster County Memorial Hospital in its conversion to a RPCH will have one physician designated as a Medical Director who would be allowed to serve in multiple roles carrying out multiple functions. If the regulations as proposed absolutely require that different individuals serve in departments listed within the regulations, it becomes practically impossible for a RPCH facility to find the necessary number of physicians who are otherwise qualified, able and or willing to serve in those roles. It appears that one method for avoiding this problem is to "eliminate the need to maintain multiple departments." As the overall treatment plans and/or policies in a RPCH facility are much more tightly integrated and restricted consequently less varied than in a general acute care hospital setting, to maintain multiple departments where the number of patients treated is small and the number of services clearly defined is unduly burdensome.

The proposed regulations require monthly medical meetings on the part of the medical staff unless each department instead holds a monthly meeting (Rule 14.1(b)(1)). These types of meetings are considered unduly burdensome to facilities of the size



**UNITED  
HOSPITAL  
CENTER**

Post Office Box 1680 ■ Clarksburg, West Virginia 26302-1680 ■ Telephone 304/624-2121

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December 17, 1993

Ruth Ann Panepinto, Ph.D.  
Secretary  
Department of Human Resources  
Regulatory Development  
State Capital Complex  
Building 3, Room 265  
Charleston, WV 25305

ATTN: Kay Howard

Dear Secretary Panepinto:

United Hospital Center, as the affiliate facility involved in the conversion of Webster County Memorial Hospital to a Rural Primary Care Hospital (RPCH) under Federal guidelines promulgated by the Health Care Financing Administration (HCFA), submits this letter of comment with respect to the proposed amendments to the licensure relations currently governing West Virginia Hospitals. The conversion of hospitals like Webster County Memorial Hospital to RPCH hospitals results in the creation of a new type of health care facility which differs in many ways from existent hospitals within the state of West Virginia and consequently certain exemptions from or changes in the proposed regulations as it applies to licensure rules in the state of West Virginia should be considered with regard to these hospitals which are approved to participate in the RPCH program.

The concerns below relate to some of the apparent requirements as proposed for "hospitals" (which at present includes RPCH facilities for regulatory purposes), and the proposed regulations governing the medical staff and medical staff department organization.

RPCH hospitals are limited by federal statute in the provision of inpatient care to 72 hours and are required to cease (assuming they already provide) obstetrical and/or surgical services which require the use of anesthetics which consequently cause concern as it pertains to the regulation of surgical and obstetrical services as proposed in the regulations. The regulations assume that hospitals will be providing surgical, obstetrical and anesthesia services and consequently appear to require those services. See Rules 11.3, 11.4, 11.5, 11.6. It is clear that the rules assume that coronary care, pediatrics and emergency services are optional because the rule as proposed states that these services apply only "when provided." E.g. Rule 11.7.1, Rule 11.7, Rule 12.2. It would appear that to avoid any confusion or any potential possible claim of liability against an RPCH facility for failure to provide surgical and related services that consideration should be made that the new rules contain a general statement

I believe these changes could  
positively help patient care.

I believe Regional Nurses  
should have some involvement in  
rules affecting their practice

Very truly yours,  
Margaret J. J. J., RN

POSTMARKED

12/17/93

RECEIVED

Miss Margaret Tebay  
64 Pleasant Drive  
Wheeling, West Virginia 26008  
REGULATORY DEVELOPMENT  
SECTION

DEC 21 1993

December 17, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, W. Va. 25305  
Attention: Kay Howard

Dear Ms Howard

I am a Registered Nurse working in  
Wheeling, W. Va. I have some concern  
regarding the hospital licensure rules  
filed in the office of the Secretary of  
State.

I have concerns regarding rental  
orders and proposed change that  
allows other health care personnel  
to provide emergency services.

Postmarked

12/17/93

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Registered Nurse practicing in an Open Heart Recovery Room unit. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

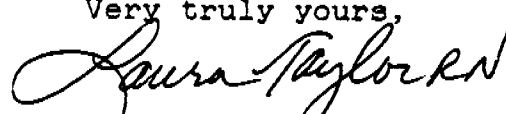
As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,



Laura Taylor, RN



St. Mary's Hospital

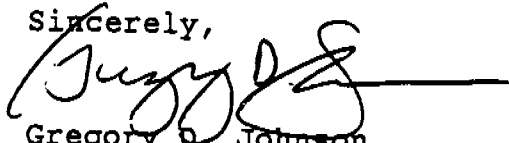
Huntington, West Virginia 25702

Extended Care Unit, we also have an employed Medical Director.

Page 41 - Section 11.11.4.b - I do not feel it is always practical for a facility to make a resident aware of the charges of various items prior to rendering a service. I don't believe this is necessarily in the patients' best interest, particularly in the case of the elderly who tend to avoid care that is in their best interest because of their outright fear of hospital prices. If interpreted literally, the facility could be in a position of getting prior approval on every item of care rendered to a patient. Like most hospitals, this facility has several thousand different charges.

Thank you for providing me with the opportunity to comment on the proposed amendments. If you have any questions on my comments, please contact me.

Sincerely,



Gregory D. Johnson  
Administrator

GDJ:ss

cc: Steven Summer, WVHA

Page 22 - Section 10.3.1h - I want to compliment the Department for modifying the rule to allow verbal and telephone orders by other personnel. This amendment is sorely needed.

Page 30 - Section 11.3.1a - I believe the sentence that states "Nurses caring for obstetrical patients shall not care for other types of patients", needs clarification. It should be permissible for hospitals to use their beds and staff to the maximum extent possible to the point that patient care is not jeopardized. There are situations where female patients, other than obstetrical patients, could and should be placed on the obstetrical unit to maximize the utilization of staff. Similarly, there are occasions when the obstetrical census is low and obstetrical nurses are "floated" to other nursing units.

Page 33 - Section 11.3.8 - This section contradicts Section 11.3.1.a in that this section allows for patients other than obstetrical patients to be housed on the obstetrical unit. The previous section prohibits such use.

Page 37 - Section 11.9.1 - Many smaller hospitals, such as ours, combine their Coronary Care Unit and their Intensive Care Unit. As such, I don't feel it is appropriate and necessary to place a limit on the number of coronary care beds that can be licensed.

Page 37 - Section 11.9.1.a - Many small (and I would say large as well) hospitals do not have an intensive care or a coronary care committee of the medical staff. In our case, where there are only 19 active physicians on our Medical Staff, all quality assurance activities of the Medical Staff are handled by one committee, the Medical Care Appraisal Committee. I believe this section needs to be clarified so as to not give the impression that a specific coronary care unit committee must be established.

Page 39 - Section 11.10.2 - Here again, I would ask for clarification so that it is clear that an intensive care unit committee is not required and that another committee of the Medical Staff can serve the same function.

Page 41 - Section 11.11.3 - Here again, I don't think it's necessary to have a specially created committee of the Medical Staff to oversee the operations of the Extended Care Facility. Once again, one committee of the Medical Staff can serve many functions. Also, in the case of our

# SMH SUMMERSVILLE MEMORIAL HOSPITAL

400 Fairview Heights Road • Summersville, West Virginia 26651 • 872-2891

**RECEIVED**

November 29, 1993

DEC - 6 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305  
Attention: Kay Howard

**REGULATORY DEVELOPMENT  
SECTION**

Re: Proposed Amendments To Hospital Licensure, 64CSR12

Dear Ms. Howard:

Thank you for this opportunity to comment on the proposed amendments, my comments are as follows:

Page 1 - Section 3.1 - There are a number of for profit hospitals in the state, do these regulations apply to for profit hospitals? If these regulations do not apply to for profit hospitals, which regulations do? If the intent is for these regulations to apply to all hospitals, both profit and nonprofit, the definition in Section 3.1 should be modified.

Page 2 - Section 3.8 - I would suggest that the word "rehabilitation" be replaced by the words "other professional healthcare". Oftentimes, the majority of nursing home patients do not require rehabilitation services. Under Medicare regulations, Medicare will not pay for physical therapy services unless the patient has potential for recovery. The definition of 3.8, if taken literally, would restrict nursing home admissions to only those patients who need rehabilitation services.

Page 11 - Section 7.21.a.(4) - I'm not sure that the Joint Commission still requires a Joint Conference Committee since we are not a Joint Commission accredited facility. I would like to suggest that membership on the Board of Trustees by the Chief of Staff and/or other physicians would fulfill the "formal liaison" requirement.

Page 15 - Section 8.3.2 - If this section is taken literally, regardless of the dollar amounts expended, any hospital which would undertake any construction project, such as the correction of a deficiency cited by OFLAC would have to go to the time and expense of obtaining architectural approval of what can be very simple matters. I would like to suggest that some dollar thresholds or other more specific criteria be utilized in this regard.

RECEIVED

DEC 10 1993

REGULATORY DEVELOPMENT  
SECTION

SANDRA A. STROM, RN  
2769½ COLLIS AVENUE  
APT. 1  
HUNTINGTON, WV 25702

December 9, 1993

Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Ms. Howard:

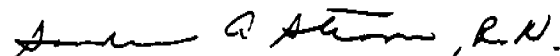
I wish to express my concern over some of the proposed rule changes affecting legislative rules regarding hospital licensure and to strongly encourage the scheduling of a public hearing regarding these proposals.

As a registered nurse and a health care consumer, I am particularly distressed about the proposal to decrease the number of professional registered nurses providing direct patient care in the critical care settings and using less qualified people to do this. So much can happen in seconds in critical situations that can directly and sometimes irreversibly affect the outcome that only a highly trained person - in particular a professional registered nurse - could be expected to detect those initial changes and be alerted to the next course of action. Lesser qualified people are not trained to this degree.

I know the bottom line is to cut health care costs, but if we jeopardize even minimal standards of care because of the money issue, we are in effect throwing the baby out with the bath water. Should these rules be adopted, I can just visualize potential litigation for malpractice and inferior service. We all should know by now what that does to overall costs in the long run. There are just some things we cannot afford to compromise and these are some of those things.

**PLEASE, PLEASE!!** We need a public hearing in order to address these concerns more fully.

Sincerely,



Sandra A. Strom, RN

SAS/mc

POSTMARKED  
12/17/93



ST.  
JOSEPH'S  
HOSPITAL

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

December 16, 1993

Ms. Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Ms. Howard:

As a Vice-President responsible for nursing practice and as a registered professional nurse bound by the W.V. Board of Registered Nursing Practice Act, I feel obligated to respond to the proposed Hospital Licensure law.

While I support the intent to update an antiquated law, I do believe the proposed rule as written has great potential to jeopardize patient care. In some areas such as sections 11.9.1 (b), vagueness of who and what gives little assurance of achieving a consistent, positive outcome. In other sections, such as 14.2, the highly prescriptive approach causes a redundancy in record keeping and a lack of flexibility in developing alternative patient care modalities.

Because of the importance of this issue, I am requesting a public hearing on Legislative Rule 64 CSR 12, to further clarify the intent.

Thank you for your consideration.

Sincerely,

Rosalie Vlahutin, RN, MPH.  
Vice President

0104S/cs

19th Street and Murdoch Ave. Parkersburg, WV 26101 1-304-424-4111

**VHA**  
Partner-VHA Mid-Atlantic  
Affiliate of the Voluntary  
Hospitals of America System.

## 64 CSR 12

ient's medical record and shall be expressed in terminology of a recognized system of disease nomenclature.

l. Medical records shall be completed promptly, authenticated and signed by the physician or dentist ~~within fifteen (15) days but not more than forty-five (45) days following discharge~~ of the patient. *Within 30 days of discharge*

m. Medical records shall be indexed according to disease, operation and physician and indexing shall be kept up to date.

~~nr--Hospitals using automatic data processing may keep indexes on punch cards or reproduced on sheets bound in books.~~

~~or n. All medical records of services to outpatients and patients treated in the emergency room shall be maintained in the files of the medical records department in locations where accessible to caregivers & where systems are established to locate divergently.~~

10.3.2. Births and Deaths Report - A complete list of all births, deaths and fetal deaths occurring within the month in licensed hospitals must shall be reported by the tenth of the following month on special blanks provided for the purpose forms provided by or approved by the director or on a comparable computer printout approved by the director to the division of state registrar of vital statistics, state department of health. All completed birth certificates should shall be sent to the county state registrar of vital statistics immediately after the end of the month within ten (10) days following the birth.

10.3.3. Communicable Disease Reports - licensed institutions must report each case of communicable disease to the local health officer within twenty-four (24) hours after the disease is discovered. Reporting post cards furnished by the state department of health may be used and shall be signed by the physician who diagnoses the case. Licensed hospitals shall comply with Reportable Diseases, 64 CSR 7 and any other applicable rules regarding the reporting of diseases or laboratory test results to the state.

~~10.3.4. Venereal Disease Reports--Licensed hospitals shall report every previously unreported case of syphilis, gonorrhea and chancroid within forty-eight (48) hours after a diagnosis is made or treatment started. The report shall be made to the state director of health on forms supplied by the state department of health.~~

or 10.3.4. Information contained on medical records in licensed hospitals relative to venereal diseases shall be made available upon request to the state director of health. The hospital shall make medical record information relative to sexually transmitted diseases available to the director on request.

~~nr--Supervisors of all laboratories in licensed hospitals~~

64 CSR 12

for each patient admitted for care in the hospital and the record shall be retained in an easily accessible manner in the hospital.

b. A complete medical record is one which includes patient identification, date, complaints, history of present illness, personal and family history, physical examination, doctor's orders including dietary orders, special examinations and consultations, clinical laboratory, x-ray and other examinations, provisional or working diagnosis, treatment and medications given, surgical reports including operative and anesthesia records, gross and microscopic pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary and autopsy findings, if performed.

c. A medical record for each newborn infant, separate from the mother's record, shall be kept.

*No "short" form acceptable*  
d. A short form medical record may be used for inpatients staying patients who are in the hospital less than forty-eight (48) hours except in the case of maternity and newborn patients. The short form shall contain sufficient information for proper diagnosis and treatment. *A final progress note may be substituted for Discharge Summary in the case of pts. with problems of a minor nature.*

*Section 2. - ok*  
e. Records, including records of patients treated in the emergency room or outpatient department, shall be preserved either in the original form or by microfilm or electronic data process. *period of hospitalization and in the case of normal newborn infants & uncomplicated obstetric deliveries*

f. All clinical information pertaining to patients shall be filed in the patient's medical record.

g. All orders for medication or treatment shall be in writing, signed by the physician in ink, and filed in the patient's medical record. *or by authorized signature star.*

h. There shall be maintained a system of nurses' clinical records and all doctors' orders shall be in writing and signed by the physician. ~~Telephone or verbal orders shall be given to a registered professional nurse and shall be signed by the physician as soon as possible thereafter.~~ Verbal and telephone orders shall be given to licensed or certified personnel that are authorized to receive these orders by the medical staff policies and procedures. Physicians shall countersign all verbal and telephone orders as determined by the medical staff bylaws.

i. All reports and entries in the patient's medical record shall be typewritten or written in ink and signed by the person making the entry.

j. Only abbreviations approved by the medical staff shall be used in preparing medical records.

k. Final diagnosis diagnoses shall be included in the pat-

## 64 CSR 12

pharmacist.

10.1.2. Medication Storage - All drugs shall be stored in proper containers and be plainly labeled. Poisons and medications for external use are to be kept in a separate compartment or section of the pharmacy or drug room.

a. All drugs on nursing units and hospital services shall be stored in a specially designated cabinet, closet or room, in or near each nurses' station, with one (1) or more sections for poisons and medications.

(1) The medicine cabinet shall have a compartment for the storing of medications for external use only.

(2) The medicine cabinet shall be well illuminated and have adequate space for the storing of medications and for their preparation and administration. It is to be provided with a lock and key; to be kept locked when not in use; and the key available only to authorized personnel.

10.1.3. Narcotics - Narcotics and controlled or dangerous drugs, ~~such as~~ which are required to conform with state and/or federal regulations shall be kept under double lock and accessible only to authorized personnel. Double locked boxes firmly attached to cabinets shall be used for storage of narcotics. Obsolete or surplus narcotics to be disposed of must shall be handled according to federal law.

10.1.4. All unused medications shall be discarded when orders have been discontinued or the patient has been discharged from the hospital, except that in the event the physician desires continuation of the medication, the patient may be permitted to take the medicine home if so ordered on the chart by the physician.

10.2. Blood Supply Service - Blood and blood substitutes shall be readily available to the hospital at all times for emergency administration. Arrangements shall be made to readily secure types of blood not ordinarily kept in the hospital. Blood shall be obtained, processed, stored and administered under the supervision of a pathologist or designated physician.

10.3. ~~Medical Records Department~~

Registered  
Administrator  
LRA

10.3.1. A hospital shall maintain a medical records department under the supervision of a ~~medical records librarian~~ or other person qualified by training and experience. The medical records department shall be conveniently located and adequate in size and equipment to enable physicians to complete medical records.

a. Accurate and complete medical records shall be written



**ST.  
JOSEPH'S  
HOSPITAL**

December 20, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305  
ATTN: KAY HOWARD

Dear Kay:

Attached are my comments on the proposed Title 64 regarding Hospital Licensure. I am commenting on the Medical Record Section. I am a Registered Record Administrator (RRA) employed as Director of Medical Records at St. Joseph's Hospital, Parkersburg, West Virginia.

The changes noted are in line with JCAHO's (Joint Commission on Accreditation of Health Care Organizations) standards for medical records.

Thank-you again for allowing me to fax my comments to you. Should you have any questions, do not hesitate to contact me at (304) 424-4685.

Sincerely,

Jill Z. Choj, RRA  
Director, Medical Records

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DEC 20 1993

**REGULATORY DEVELOPMENT  
SECTION**



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JOSEPH'S  
HOSPITAL**

December 15, 1993

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DEC 16 1993

**REGULATORY DEVELOPMENT  
SECTION**

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Attn: Kay Howard

**SUBJECT: PROPOSED AMENDMENT TO HOSPITAL LICENSURE RULE  
64 CSR 12**

Gentlemen:

I have just recently had the opportunity to review the proposed changes to the legislation regarding licensure of hospitals. There is a segment to which I strongly object and urge you to change.

Section 14.2 NURSING DEPARTMENT, specifically 14.2.3, requires that certain "records shall be available in the nursing department"..."b. Personnel records including employment application forms and verification of credentials and character references for each nursing department employee."

That these records should be maintained and available is not a problem. That they should be maintained and available in the nursing department is objectionable. The retention of employee files and records is the accepted responsibility of the Human Resources or Personnel office of the hospital. Confidentiality can be more easily maintained if all employee records are kept in one location rather than throughout the hospital. Duplicate records increase the possibility of incomplete or inaccurate records.

Again, I ask you to change this portion of your proposed amendment and thank you for your consideration.

Very truly yours,

Adele Watson, Director  
Compensation & Benefits

19th Street and Murdoch Ave. Parkersburg, WV 26101 1-304-424-4111

**VHA**  
Partner-VHA Mid-Atlantic  
Affiliate of the Voluntary  
Hospitals of America System

14.2.3. We disagree with the proposition that the following records should be maintained in the nursing department.

- a. List of all nursing personnel with individual's license number. We believe that all information pertaining to an employee (with the exception of an employee health record), should be maintained in and by the Human Resources (Personnel) Department.
- b. Personnel Records, including employment application forms and verification of credentials and character should only be maintained by the Human Resources (Personnel) Department of the Licensed Hospital.

14.2.4. We disagree with the licensure law establishing a minimum staffing requirement and chain of command (assistants to the DON). We further disagree with the use of such terms as appropriate, immediately available, etc., when describing staffing. These terms leave the Hospital open to whatever opinion an evaluator may apply.

11.3.3. Nursery Unit... It shall be conveniently located with reference to the mothers' rooms and shall be preferable an outside room so located as to receive sunshine some portion of the day.

Changed 11.3.3 Nursery Unit... It shall be conveniently located with reference to the mothers' rooms and shall be preferable an outside room so located as to receive natural light some portion of the day.

Use of the word sunshine implies direct light from the sun. This would be impractical on overcast and cloudy days. A better choice of words is natural light. This would allow the use of filtered and reflected light from the sun.

11.4.6. An ungrounded electrical distribution system...shall comply with the natural fire protection association, No.56.

Proposed revision 11.4.6. An ungrounded electrical distribution system...shall comply with the national fire protection association, No. 99.

Change the reference to reflect the location of applicable codes.

12.2.1 (a). "The Emergency Service" of the hospital shall be under the direct control of the director of the outpatient department.

Recommendation: Delete this section. Not all hospitals have outpatient directors. The position to whom the ED reports should be a decision made by the hospital.

12.2.2. We support these changes as presented. They will be beneficial in staffing our Emergency Department.

13.2.2. We disagree with the licensure law attempting to establish minimum levels and types of education and experience of Hospital personnel. We also disagree with the Licensure law establishing a chain of command for management or a minimum level of management.

13.4.1 Examination and Treatment Rooms (BMR, EKG, etc.)- "separate space shall be provided for each service provided". What is definition of "service", Nursing Unit, Department, Med-Surg, etc.? Non-manual controls should only be required if dictated by good infection control practices.

10.3.1 (l). "Medical records shall be completed promptly, authenticated and signed by the physician or dentist within forty-five days following discharge of the patient.

Recommendation:

Change this to read thirty (30) days. Thirty days is consistent with the Joint Commission and the Medical Conditions of Participation.

Proposed Revision:

"Medical records shall be completed promptly, authenticated and signed by the physician or dentist within thirty (30) days following discharge of the patient."

10.3.1 (n). "All medical records of services to outpatients and patients treated in the emergency room shall be maintained in the files of the medical records department."

Recommendation:

Delete entire phrase. It is impossible for medical record departments to store all outpatient lab, x-rays, etc. There is a space constraint. Since the hospital is required to retain medical records, each hospital should decide the location which is best for them.

11.2.7. Janitor's Closet... The area should be adequate to store mop buckets on a roller carriage, a wet and dry vacuum machine and a floor scrubbing machine.

Proposed Revision 11.2.7. Janitor's Closet... The area should be adequate to store mop buckets on a roller carriage, a wet and dry vacuum machine and a floor scrubbing machine as necessary.

The proposed rule's language makes it seem as though this equipment is required in each closet. Space for storage needs to be adequate for the equipment stored in each closet not all potential equipment that could find its way to a floor.

11.3.1. (d). Under this section, nurses caring for obstetrical patients shall not care for other types of patients. This statement disallows for the practice of sound nursing judgments. There are times when nurses caring for obstetrical patients can safely and appropriately care for non-infected, clean gynecological patients.

10.3.1(e). "Records, including records of patients treated in the emergency room or outpatient department, shall be preserved either in the original form or by microfilm or electronic data process."

Recommendation:

This needs to be more specific regarding how long these records need to be maintained or by allowing hospitals to decide the length of retention. The Medicare Conditions of Participate require a five year retention.

Proposed Revision:

"Medical records must be retained in their original or legally reproduced form for a period of at least five years."

10.3.1 (g). "All orders for medication or treatment shall be in writing, signed by the physician in ink and filed in the patient's medical record.

Recommendation: Add a section to allow for electronic signature.

Proposed Revision: "All orders for medication or treatment shall be in writing, signed by the physician in ink or with electronic signature and filed in the patient's medical record."

10.3.1 (h). The proposed amendment to this section permits the hospital's medical staff to determine who may accept verbal or telephone orders. The terms licensed or certified personnel include a broad range of disciplines with various breath of knowledge regarding the whole patient. All are not equally prepared to assess appropriateness of the orders received. Such professionals as registered pharmacists, registered dieticians and registered respiratory therapists are however prepared to address treatment orders relative to their respective disciplines.

We support this endeavor if the parameters are clearly defined. A mechanism must be developed to allow the registered nurse to continue to fulfill the role of the coordinator for patient care. Strong, consistent communication systems must also exist to support this change in practice. While input from both medical and nursing staff is critical, determinations of which disciplines can accept verbal orders within the confines of a particular hospital should be the sole responsibility of hospital administration.

tile joints, shall be resistant to food acids. In all areas subject to frequent wet-cleaning methods, floor materials shall not be physically affected by germicidal cleaning solutions. Floors subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) shall have a non-slip surface."

The proposed rule is too vague as to the definition of an area requiring a smooth washable surface.

8.6.4. No recirculation of air shall be permitted in operating rooms, delivery rooms, etc., and adjacent service areas.

Proposed Revision 8.6.4. Recirculation of air shall be permitted in operating rooms, delivery rooms, etc. and adjacent service areas as allowed in the 1993-93 edition of Guidelines for Construction and Equipment of Hospital and Medical Facilities.

Recirculation of air is permitted in areas where anesthesia is administered as long as waste anesthetic gas scavenging is accomplished with systems that do not connect to the ventilation system.

9.1.5b. Garbage containers shall be emptied at frequent intervals and shall be thoroughly washed and sanitized before being used again.

Proposed Revisions 9.1.5b. Garbage containers shall be emptied at frequent intervals. Those containers that do not use an auxiliary liner shall be thoroughly washed and sanitized before being used again.

The proposed rule does not differentiate among trash, garbage, and bio-hazard waste that is normally collected in cans in the hospital. Further, it does not allow for the practice of using poly can liners. This distinction among the types of collection cans needs to be made.

10.3.1 "A hospital shall maintain a medical records department under the supervision of a medical records librarian or other person....."

Recommendation:

Delete the term "librarian" because it is outdated.

Proposed Revision:

Substitute the work "practitioner" for librarian. The revision would read, "A hospital shall maintain a medical records department under the supervision of a medical record practitioner who is qualified by training and experience."

Comments Concerning Proposed Rules  
Hospital Licensure

7.2.1 (a) Governing Authority - "Develop and maintain a suitable formal liaison with the medical staff by means of a joint conference committee."

Recommendation:

Delete the reference to a joint conference committee. The JCAHO no longer requires this. It would be sufficient to say that a suitable liaison between the medical staff and the hospital is developed and let them decide how to do this.

Proposed Revision:

"Develop and maintain a suitable formal liaison with the medical staff."

7.3.8 - Does this regulation demand that the Board's first consideration be "assuring" consideration of those mentioned? Isn't its first responsibility to attend to the overall good of the hospital and the community it serves? This regulation seems, in itself, to be discriminatory and smacks of "filling slots" or trying to "look good."

8.4.2 Complete construction drawings and specifications for any hospital addition, alteration, or renovation project shall be submitted to the director....

Proposed Revision 8.4.2....any hospital addition, alteration, renovation project that requires a Certificate of Need shall be...

The language that refers to the projects does not include a reference to the scope of the project. Would the refinishing of surfaces be a renovation project? Would the changing of the function of a hospital unit qualify if there were no structural changes? This paragraph needs further qualification as to when to apply the rules.

8.5.2 Floors shall be smooth, nonabsorbent and constructed for easy and effective cleaning. Approved carpeting may be used in areas other than those requiring a smooth washable surface.

Proposed Revision 8.5.2. Adopt paragraph 7.2884 of 1992-93 edition of Guidelines for Construction and Equipment of Hospital and Medical Facilities. "Floor materials shall be easily cleanable and appropriately wear-resistant for the location. Floors in areas used for food preparation or food assembly shall be water-resistant. Floor surfaces, including



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REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

ATTN: Kay Howard

Dear Ms. Howard:

Please find attached our comments concerning amendment of legislative rule, "Hospital Licensure", W.Va. 12 Code 16.5B-8. We support your efforts to revise or delete certain outmoded hospital licensure standards. You will note from our comments that we feel some of the proposed changes need additional revisions and/or clarifications prior to implementation.

The proposed changes to the Hospital Licensure Rule are substantive and should be given due consideration. We are requesting that you hold a public hearing to provide the opportunity for additional clarification and input from all effected parties.

Thanks for your consideration of our comments concerning the proposed amendments.

Sincerely,

Arthur A. Maher  
President & Chief Executive  
Officer

AAM/bmb  
12-17-93  
Attachments

Postmarked  
12/17/93

**OV/MC**  
**OHIO VALLEY MEDICAL CENTER**  
2000 Eoff Street  
Wheeling, WV 26003

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**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

ATTENTION: Kay Howard

Dear Ms. Howard,

I am writing in regard to the proposed rules regarding hospital licensure which have been filed in the office of the Secretary of State. I have several concerns which I want to share with your.

Many of the proposed changes directly impact professional nursing in West Virginia and I was most distressed to learn that none of the professional nursing organizations were consulted for input.

The stated purpose of the proposed amendments is to revise or delete certain outmoded hospital licensure standards, yet staffing ratios are clearly outdated. The proposal also misquotes federal rules.

I believe a public hearing should be held so that the nurses in West Virginia will have an opportunity to contribute their knowledge to these changes. Our common interest is providing safe, appropriate care to the patients we care for.

Yours truly,

*Sara E. Smith*

Sara E. Smith, RN, MSN, CNAA  
Associate Administrator/  
Director of Nursing

OHIO VALLEY MEDICAL CENTER  
EAST OHIO REGIONAL HOSPITAL  
PETERSON REHABILITATION HOSPITAL

Ohio Valley Health Services and Education Corporation

**OV/MC**  
**ES**

As present it is hard enough to co-ordinate the complex care given in hospitals by one person, let alone opening it up so numerous groups can receive orders would only ↑ the chance of breakdown communication & ↑ the chance of error — a very unsafe environment for consumers.

Acuity of ER, cardiac, & ICU patients has greatly risen over the years. Therefore, permitting the use of health care personnel other than nurses is a step back to the dark ages rather than an ↑ in the standard of care. Mortality has been shown to rise in <sup>practices</sup> such as this. I as a consumer do not want to receive care in this type of setting.

A standard of 1 RN + 1 LPN in an ICU per 6 patients is dangerous. Also, using other health care personnel qualified by training & state law to provide intensive care services is frightening — you can teach a dog tricks, but can you train him to assess, plan, & evaluate. State law should protect the public — not give institutions the ticket to provide unsafe, sub-standard care.

I could go on. I oppose these proposed rules & request a public hearing or suggest a ~~drawal~~ withdrawal of them as proposed.

Sincerely,  
 Janice M. Smith, MSN, RN

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DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION

1302 Kanawha Ave  
Dunbar, W. Va. 25064

12-17-93

Regulatory Development  
State Capitol Complex  
Bldg. 3, Rm 265  
Charleston, W. Va. 25305

To whom it may concern:

As a practicing RN in W. Va. I am writing to oppose the hospital licensure rules filed in the office of the Secretary of State. This is also to request a public hearing on these proposed rule changes.

I am in opposition because I feel they are not in the best interests of consumers & the reasons given for change are plausible.

Variance from current standards of good hospital practice & to revise or delete certain outmoded hospital licensure is not accomplished through these proposed rules. Because certain hospitals employ unlicensed personnel to provide care that should be given by licensed personnel, is a poor excuse to OK this by law. Allowing individual hospitals to determine which licensed or certified personnel may receive verbal & telephone orders through P/P set by the medical staff is dangerous & means patients could receive different standards of care in Welch, Charleston, Beckley, etc.

Postmarked  
12/17/93

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December 16, 1993

DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

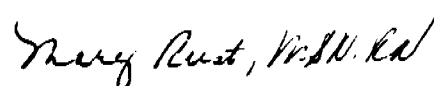
Dear Ms. Kay Howard:

I am writing requesting your decision against the legislative issue about verbal and telephone orders from licensed or certified personnel to Registered Nurses.

I am a nurse in West Virginia and this would jeopardize quality care to the patients. My concern is taking orders from others than a licensed physician or dentist. If this issue is passed, many different persons could give me orders for the same patient, thus causing more of a change for error in giving medications and treatments. Health Care costs would increase due to the time involved in clarifying orders and time is of essence in patient care.

As a Post Anesthesia Care Unit nurse, this is not an appropriate time to decide whose order I would follow for the best care of a critical patient. The direction of orders must come from a qualified physician not another certified person. Patients lives could be the end result of inadequate and incorrect orders.

Sincerely,



Mary Rust, M.S.N., R.N.  
24 Sycamore Ave.  
Wheeling, WV. 26003

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12/17/93

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**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Registered Nurse practicing in an Open Heart Recovery Room unit. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

  
Jody Ross, RN



**St. Mary's Hospital**

Huntington, West Virginia 25702

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DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Attention: Kay Howard

Dear Ms. Howard:

I am a Registered Nurse currently practicing in an emergency trauma center in Wheeling. Therefore I am particularly concerned about the recent hospital licensure rules filed in the office of the Secretary of State. These rules could directly impact my practice as a nurse and I am disappointed that there was not any nursing input into the rule changes under consideration.

One of the rule changes that gives me the most concern is the rule regarding verbal orders. I am only able to take orders from a licensed physician or dentist. The proposed rule creates confusion for me as a professional as to which rule I am to follow. Additionally this could lead to much confusion and risk of poor communication thereby jeopardizing the safety of patients.

As an emergency room nurse I am especially concerned about the rule regarding the provision of such services. In an effort to protect the public I believe that nursing care should be performed by licensed qualified nurses not by other health care personnel. This provision would allow hiring of people who may not have the knowledge or skills that are required to provide care and would again put our patients at risk.

Please contact me if there is a need to further discuss my concerns.

Sincerely,

*Catherine A. Robinson*

Catherine A. Robinson RN, MS, CEN, CCRN  
30 Romney Road  
Wheeling, WV 26003

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DEC 20 1993

December 17, 1993

**REGULATORY DEVELOPMENT  
SECTION**

Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

Dear Ms. Howard:

I am writing in response to the proposed amendments to the hospital licensure rules by the Department of Health and Human Services.


Verbal and telephone orders are one of the most hazardous roles of nursing practice. Many times physicians' orders are received by the above modes and are miscommunicated by the receiving nurse. Physicians have been known to deny they gave the nurse the order. To allow other health care workers (as deemed by the medical staff bylaws) to give orders for nurses to follow places the patient at serious risk.

The proposed changes which affect the practice of nursing require two things:

- 1) Involvement of professional nurses, and
- 2) Review of the Nurse Practice Act.

The quality of patient care and the risk management factors make a public hearing important so all may respond to the changes. I request a public hearing.

Sincerely,



Lorraine Ritz, R.N.

Lorraine Ritz, R.N.  
41 Delwood Avenue  
Wheeling, WV 26003

that can impact patient outcomes.

Another concern I have concerns the proposed change that allows other health care personnel to provide emergency services. Nursing care needs to be performed by licensed qualified nurses to protect and safeguard the consumer. I believe the proposed change could open the door for hospitals to hire persons without adequate knowledge and skills and therefore jeopardize safe care.

Please inform me if there is a public hearing prior to the rules being changed so I can further discuss my concerns.

Yours truly,

Marcha Richardson, R.N., R.S.N.

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12/20/93

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DEC 22 1993

REGULATORY DEVELOPMENT  
SECTION

147 Crisswell Rd  
St. Clairsville, Ohio  
December 16, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia  
Attention: Kay Howard

Dear Ms Howard:

I am a Registered Nurse who has practiced nursing for twenty eight years in West Virginia. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

I have several concerns. I believe there should have been a public hearing and I would have attended to express these concerns. I unquestionably believe that Registered Nurses must be involved in the drafting of rules that directly impact their practice.

The proposed rule regarding verbal orders will place me in a difficult situation as I still will only be able to take orders from a physician or dentist. I firmly believe this will impact the quality of nursing care when there is not a clear avenue for communication

Postmarked  
12/20/93

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DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

**LAURA SKIDMORE RHODES, R.N., M.S.N.**  
5334 Shadowbrook Rd  
Charleston, WV 25313

December 17, 1993

Department of Health and Human Resources  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

RE: Hospital Licensure  
W. Va. Code §16-5B-8

ATTN: Kay Howard

Dear Ms. Howard:

I appreciate the opportunity to respond to the proposed rule changes offered by the Department of Health and Human Resources to the Hospital Licensure Rule.

The summary of the rule included in the Rule Abstract put forth that "The purpose of the proposed amendments to Hospital Licensure is to revise or delete certain outmoded hospital licensure standards which are creating problems due to their variance from current standards of good hospital practice." I respectfully suggest that many of the changes do not support this premise and perhaps extend to the point of compromising patient care.

I concur with the concerns put forth by the West Virginia Board of Examiners for Registered Professional Nurses and trust that serious consideration will be given to them.

Once again, thank you for the opportunity to respond to the Rules.

Sincerely,



Laura Skidmore Rhodes, R.N., M.S.N.

Pastmarked  
12/17/93

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DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Registered Nurse practicing in an Open Heart Recovery Room unit. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

*Susan Reasor, RN, CCRN*

Susan Reasor, RN, CCRN



**St. Mary's Hospital**

Huntington, West Virginia 25702

Postmarked  
12/17/93

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

December 15, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305  
Attn. Kay Howard

Dear Dr. Ruth Ann Pancipinto:

I am a registered professional nurse practicing at the Charleston Area Medical Center. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons:

According to the West Virginia Nurse Practice Act, nurses will still only be able to take orders from physicians and licensed dentists. Thus, passage of this rule, will put nurses and others in difficult situations that could be avoided during their daily practice. Nurses will be forced to decide which part of the Code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules. As I periodically work as a staff nurse, I would find it very difficult and unlawful to follow the rules as proposed in conflict with the State Act that governs my practice. It appears as a conflict of interest at the state level.

Furthermore, by allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, it is probable that the level of patient care will decline due to institutions hiring personnel who could not perform at an optimal level of patient care due to a lack of specialized judgement and skill based on the knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Sincerely,

*Mary C. Ramsburg BSN, RN*

Mary C. Ramsburg, BSN, RN

Mary C. Ramsburg  
6907 Boreman Drive  
Charleston, WV 25312

Postmarked

12/17/93

RECEIVED

December 17, 1993

DEC 21 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

REGULATORY DEVELOPMENT  
SECTION

I am a Registered Nurse practicing in Huntington. I am writing in response to the Hospital Licensure Rules in the office of the Secretary of State. I have a great concern about these rules. As filed, the rules are not beneficial to patient care in West Virginia. Areas which concern me especially include:

Allowing verbal and telephone orders to "be given to license or certified personnel that are authorized to receive these orders by the medical staff policies and procedures". By allowing persons other than registered nurses to perform this function, patient care and management is at jeopardy. Registered nurses assume the role of coordinator of care for patients as well as provider of care. They are aware of current orders and treatments for a patient and can clarify orders if needed since most patients now have more than one physician provider due to specialization of health care.

Allowing "other health care personnel qualified by training and State law to provide intensive care services" and emergency services and to work in designated areas of the hospital. Technology has increased and therefore those working in advanced technological areas should have advanced education. This does not allow for other qualified health care personnel. If myself or my family member is in the emergency room or intensive care unit struggling for life, I want the best available care. That means care by a registered nurse whose has an education which allows high quality of care. I do not feel the standards of care for the patient should be compromised in order to save dollars. Lives come before money.

Allowing "one registered nurse and one practical nurse per unit of six patients each shift are sufficient for proper patient care". This is very unrealistic. A seriously ill patient needs one nurse to one patient ratio. Seriously ill patients struggling for life have many needs. They require numerous medications, care of the their respirator, constant minute to minute assessment of their condition, numerous calls to physicians about the change in the patients condition, frequent turning to prevent bed sores and discomfort, frequent mouth care. This is only to mention a few.

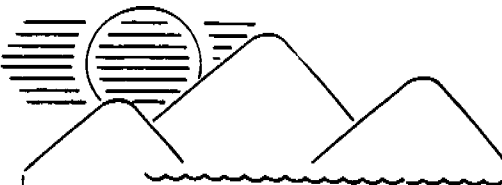
I would like for these rules to be evaluated in more depth prior to enactment. I would be happy to discuss the implication of the rules if a public hearing is held.

Sincerely,

*Sandra K. Prunty*

Sandra K. Prunty, MSN, RN, CS, FNP

*Prunty*  
1924 Withhric Blvd.  
Huntington WV 25701



PRESTON MEMORIAL HOSPITAL

**RECEIVED**

DEC 13 1993

REGULATORY DEPARTMENT  
SECTION

December 9, 1993

Kay Howard  
Regulatory Development  
State Capital Complex  
Building 3, Room 265  
Charleston, WV 25305

Dear Ms. Howard,

This letter is in response to the comment period for the prepared amendments to the Hospital Licensure.

Under 10.3 Medical Records and Reports: Section, 10.3.1 h, I recommend striking the work "Certified" and inserting "Registered" and adding at the end of that sentence "in their own area of practice". Certified personnel could include nurse's aides or home health aides. It is not appropriate nor are these caregivers trained or qualified to take physician orders.

Under 11.10.4 Staffing: a. in place of "non professional" add "licensed".

Under 11.10.4 Staff: b. (2) in place of "non professional" add "licensed".

Under 12.2 Emergency Department: Section 12.2.2, add "licensed" before "practical nurse".

Thank you for your consideration.

Sincerely Yours,

Helen C. Nikirk  
Director of Nursing

HCN/skg

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DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305

To Whom It May Concern:

I am a Clinical Manager practicing in an Open Heart Recovery unit. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care in West Virginia for the following reasons.

Passages of the rule will put both nurses and others in a difficult situation in the course of their practice. According to the Nurse Practice Act, nurses will still only be able to take orders from physicians or dentists. Nurses will have to decide which part of the code to follow and may be put at odds with the State Code which governs their practice and certain hospital rules.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing.

I would be happy to further discuss the implication of the rules if a public hearing is held prior to their enactment.

Very truly yours,

*Carol Porter, RN, CCRN, CPAN*

Carol Porter, RN, CCRN, CPAN

*Carol Porter, RN*

**St. Mary's Hospital**

Huntington, West Virginia 25702



Postmarked

12/19/93

**Peterson Rehabilitation Hospital  
And Geriatric Center**

Homestead Avenue  
Wheeling, WV 26003

**RECEIVED**

DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

December 16, 1993

Regulatory Development  
State Capitol Complex  
Att'n: Kay Howard  
Building 3, Room 265  
Charleston, WV 25305

Dear Ms. Howard:

The purpose of this letter is to provide comments to the proposed legislative rules, WV Code 16-5B-8, Section 11.11.4. Financial Rights and Responsibilities.

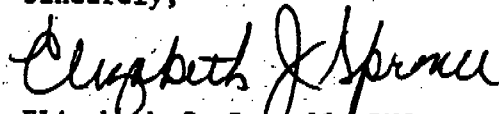
Peterson Rehabilitation Hospital is a licensed rehabilitation hospital, with a distinct part unit. Since the OBRA 1987, Peterson has, upon written permission of the patients/residents, established savings accounts for funds as directed by those regulations.

In regards to section k, l and m, we currently have eight (8) residents whose family or patient/resident, have requested Peterson to act as representative payee. I agree with the premise of the proposed rules, but in the above cases, there is either no family available or willing to take this responsibility. In addition, the cost to the institution to initiate guardianship or incompetency proceedings would be prohibitive.

As the citizens of West Virginia continue to age, as the rest of the nation, it will be likely that the number of patients/residents requesting Peterson to serve as representative payee will increase. Two of the eight residents already have guardians who are unwilling to assume this responsibility.

Please consider these type of situations when implementing such rules.

Sincerely,



Elizabeth J. Sproull, RNC, M.Ed.  
Administrator/Director of Nursing

EJS/jmc

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12/20/93

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DEC 22 1993

December 16, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, West Virginia 25305  
Attention: Kay Howard

REGULATORY DEVELOPMENT  
SECTION

Dear Ms. Howard:

I am a Registered Nurse in Wheeling, West Virginia. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

I am concerned about several issues. I believe there should have been a public meeting where I could have attended and had an opportunity to express these concerns. I firmly believe that Registered Nurses should be involved in drafting rules that directly affect their practice.

The proposed rule regarding verbal orders will place me in a difficult situation as I still will only be able to take orders from a physician or dentist. Which rule will I follow? I also believe patient care would not be safe as too much confusion and unclear communication would exist about who's taking the order and who's carrying it out and so forth.

I am also concerned about the proposed change that allows other health care personnel to provide emergency services. Nursing care needs to be performed by licensed qualified nurses to protect and safeguard the public. I believe the proposed change could open the door for hospitals to hire persons without adequate knowledge and skills and therefore jeopardize safe care.

Would you please let me know if there is a public hearing prior of the rules being changed so I could further discuss my concerns?

Very truly yours.

*Martha L. Packard RNC*  
*Rt. 1 Box 317A*  
*Adena, Ohio 43901*



December 20, 1993

Ms. Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

HOSPITAL LICENSURE, 64 CSR 12

Dear Ms. Howard:

Please accept this letter as our protest to Hospital Licensure, 64 CSR 12.

Our personnel files are maintained in strict confidence. We believe that the confidentiality of an employee's personnel file may be lost if placed in two separate locations. Furthermore, the time involved in duplicating and maintaining these files could be excessive. We have no fulltime clerical support staff in the nursing department, which could lead to further problems if these files are to be maintained in nursing.

Our Department Directors have access to their employee's files on all three shifts. By having this service available we see no reason to duplicate/maintain separate files.

We ask that serious consideration be given to the above before it is actually passed into law.

Sincerely,

Sue Cales  
Director of Human Resources

esc

Post-It™ Fax Note .7671		Date	12/20/93	# of pages	1
To	Kay Howard	From	Sue Cales		
Co./Dept.		Co.	NSHRRH		
Phone #	558-8915	Phone #	487-8104		
Fax #	558-1130	Fax #	425-7435		

**NovaCare Southern Hills Regional Rehabilitation Hospital**

120 Twelfth Street Princeton, West Virginia 24740 304 487 8000 Fax 304 425 7435

Postmarked  
12/17/93

# PETERSON HOSPITAL RECEIVED

Homestead Avenue  
Wheeling, WV 26003

DEC 21 1993

REHABILITATION PROGRAM  
PAIN MANAGEMENT PROGRAM

REGULATORY DEVELOPMENT  
SECTION

12 - 17 - 93

Kay Howard  
Regulatory Development  
State Capital Complex  
Bldg 3, Room 265  
Charleston WV 25305

Dear Ms Howard,

Regarding proposed legislation WV Code 16-5B-8 Section 11.11.4 dealing with financial rights & responsibilities, as an advocate for rights of residents in our long term care facility & in accordance with what I consider their best interests the statute is not clear or specific for a resident who has no known family or no responsible family member or family who feel they cannot handle resident's financial affairs. We cannot serve as their legal guardian & the sheriff of Ohio County, who I understand is the designated legal guardian in such cases, has not been authorized to do so. Who will serve as guardian or committee? It seems to me that the facility in which the resident resides must by circumstances be in the resident's best interest. Federal agencies, (Social Security Veterans Administration for example) regularly recommend the use of designated payees & they have mechanisms in place for resident fiduciary accountability per yearly review. We must also account to WV Dept of Health & Human Services for Medicaid review. The issue as I view it is accountability & Peterson can satisfy legal, moral, social and economic accountability.

Thank you for your consideration.

Sincerely,  
Dr. Elizabeth D. March  
Sue W. Weller  
Long Term Care

OHIO VALLEY MEDICAL CENTER  
EAST OHIO REGIONAL HOSPITAL  
PETERSON HOSPITAL

Ohio Valley Health Services and Education Corporation



 Mountain View Regional  
Rehabilitation Hospital

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DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION

December 17, 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

**Re: Proposed Amendments to Hospital Licensure, 64 CSR 12**

I am writing this letter to register our extreme apprehension about a portion of the proposed amendment that affects the Nursing Department. Specifically, we are troubled by section 14.2.3.b that mandates Personnel records be available in the nursing department.

As a Human Resources professional, I have spent the better part of the past dozen years working to maintain the confidentiality of employee records. Moving or duplicating records is a potential betrayal of employee trust, a possible catalyst for major employee dissatisfaction, a risky move that increases a facility's liability and an unnecessary duplication of time, energy and paper.

Employment application forms, verification of credentials and character references for nursing department employees contain very sensitive information that needs to be safeguarded not pulled away from other employee records in Human Resources. It is extremely difficult to ensure that such information could be kept confidential if it were either duplicated or shifted to nursing.

In our particular situation, the small nursing administration office is next to Human Resources so there is no need to move or duplicate documents. However, the nursing units are in opposite corners of the building. Would records for pulmonary nurses need to be located in that unit, while records for other nurses would be distributed throughout the building?

We strongly object to the proposed amendment and hope that you will take our views into consideration before recommending changes that would adversely impact our employee population and the smooth operation of this hospital and increase our legal liability.

Respectfully,

  
Richard W. Klomp  
Director Human Resources

A Rehab Systems Hospital  
a NovaCare operating company

# RECEIVED

DEC 13 1993

## REGULATORY DEVELOPMENT SECTION

December 7, 1993

Ruth Ann Panepinto Ph.D.  
Secretary  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

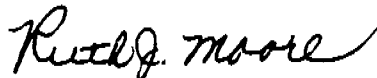
Dear Dr. Panepinto:

This is in reference to the Department of Health and Human Services Legislative Rule changes being proposed for the Hospital Licensure document. I express my opposition to the proposed changes and request a formal public hearing.

The stated purpose of the amendments "to revise or delete certain outmoded standards which are creating problems due to their variance ....." is questionable when other more problematic issues remain unchanged. These proposed changes are not in the interest of health care consumers of service in West Virginia. The focus of health care must be on cost, quality and outcomes. I believe these proposed changes will decrease quality, negatively affect outcomes and increase cost. The lowering of standards of care and practice result in an environment conducive to increased errors. This is not in harmony with JCAHO, national and specialty organization and association standards. The proposed changes lack input from nursing, attention to the nurse practice act and show inconsistency throughout the hospital setting.

My recommendation is to gain input from nurses via the West Virginia Nurses Association, West Virginia Organization of Nurse Executives and West Virginia Board of Nurses to assist in amending the rules. "Good hospital practice" shall provide quality health care and not adversely affect the citizens of West Virginia. I adamantly oppose the proposed amendments.

Sincerely,



Ruth J. Moore, R.N., Ed.D.  
Director, Practice & Development

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DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION



Monongalia  
General  
Hospital

December 15, 1993

Kay Howard  
Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

1200  
J.D. Anderson Drive  
Morgantown, WV  
26505  
304-598-1200

Dear Ms. Howard:

The purpose of this letter is to formally respond to the proposed rules for hospital licensure published by the Department of Health and Human Resources dated November 19, 1993.

1. Rule 8.3.2 - Concerning the paragraph requiring that complete construction drawings and specifications be submitted to the Director for ANY hospital construction project prior to it being undertaken. This requirement is MUCH MORE restrictive than prior language, which was only applicable to those projects requiring CON approval. We very much object to this more restrictive language.

2. Rule 13.2.3 - While there are no major changes to this rule, I do want to comment on parts of the rule we think should be reviewed. First, I question the purpose of having a hot air sterilizer in addition to an autoclave. Secondly, the balance and weight requirement is obsolete and is not necessary to the existing regulations. Finally, when looking at "k", I suggest replacing this with "adequate equipment, maintained in good condition to accurately perform all tests reported by the laboratory."

3. Rule 13.4.2 a. - It is our understanding that hospitals in the future will be of 100-200 bed capacity. For reasons of maximum efficiency and medical effectiveness, our Physical Therapy Department feels that the requirements for adequate space for electrotherapy, hydrotherapy, massage, and exercise specified in this rule, be maintained.

If there are any questions, please contact us here at Mon General.

Sincerely,

Kristina E. Gilpin  
Administrative Fellow

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12/17/93

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

December 16, 1993

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Attention: Kay Howard

Dear Ms. Howard:

As a Registered Nurse currently practicing in Wheeling, I have several concerns about the recent hospital licensure rules filed in the office of the Secretary of State. These rules could directly impact my practice as a nurse and I do not believe that there was any nursing input into the rule changes under consideration.

One of the rule changes that gives me the most concern is the rule regarding verbal orders. I am only able to take orders from a physician or dentist. The proposed rule puts me in a bind as to which rule I am to follow. Also this rule could lead to much confusion and risk of poor communication and then the safety of the patient would be in jeopardy. I do not believe that anyone wants to put the safety of the patient in a risky position.

I have worked in the emergency room and am also concerned about the rule regarding the provision of such services. In an effort to protect the public I believe that nursing care should be performed by licensed qualified nurses not by other health care personnel. This provision would allow hiring of people who may not have the knowledge or skills that are required to provide care and would again put our patients at risk.

Please contact me if there is a need to further discuss my concerns.

Sincerely,

*Mary G. McKinley*

Mary G. McKinley, RN, MSN, CCRN  
33 Walnut Ave  
Wheeling, WV 26003

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December 18, 1993  
DEC 22 1993

Regulatory Development  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

REGULATORY DEVELOPMENT  
SECTION

To Whom It May Concern:

I am a registered nurse practicing in Marion County. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

As filed, the rules are not beneficial to patient care and the safety of the public in West Virginia for the following reasons:

Section 10.3.h, page 22. The language relating to telephone and verbal orders that has been added to replace the current rule would impose confusion to delivering safe patient care, and, would interfere with the coordination of care by the registered nurse. Permitting others besides the registered nurse to receive physicians' orders would add another step in the process in seeing that those orders were carried out by unlicensed personnel.

It is the registered nurse who is responsible for the coordination and implementation of care rendered for the patient. If that care is delegated to another caregiver who is not licensed, it is the registered nurse who remains responsible for the actions of those individuals to whom the care is delegated.

Section 11.9.1.b, page 37. Language added to this section including "other health care personnel qualified by training and State law to provide emergency care services," is inappropriate for coronary care units. Only qualified registered nurses and licensed practical nurses with special care training should give direct patient care in these areas.

Sections 11.40.4.a and 11.10.4.b., page 40. Staffing in intensive care units should be adequate to give safe and effective care to those patients requiring special, high technology care. Only those individuals licensed, and with special training, such as registered nurses and licensed practical nurses, should be responsible for direct patient care.

Section 12.2.2 Emergency Department. It is inappropriate to have unlicensed and untrained personnel delivering nursing care to patients in an emergency room setting. The registered nurse should not have to assume the responsibility for nursing care delivered by unqualified persons.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care may decline because some institutions may use this as a means to hire personnel who could not perform patient care requiring the substantial specialized judgment and skill based on knowledge and application of principles of nursing practice.

I would ask that a public hearing be held before these rules are presented.

EMILY McDOWELL  
721 COLEMAN AVE.  
FAIRMONT WV 26354

Emily McDowell, RN-CS, FNP

Emily McDowell



SCHOOL OF NURSING  
400 Hal Greer Boulevard  
Huntington, West Virginia 25755-9500  
304/696-6750

RECEIVED

DEC 15 1993

REGULATORY DEVELOPMENT  
SECTION

December 14, 1993

Regulatory Development  
State Capitol Complex  
Bldg. 3, Room 265  
Charleston, WV 25305  
Attn: Kay Howard

Dear Ms. Howard:

As a registered nurse in West Virginia and a nursing educator, I am very concerned over the proposed rules regarding hospital licensure which have been filed in the office of the Secretary of State.

As we move into a new era of health care reform, providing access while decreasing quality is not beneficial to the public. Registered professional nurses have specialized knowledge and the preparation to make judgements about patient care. By-passing the registered nurse to give decision making power to ancillary personnel is extremely dangerous.

Nursing education is striving to prepare nurses to assume responsible roles in health care. This effort by hospitals to circumvent a professional group clearly for financial reasons makes a mockery of health care reform.

I urge you to oppose supporting such rules. Thank you.

Sincerely,

A handwritten signature in cursive script that reads 'Judith Sortet'.

Judith Sortet, EdD, RN  
Director, BSN Program

/vc

RECEIVED

DEC 20 1993

December 17, 1993

REGULATORY DEVELOPMENT  
SECTION

Regulatory Department  
State Capitol Complex  
Building 3, Room 265  
Charleston, WV 25305

Attention: Kay Howard

Dear Ms. Howard:

I am a Registered Nurse working at the Ohio Valley Medical Center in the Emergency Trauma Department in Wheeling, West Virginia. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

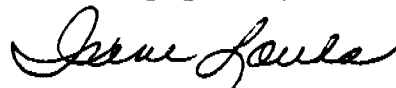
I am concerned about several issues. I believe there should have been a public meeting where I could have attended and had an opportunity to express these concerns. I firmly believe that Registered Nurses should be involved in drafting rules that directly affect their practice.

The proposed rule regarding verbal orders will place me in a difficult situation as I still will only be able to take orders from a physician or dentist. Which rule will I follow? I also believe patient care would not be safe as too much confusion and unclear communication would exist about who's taking the order and who's carrying it out and so forth.

I am especially concerned about the proposed change that allows other health care personnel to provide emergency services. Nursing care needs to be performed by licensed qualified nurses to protect and safeguard the public. I believe the proposed change could open the door for hospitals to hire persons without adequate knowledge and skills and therefore jeopardize safe care.

Would you please let me know if there is a public hearing prior of the rules being changed so I could further discuss my concerns.

Sincerely yours,



Irene Louda, BSN, MHA, CEN, CNA, RN

IL/abj

*Irene Louda*  
*Ohio Valley Medical Center*  
*2000 Eff. Street*  
*Wheeling, W. Va. 26003*

of Examiners for Registered Professional Nurses, large and small hospitals, inpatient and outpatient clinicians whose practice will also be affected.

The Public's health and welfare is at stake.

I am willing to discuss these issues with you, and will continue to follow this issue.

Sincerely,  
Brenda Halbough MS, RN, C-FNP

POST MARKED  
12/17/93

RECEIVED

Brian J. Loshbough  
1010 - 12th Avenue, Apt. 1  
Huntington, West Virginia 25701

DEC 21 1993

REGULATORY DEVELOPMENT

SECTION

Dec 17, 1993

Dear Dr. Panepinto,

I oppose the changes in hospital licensure rules proposed by the Department of Health and Human Resources.

I am a registered nurse and a family nurse practitioner, practicing in West Virginia since the first day I was licensed.

I am concerned that these rules changes

1. allow for hospitals, and eventually other health facilities, to independently qualify and utilize inadequately prepared technicians in the provision of care to patients

2. thwart oversight of care of patients by allowing technicians ill-prepared to coordinate care take orders and thereby begin the implementation of care in complex clinical environments.

I understand these proposed rules changes are for the purpose of addressing "certain outdated hospital licensure standards which are creating problems due to variance from standards of good hospital practice." Having registered nurses, who are educated to coordinate and provide patient care, and safeguard the patient, is good hospital practice.

This is especially the case in Coronary Care Units, Surgical Units and Emergency Departments, all areas of great complexity.

It is my request that nurses be consulted before these changes are introduced, or promoted to any further extent. These nurses should come from West Virginia's nursing community, and include nursing leaders from the professional association, the Board

Postmarked  
12/16/93

RECEIVED

DEC 22 1993

Date: December 16, 1993  
To: Members of Rules Committee  
Re: Hospital Licensure Proposal

REGULATORY DEVELOPMENT  
SECTION

The purpose of this writing is to express concern for the proposed changes in the hospital licensure bill.

I have been a nurse for nineteen years. I have worked in intensive care and coronary care units throughout the state of West Virginia. I have worked in small rural hospitals as well as the open heart unit at Charleston Area Medical Center. As my career in critical care has evolved, I have seen a change in our patient population - they are much sicker now than ever before.

Care provided in these units is not "emergency care" but nursing care. Persons trained in only emergency care are not prepared for a role in nursing care. Often as a nurse I employ nursing knowledge to prevent emergency situations from occurring. My training as a nurse allows me to view a patient in a holistic way and still see the biological part as important.

Proposed changes in the hospital licensure act would impact the quality of care provided to persons in critical care units throughout the state. Many persons who now experience recovery because of care received in these units would have a much dimmer outcome if these changes are brought about.

A public hearing is indicated so that these concerns as well as others can be expressed.

Sincerely,

*Barbara W. Law*

Barbara W. Law, RN, BSN, MSN, CCRN, CS  
Instructor of Nursing  
Washington State Community College



Barbara W. Law  
102 Society Mnr  
Bellevue, OH. 45714-2154

To Whom It Might Concern:

I am the president of the West Virginia Nurses' Association. However, I am writing this letter as an individual.

I am a registered nurse practicing in Huntington, West Virginia as a nurse educator. I am writing in response to the hospital licensure rules filed in the office of the Secretary of State.

I have grave concerns regarding these rules as filed. I do not believe they are beneficial to patient care. I believe that the nurses who are directly involved with patient care are the most qualified to determine what the specific staffing mix should be. Many times it is necessary for critically ill patients to be monitored so closely that the appropriate nurse-patient ratio is 1 to 1. I sincerely believe that hospitals will use these suggested numbers as proposed by the rules as standards. Trust me- the quality of patient care will decline if these rules are accepted. I am in the clinical setting several times a week with students, and the staffing mix must be determined by the nurses- not a business person.

According to the Nurse Practice Act, nurses can take orders only from licensed physicians or dentists. These proposed rules are in conflict with that act. I can tell you from experience that it is difficult at best to serve as an advocate for the patient without also having to clarify and verify written orders from other types of health care providers who do not know the total patient history, as often these other health providers are only involved in one aspect of the patient's care. An example- the respiratory therapist does only the respiratory treatments, they do not know the other treatments (including medications) that are ordered, nor do they know the complete patient history. The registered nurse who is caring for the patient is aware of the whole patient- it's included in the educational process the nurse has received.

By allowing "other health care personnel qualified by training and State law to provide emergency services" to work in designated areas of the hospital, the level of patient care can decline. I have great admiration for the men and women who work as EMT's and paramedics- they do a fantastic service. Again- their education focuses on a specific task; once the patient is admitted to the hospital, there are more concerns that cannot be met by these personnel because they are not educated to assist the patient in meeting those unmet needs.

I would be happy to discuss the implications of the rules if a public hearing is held prior to their enactment.

*Shelia Kyle*  
1418 Charleston Ave  
Huntington, WV  
25701

Sincerely,

*Shelia M. Kyle*

Shelia M. Kyle, M.S.N., R.N., C.

In closing, I would like to say that I feel very strongly that a public meeting should be scheduled at which I could further elaborate my concerns.

Yours truly,

Suzanne M. Kolas, RN, BSN

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DEC 20 1993

REGULATORY DEVELOPMENT  
SECTION

34 Allendale Road  
Wheeling, West Virginia 26003

Regulatory Department  
State Capital Complex  
Building 3, Room 265  
Charleston, West Virginia 25305  
Attention: Kay Howard

Dear Ms. Howard:

I am a Registered Nurse of 20 years experience in Wheeling, West Virginia. I am writing in response to the proposed hospital licensure rules filed in the Office of the Secretary of State.

Due to the magnitude and effect the proposed rules would have on the practice of nursing, I feel a public meeting should have been scheduled where I could voice my concern. I firmly believe Registered Nurses should be involved in drafting rules which directly affect their practice.

Of particular concern to me is the proposed rule regarding verbal orders. Verbal/telephone orders already place nurses in a difficult position. Under the current Nurse Practice Act, I am only permitted to take orders from physicians and dentists. Hospital licensure rules would not alter that fact - I must follow the rules governing the practice of nursing in the state of West Virginia. Central to my concern, is the issue of patient safety. Unclear communication would exist about who's taking the order, who's carrying it out, and so forth.

My other area of concern is the proposed change that allows other health care personnel to provide emergency care. Clients should be guaranteed that the person providing and directing their care are Professional Registered Nurses, licensed and qualified. This proposed change could open the door for hospitals to hire persons without adequate knowledge and skills, jeopardizing safe, competent care.

Registered Nurses, but to be a part  
of the teamwork it takes to pull  
patients through a crisis.

Sincerely,

Desia M Hurst EMT

Desia Hurst  
PO Box 222  
Rushmead, WV 24733

Postmarked  
12/17/93

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DEC 21 1993

**REGULATORY DEVELOPMENT  
SECTION**

**RECEIVED**

December, 17, 1993

**REGULATORY DEVELOPMENT  
SECTION**

Dear Mrs. Howard

My name is Lesia Hurst and I am a Paramedic currently employed by Princeton Rescue Squad and Princeton Community Hospital Emergency Dept. in Mercer Co., WV.

My skills include advanced cardiac (ACLS) and trauma (BLS) care. I must recertify in IV insertion, drug administration, defibrillation, 3-lead EKG monitoring, as well as other advanced skills every 2 years. This is not a written test, but an actual "hands on" practical test.

I perform my skills in a "field" environment through the direction of a physician at a Medical Control base. He is not on scene, but has confidence & trust in my ability. Paramedic is defined as "The eyes, ears and hands of the physician."

For these reasons, I feel that Paramedics have an integral part to play in the Emergency Dept setting. We are not here to replace

Post MARKED  
12/17/93

December 17, 1993

Regulatory Department  
State Capital Complex  
Building 3, Room 265  
Charleston, West Virginia 25305  
Attention: Kay Howard

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DEC 21 1993

REGULATORY DEVELOPMENT  
SECTION

James A. Hummel RN  
608 Washington Ave  
Glen Dale WV 26038  
City State Zip Code

Dear Mr. Howard:

Because I am a Registered Nurse in Wheeling, W. V., I'm writing in response to the hospital licensure rules filed in the office of the Secretary of State.

I'm concerned I was not able to attend a public meeting to express concerns about certain issues. I most definitely believe Registered Nurses should be involved in making decisions or rules that affect their practice.

Regarding the proposed rule with Verbal orders, which rule will I follow? Patient care cannot be compromised therefore confusion & unclear communication should not be allowed to happen. Who's taking orders? Who's carrying out the orders?

Lastly, I believe Nurses should provide Nursing Care and should be appropriately licensed to do so. I believe the Proposed Change would allow Hospitals to hire just anyone without adequate knowledge & skills, thereby jeopardizing patient care.

Thank you for your attention and reading this letter. If a public hearing is available, thank you for informing me.  
Yours truly, James Hummel, RN

Claiming to be interested "only in what is best for the patient" is a common statement in health care turf battles and should be seen for the ploy that it is. No group should be allowed to claim superiority above any others in observance of this ideal. All of us, all types of health care providers, are concerned for the well being of the patient. No group desires to advance their professional privileges at the expense of the patient. Each professional group has special expertise which it hopes and strives to make available to the patient and the health care system. Additionally, Physician Assistants not only expect and desire to be held to the standards of the same vigilant monitoring system which currently protects patients, but to ultimately improve safety and quality of care as a result of this new privilege.

In summary, the changes proposed in Section 10.3, Series 12, are needed in light of modern health care professions and delivery systems. This change will allow more effective use of health manpower resources and will enable us to provide more and better care to our patients. I encourage you to proceed with this amendment.

Sincerely,



Michael W. Holt, PA-C  
Instructor, Physician Assistant  
Program, Alderson-Broaddus College  
Practicing Physician Assistant  
Member, West Virginia Association of  
Physician Assistants  
Chairperson, West Virginia Association  
of Physician Assistants, Placement  
Service

MWH:rjj

If one considers the possibility of error in order documentation, it is obvious that knowledge, experience and, most importantly, a functional two-way dialogue with physicians is necessary to transmit orders without errors in content due to misinterpretation. Perfect reproduction of the physician's dictation unfortunately will frequently result in, at least, a technically incorrect order, at most a serious error. Any person authorized to transmit physician orders must also be reasonably prepared to recognize errors in the physician presentation.

The best person to transmit physician orders is one who has an adequate understanding of the patient and problem being addressed, therapeutic principles and practices and a fully functional two-way scientific dialogue with the physician. They must fully understand both the content and intent of the order. Physician Assistants are routinely utilized in a manner which uniquely allows for greater accuracy and less error in hospital orders should the rule changes be enacted.

As it is now, and should remain, all health care providers are obligated to recognize and question an incorrect order or be held accountable for its consequences - no matter where the order originated or who transmitted it.

I have heard from practicing nurses and pharmacists working closely with Physician Assistants who have order transmission privileges and contrary to prediction, the sky does not fall. Things work rather well. I have personally been told by both nurses and hospital pharmacists that orders transmitted through the Physician Assistant have fewer errors and omissions than those written directly by the physician. Additionally, to paraphrase their remarks, the Physician Assistant has been far more available, approachable and helpful in questions related to physician orders. In other words, quality of care has improved as a result. This is what Physician Assistants feel we have to offer and it is that for which we strive.

Research has been done (in another state) which revealed that nursing staffs which had little or no exposure to working Physician Assistants held high levels of negative opinion and concern about their activities, including order transmission. Nurses who worked with Physician Assistants daily, however, were found to not only have positive opinion and low level of concern about Physician Assistants, but also viewed them as an asset in their facility. All of this is, of course, unrelated to the specifics of the proposed rules change, except to shed some light on the various positions held on this issue by different parties.

My life, professional education, and practice as a Physician Assistant in West Virginia will soon be twenty consecutive years. I was among the first Physician Assistants in the state, beginning as a student in the Physician Assistant Program at Alderson-Broadus College. Following that, I was employed as a full time practicing Physician Assistant for many years. More recently, I have held a faculty position in the Physician Assistant Program at Alderson-Broadus College. I continue to practice clinically part-time. Additionally, for the past several years, I have been chairperson for the Physician Assistant Placement Service of the West Virginia Association of Physician Assistants which endeavors, free to all parties, to attract Physician Assistants to fill vacancies throughout the state. All of this has placed me in a position to experience first-hand, and observe state-wide the growing pains of a new health profession.

The issue of order transmission, as we refer to it, is not new to Physician Assistants in West Virginia. Speaking from personal experience, no issue or problem presented more obstruction or stifling of my professional function and development, or limited my value to patients and employers, than did this problem of order transmission.

From the point of view of one who has worked long and hard to attract Physician Assistants to work all across the state, it is, from experience, my opinion that this specific issue has more effect on the attraction and retention of Physician Assistants in West Virginia than any other and possibly all others combined. Responders to the Physician Assistant Placement Service frequently inquire of the State's order transmission regulations before considering any of our listings. The current rules have clearly limited the potential supply of Physician Assistants for West Virginia and has also caused many well trained, effective Physician Assistants to leave practice here for other states.

Opponents of the proposed changes have repeatedly speculated that extending order transmission privileges to Physician Assistants would increase errors in communication and documentation leading to more danger for patients and liability exposure for nurses. Mostly, this position owes its life to leaders, managers, and policy makers at levels removed from the day-to-day challenge of taking care of patients. In essence, the rear echelon, not the front lines and trenches.

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DEC 20 1993

December 16, 1993

**REGULATORY DEVELOPMENT  
SECTION**

Regulatory Development Section  
Department of Health and Human Resources  
Building 3  
Capitol Complex  
Charleston, West Virginia 25305

**TO WHOM IT MAY CONCERN:**

I am writing in response to the call for comment on the proposed rule change in Section 10.3, Series 12, Hospital Licensure, West Virginia Legislative Rules, Board of Health. I am a Physician Assistant and educator who has lived and worked in West Virginia since 1970.

The proposed change has been needed for the past several years. Advancing knowledge and technology and the desire to deliver its potential to all sectors of the public has led to the emergence of new health professions for whom sophisticated, accredited training and governmental credentialing is required. The art and science of medicine has developed beyond the day when the doctor and nurse were the only "health professionals".

In the care of the patient, it has always been the physician who determines the treatments and therapies. Under the proposed change this will, and, in my view, should remain so. What is at issue, and would change for the better, is who may transmit and record physician originated orders. Until now, this privilege has been allowed only to registered nurses, depriving other health professionals who also collaborate with the physician in the care of the patients, the ability to provide and make available the full benefit of their expertise to patients and the health care delivery system. The specific effect has been to make the work of these professionals clumsy and inefficient in the delivery system which now requires the physician to repeat or duplicate work already performed by another. The inability, for example, of Physician Assistants to transmit orders on behalf of their supervising physician has greatly undermined the overall development and utilization of this provider across West Virginia, thereby depriving the public and the health care system. Potential benefit to all in the areas of quality of care, efficiency, cost and access have not and will not be realized under the current rules.