TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES

PART 250
HOSPITAL LICENSING REQUIREMENTS

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Section

AUTHORITY: Implementing and authorized by the Hospital Licensing Act [210 ILCS 85].

SOURCE: Rules repealed and new rules adopted August 27, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 21, p. 49, effective May 16, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 45, p. 85, effective November 6, 1978; amended at 3 Ill. Reg. 17, p. 88, effective April 22, 1979; amended at 4 Ill. Reg. 22, p. 233, effective May 20, 1980; amended at 4 Ill. Reg. 25, p. 138, effective June 6, 1980; amended at 5 Ill. Reg. 507, effective December 29, 1980; amended at 6 Ill. Reg. 575, effective December 30, 1981; amended at 6 Ill. Reg. 1655, effective January 27, 1982; amended at 6 Ill. Reg. 3296, effective March 15, 1982; amended at 6 Ill. Reg. 7835 and 7838, effective June 17, 1982; amended at 7 Ill. Reg. 962, effective January 6, 1983; amended at 7 Ill. Reg. 5218 and 5221, effective April 4, 1983 and April 5, 1983; amended at 7 Ill. Reg. 6964, effective May 17, 1983; amended at 7 Ill. Reg. 8546, effective July 12, 1983; amended at 7 Ill. Reg. 9610, effective August 2, 1983; codified at 8 Ill. Reg. 19752; amended at 8 Ill. Reg. 24148, effective November 29, 1984; amended at 9 Ill. Reg. 4802, effective April 1, 1985; amended at 10 Ill. Reg. 11931, effective September 1, 1986; amended at 11 Ill. Reg. 10283, effective July 1, 1987; amended at 11 Ill. Reg. 10642, effective July 1, 1987; amended at 12 Ill. Reg. 15080, effective October 1, 1988; amended at 12 Ill. Reg. 16760, effective October 1, 1988; amended at 13 Ill. Reg. 13232, effective September 1, 1989; amended at 14 Ill. Reg. 2342, effective February 15, 1990; amended at 14 Ill. Reg. 13824, effective September 1, 1990; amended at 15 Ill. Reg. 5328, effective May 1, 1991; amended at 15 Ill. Reg. 13811, effective October 1, 1991; amended at 17 Ill. Reg. 1614, effective January 25, 1993; amended at 17 Ill. Reg. 17225, effective October 1, 1993; amended at 18 Ill. Reg. 11945, effective July 22, 1994; amended at 18 Ill. Reg. 15390, effective October 10, 1994; amended at 19 Ill. Reg. 13355, effective September 15, 1995; emergency amendment at 20 Ill. Reg. 474, effective January 1, 1996, for a maximum of 150 days; emergency expired May 29, 1996; amended at 20 Ill. Reg. 3234, effective February 15, 1996; amended at 20 Ill. Reg. 10009, effective July 15, 1996; amended at 22 Ill. Reg. 3932, effective February 13, 1998; amended at 22 Ill. Reg. 9342, effective May 20, 1998; amended at 23 Ill. Reg. 1007, effective January 15, 1999; emergency amendment at 23 Ill. Reg. 3508, effective March 4, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9513, effective August 1, 1999; amended at 23 Ill. Reg. 13913, effective November 15, 1999; amended at 24 Ill. Reg. 6572, effective April 11, 2000; amended at 24 Ill. Reg. 17196, effective November 1, 2000; amended at 25 Ill. Reg. 3241, effective February 15, 2001; amended at 27 Ill. Reg. 1547, effective January 15, 2003; amended at 27 Ill. Reg. 13467, effective July 25, 2003; amended at 28 Ill. Reg. 5880, effective March 29, 2004; amended at 28 Ill. Reg. 6579, effective April 15, 2004; amended at 29 Ill. Reg. 12489, effective July 27, 2005; amended at 31 Ill. Reg. 4245, effective February 20, 2007; amended at 31 Ill. Reg. 14530, effective October 3, 2007; amended at 32 Ill. Reg. 3756, effective February 27, 2008; amended at 32 Ill. Reg. 4213, effective March 10, 2008; amended at 32 Ill. Reg. 7932, effective May 12, 2008; amended at 32 Ill. Reg. 14336, effective August 12, 2008; amended at 33 Ill. Reg. 8306, effective June 2, 2009; amended at 34 Ill. Reg. 2528, effective January 27, 2010; amended at 34 Ill. Reg. 3331, effective February 24, 2010; amended at 34 Ill. Reg. 19031, effective November 17, 2010; amended at 34 Ill. Reg. 19158, effective November 23, 2010; amended at 35 Ill. Reg. 4556, effective March 4, 2011;

amended at 35 Ill. Reg. 6386, effective March 31, 2011; amended at 35 Ill. Reg. 13875, effective August 1, 2011; amended at 36 Ill. Reg. 17413, effective December 3, 2012; amended at 38 Ill. Reg. 13280, effective June 10, 2014; amended at 39 Ill. Reg. 5443, effective March 25, 2015; amended at 39 Ill. Reg. 13041, effective September 3, 2015; amended at 41 Ill. Reg. 7154, effective June 12, 2017; amended at 41 Ill. Reg. 14945, effective November 27, 2017; amended at 42 Ill. Reg. 9507, effective May 24, 2018; amended at 43 Ill. Reg. 3889, effective March 18, 2019; amended at 43 Ill. Reg. 12990, effective October 22, 2019; emergency amendment at 44 Ill. Reg. 5934, effective March 25, 2020, for a maximum of 150 days; emergency expired August 21, 2020; emergency amendment at 44 Ill. Reg. 7788, effective April 16, 2020, for a maximum of 150 days; emergency repeal of emergency amendment at 44 Ill. Reg. 14333, effective August 24, 2020; emergency amendment at 44 Ill. Reg. 14804, effective August 24, 2020, for a maximum of 150 days; emergency expired January 20, 2021; amended at 44 Ill. Reg. 18379, effective October 29, 2020; emergency amendment at 45 Ill. Reg. 1202, effective January 8, 2021, for a maximum of 150 days; emergency amendment expired June 6, 2021; emergency amendment at 45 Ill. Reg. 1715, effective January 21, 2021, for a maximum of 150 days; emergency expired June 19, 2021; emergency amendment at 45 Ill. Reg. 7544, effective June 7, 2021, for a maximum of 150 days; emergency expired November 3, 2021; emergency amendment at 45 Ill. Reg. 8096, effective June 15, 2021, for a maximum of 150 days; emergency expired November 11, 2021; emergency amendment at 45 Ill. Reg. 8503, effective June 20, 2021, for a maximum of 150 days; emergency expired November 16, 2021; emergency amendment at 45 Ill. Reg. 11907, effective September 17, 2021, for a maximum of 150 days; emergency expired February 13, 2022; emergency amendment at 45 Ill. Reg. 14519, effective November 4, 2021, for a maximum of 150 days; emergency expired April 2, 2022; emergency amendment at 45 Ill. Reg. 15115, effective November 12, 2021 through December 31, 2021; emergency amendment at 45 Ill. Reg. 15375, effective November 17, 2021, for a maximum of 150 days; emergency expired April 15, 2022; emergency amendment at 46 Ill. Reg. 1911, effective January 13, 2022, for a maximum of 150 days; emergency expired June 11, 2022; emergency amendment at 46 Ill. Reg. 3208, effective February 14, 2022, for a maximum of 150 days; emergency expired July 13, 2022; emergency amendment at 46 Ill. Reg. 6142, effective April 3, 2022, for a maximum of 150 days; emergency expired August 30, 2022; emergency amendment at 46 Ill. Reg. 6808, effective April 16, 2022, for a maximum of 150 days; emergency expired September 12, 2022; amended at 46 Ill. Reg. 8914, effective May 12, 2022; emergency amendment at 46 Ill. Reg. 10950, effective June 12, 2022, for a maximum of 150 days; emergency amendment to emergency rule at 46 Ill. Reg. 12643, effective July 6, 2022, for the remainder of the 150 days; emergency expired November 8, 2022; emergency amendment at 46 Ill. Reg. 13344, effective July 14, 2022, for a maximum of 150 days; emergency amendment to emergency rule at 46 Ill. Reg. 18185, effective October 27, 2022, for the remainder of the 150 days; emergency expired December 10, 2022; emergency amendment at 46 Ill. Reg. 15824, effective August 31, 2022, for a maximum of 150 days; emergency expired January 27, 2023; amended at 46 Ill. Reg. 15597, effective September 1, 2022; emergency amendment at 46 Ill. Reg. 16271, effective September 13, 2022, for a maximum of 150 days; emergency expired February 9, 2023; emergency amendment at 46 Ill. Reg. 18902, effective November 9, 2022, for a maximum of 150 days; emergency expired April 7, 2023; amended at 46 Ill. Reg. 18995,

effective November 10, 2022; emergency amendment at 46 Ill. Reg. 20211, effective December 11, 2022, for a maximum of 150 days; emergency expired May 9, 2023; emergency amendment at 47 Ill. Reg. 2189, effective January 28, 2023, for a maximum of 150 days; emergency expired June 26, 2023; emergency amendment at 47 Ill. Reg. 2862, effective February 10, 2023 through May 11, 2023; amended at 47 Ill. Reg. 6477, effective April 27, 2023; emergency amendment at 47 Ill. Reg. 8896, effective June 8, 2023, for a maximum of 150 days; SUBPART G recodified at 47 Ill. Reg. 8964; emergency amendment at 47 Ill. Reg. 9499, effective June 27, 2023, for a maximum of 150 days; emergency expired November 23, 2023; amended at 47 Ill. Reg. 14455, effective September 26, 2023; emergency amendment at 47 Ill. Reg. 18178, effective November 24, 2023, for a maximum of 150 days; emergency repeal of emergency rule at 48 Ill. Reg. 4225, effective February 27, 2024; amended at 48 Ill. Reg. 450, effective December 20, 2023; amended at 48 Ill. Reg. 2516, effective January 30, 2024; amended at 48 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 250.100 Definitions

Act – the Hospital Licensing Act [210 ILCS 85].

Advanced Practice Registered Nurse – a person licensed to practice under Article 65 of the Nurse Practice Act.

Advanced Practice Provider – an advanced practice registered nurse or a physician assistant.

Allied Health Personnel – persons other than medical staff members, licensed or registered by the State of Illinois or recognized by an organization acceptable to the Department and recognized to function within their licensed, registered or recognized capacity by the medical staff and the governing authority of the hospital.

Dentist – any person licensed to practice dentistry as provided in the Illinois Dental Practice Act.

Department – the Illinois Department of Public Health.

Dietetic Service Director − a person who:

is a dietitian;

is a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the

Academy of Nutrition and Dietetics, or the American Clinical Board of Nutrition;

is a graduate, prior to July 1, 1990, of a Department-approved course that provided 90 or more hours of classroom instruction in food service supervision and has had experience as a supervisor in a health care institution which included consultation from a dietitian;

has successfully completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course;

is certified as a Certified Dietary Manager or Certified Food Protection Professional by the Association of Nutrition & Foodservice Professionals; or

has training and experience in food service supervision and management in a military service equivalent in content to the programs in the second, third or fourth paragraph of this definition.

Dietitian – a person who is a registered dietitian or registered dietitian nutritionist as defined in the Dietitian Nutritionist Practice Act.

Drugs – the term "drugs" means and includes:

articles recognized in the official United States Pharmacopoeia, official National Formulary, or any supplement to either of them and being intended for and having for their main use the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals;

all other articles intended for and having for their main use the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals;

articles (other than food) having for their main use and intended to affect the structure or any function of the body of man or other animals; and

articles having for their main use and intended for use as a component or any articles specified in this definition, but does not include devices or their components, parts or accessories.

Federally designated organ procurement agency – the organ procurement agency designated by the Secretary of the U.S. Department of Health and Human

Services for the service area in which a hospital is located; except that in the case of a hospital located in a county adjacent to Wisconsin which currently contracts with an organ procurement agency located in Wisconsin that is not the organ procurement agency designated by the U.S. Secretary of Health and Human Services for the service area in which the hospital is located, if the hospital applies for a waiver pursuant to 42 U.S.C. 1320b-8(a), it may designate an organ procurement agency located in Wisconsin to be thereafter deemed its federally designated organ procurement agency for the purposes of the *Act.* (Section 3(F) of the Act)

Follow-up healthcare – healthcare services related to a sexual assault, including laboratory services and pharmacy services, rendered within 180 days after the initial visit for medical forensic services. (Section 1a of the Sexual Assault Survivors Emergency Treatment Act)

Hospital – the term "hospital" shall have the meaning ascribed in Section 3(A) of the Act.

Hospitalization – the reception or care of any person in any hospital either as an inpatient or as an outpatient.

House Staff Member – an individual who is a graduate of a medical, dental, osteopathic, or podiatric school; who is licensed as appropriate; who is appointed to the hospital's medical, osteopathic, dental, or podiatric graduate training program that is approved or recognized in accordance with the statutory requirements applicable to the practitioner; and who is participating in patient care under the direction of licensed practitioners who have clinical privileges in the hospital and are members of the hospital's medical staff.

Licensed Practical Nurse – a person with a valid Illinois license to practice as a practical nurse under the Nurse Practice Act.

Medical Staff – an organized body composed of the following individuals granted the privilege by the governing authority of the hospital to practice in the hospital: persons who are graduates of a college or school approved or recognized by the Illinois Department of Financial and Professional Regulation, and who are currently licensed by the Illinois Department of Financial and Professional Regulation to practice medicine in all its branches; practice dental surgery; or, practice podiatric medicine in Illinois, regardless of the title of the degree awarded by the approving college or school.

Medicines – drugs or chemicals or preparations of drugs or chemicals in suitable form intended for and having for their main use the prevention, treatment, relief,

or cure of diseases in humans or animals when used either internally or externally.

Nurse – a registered nurse or licensed practical nurse as defined in the Nurse Practice Act.

Nursing Administrator (or Chief Nursing Officer or Director of Nursing) – a registered professional nurse who is employed full-time within the hospital as director of the nursing administration pursuant to Section 250.910.

Nursing Staff – registered nurses, licensed practical nurses, nursing assistants and others who render patient care under the supervision of a registered professional nurse.

Patient Care Unit or Nursing Care Unit – an organized unit in which nursing services are provided on a continuous basis. This unit is a clearly defined administrative and geographic area to which specific nursing staff is assigned.

Pharmacist – a person who is licensed as a pharmacist under the Pharmacy Practice Act.

"Pharmacy – a location where pharmacist care is provided by a pharmacist and where drugs and medicines are dispensed, sold, offered or displayed for sale at retail; where prescriptions of physicians, dentists, advanced practice registered nurses, physician assistants, podiatric physicians, or optometrists, within the limits of their licenses, are compounded, filled or dispensed; and which has a sign bearing the word or words "Pharmacist", Druggist", " Pharmacy", Pharmaceutical Care", or similar terms or where the characteristic prescription sign (Rx) or similar design is exhibited. (Section 3 of the Pharmacy Practice Act). Any room or designated area where drugs and medicines are dispensed (including repackaging for distribution) shall be considered to be a pharmacy and shall be required to be licensed by the Illinois Department of Financial and Professional Regulation.

Pharmacy practice – includes the following services as defined in the Pharmacy Practice Act:

> *the interpretation and the provision of assistance in the monitoring, evaluation, and implementation of prescription drug orders;*
>
> *the dispensing of prescription drug orders;*
>
> *participation in drug in drug and device selection;*

drug administration limited to administration of oral, topical, injectable, and inhalation as follows:

in the context of patient education on the proper use or delivery of medications;

pursuant to a valid prescription or standing order by a physician licensed to practice medicine in all its branches, upon completion of appropriate training, including how to address contraindications and adverse reaction pursuant to Pharmacy Practice Act rules (68 Ill. Adm. Code 1330), *with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedure:*

vaccination of patients 7 years of age and older;

following the initial administration of long-acting or extended-release form opioid antagonists by a physician licensed to practice medicine in all its branches, administration of injections of long-action or extended-release form opioid antagonists;

administration of injections of alpha-hydroxyprogesterone caproate;

administration of injections of long-term antiphyschotic medications (appropriate training must be conducted by an *Accreditation Counsel of Pharmaceutical Education accredited provider);*

drug regimen review;

drug or drug-related research;

the provision of patient counseling;

the practice of telepharmacy;

the provision of those acts or services necessary to provide pharmacist care;

medication therapy management; and

the responsibility for compounding and labeling of drugs and devices (except labeling by a manufacturer, repackager, or distributor of non-prescription drugs and commercially package legend drugs and devices), proper and safe storage of drugs and devices, and maintenance of required records as defined in the Pharmacy Practice Act. (Section 3 of the Pharmacy Practice Act)

Physical Rehabilitation Facility – a licensed specialty hospital or clearly defined special unit or program of an acute care hospital providing physical rehabilitation services either through the facility's own staff members or when appropriate, through the mechanism of formal affiliations and consultations.

Physical Rehabilitation Services – a complete, intensive multi-disciplinary process of individualized, time-limited, goal-oriented services, including evaluation, restoration, personal adjustment, and continuous medical care under the supervision and direction of a physician qualified by training and experience in physical rehabilitation. Physical rehabilitation has two major components: inpatient and outpatient care. Both components involve the patient and, whenever possible, the family in establishing treatment goals and discharge plans, and consist of the following scope of services available for inpatient care: physician, rehabilitation nursing, physical therapy, occupational therapy, speech therapy, audiology, prosthetic and orthotic services, as well as rehabilitation counseling, social services, recreational therapy, psychology, pastoral care, and vocational counseling. Basic scope of services for outpatient facilities shall include at least a physician, physical therapy, occupational therapy, speech therapy, vocational services, psychology and social service. The purpose of multi-faceted services is to reduce the disability and dependency in activities of daily living while promoting optimal personal adjustment in dimensions such as psychological, social, economic, spiritual and vocational.

Physician – a person licensed to practice medicine in all of its branches as provided in the Medical Practice Act of 1987.

Physician Assistant – a person authorized to practice under the Physician Assistant Practice Act of 1987.

Podiatrist – a person licensed to practice podiatry under the Podiatric Medical Practice Act of 1987.

Reference Materials – a sample in which the chemical composition and physical properties resemble the specimen to be analyzed on which sufficient analyses have been run to give a reasonably good approximation of the concentration of

the constituent being assayed. The reference materials are routinely analyzed along with patient specimens to determine the precision and accuracy of the analytical process used.

Registered Nurse – a person with a valid Illinois license to practice as a registered professional nurse under the Nurse Practice Act.

Rural Emergency Hospital (REH) – an entity that operates for the purpose of providing emergency department services, observation care, and other outpatient medical and health services, in which the annual per patient average length of stay does not exceed 24 hours. The entity must not provide inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-REH or post-hospital extended care services pursuant to 42 CFR 485.502.

Safe Lifting Equipment and Accessories – mechanical equipment designed to lift, move, reposition, and transfer patients, including, but not limited to, fixed and portable ceiling lifts, sit-to-stand lifts, slide sheets and boards, slings, and repositioning and turning sheets. (Section 6.25(a) of the Act)

Safe Lifting Team – at least 2 individuals who are trained in the use of both safe lifting techniques and safe lifting equipment and accessories, including the responsibility for knowing the location and condition of such equipment and accessories. (Section 6.25(a) of the Act)

Standard Solution – a solution used for calibration in which the concentration is determined solely by dissolving a weighted amount of primary standard material in an appropriate amount of solvent.

Surgical smoke plume – the by-product of the use of energy-based devices on tissue during surgery and containing hazardous materials, including, but not limited to, bioaerosols, smoke, gases, tissue and cellular fragments and particulates, and viruses. (Section 6.32(a) of the Act)

Surgical smoke plume evacuation system – a dedicated device that is designed to capture, transport, and filter surgical smoke plume at the site of origin and before it can diffuse and pose a risk to the occupants of the operating or treatment room. (Section 6.32(a) of the Act)

Tissue bank – any facility or program operating in Illinois that is certified by the American Association of Tissue Banks or the Eye Bank Association of America and is involved in procuring, furnishing, donating, or distributing corneas, bones, or other human tissue for the purpose of injecting, transfusing or transplanting

any of them into the human body. "Tissue bank" does not include a licensed blood bank. For the purposes of the *Act, "tissue" does not include organs.* (Section 3(G) of the Act)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 250.105 Incorporated and Referenced Materials

a) The following regulations and standards are incorporated in this Part:

1) Private and Professional Association Standards

A) American Society for Testing and Materials (ASTM), Standard No. E90-99 (2009): Standard Test Method for Laboratory Measurement of Airborne Sound Transmission Loss of Building Partitions and Elements, which may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959

B) ASTM E 662 (2012), Standard Test Method for Specific Optical Density of Smoke Generated by Solid Materials, which may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959

C) ASTM E 84 (2010), Standard Test Method for Surface Burning Characteristics of Building Materials, which may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959

D) The following standards of the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE), which may be obtained from the American Society of Heating, Refrigerating, and Air-Conditioning Engineers, Inc., 180 Technology Parkway NW, Peachtree, GA 30092:

i) ASHRAE Handbook of Fundamentals (2009)

ii) ASHRAE Handbook for HVAC Systems and Equipment (2004)

iii) ASHRAE Handbook-HVAC Applications (2007)

iv) ASHRAE Guideline 12-2020, "Managing the Risk of Legionellosis Associated with Building Water Systems" (March 30, 2021)

v) ASHRAE Standard 188-2021, "Legionellosis: Risk Management for Building Water Systems" (August 2021)

E) The following standards of the National Fire Protection Association (NFPA), which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169:

i) NFPA 101 (2012): Life Safety Code and all applicable references under Chapter 2, Referenced Publications

ii) NFPA 101A (2013): Guide on Alternative Approaches to Life Safety

F) American Academy of Pediatrics and American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, Eighth Edition (September 2017), which may be obtained from the American College of Obstetricians and Gynecologists online at https://publications.aap.org/aapbooks/book/522/Guidelines-for-Perinatal-Care?autologincheck=redirected~~acog.org/store~~ or by phone at 800-762-2264, 409 12th Street SW, Washington, DC 20024-2188 (See Section 250.1820.)

G) American College of Obstetricians and Gynecologists, Guidelines for Women's Healthcare, Fourth Edition (2014), which may be obtained online at: https://www.scribd.com/document/359258258/american-college-of-obstetricians-and-gynecologists-guidelines-for-women-s-health-care-a-resource-manual~~from the American College of Obstetricians and Gynecologists online at: https://dl-manual.com/doc/american-college-of-obstetricians-and gynecologists-guidelines-for-womens-health-care-a-resource-manual-8z6dgqx94qol~~ (See Section 250.1820.)

H) American Academy of Pediatrics (AAP), Red Book: Report of the Committee on Infectious Diseases, 32nd Edition (January 2021), available at: https://publications.aap.org/redbook or from the American Academy of Pediatrics, 345 Park Blvd., Itasca, IL 60143 (See Section 250.1820.)

I) American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, Part 4: Pediatric and Basics and Advanced Life Support and Part 5: Neonatal Resuscitation (October 2020), available at: https://tinyurl.com/38zny85p and https://tinyurl.com/2s3dpb8c, respectively, or from the American Heart Association, 7272 Greenville Ave., Dallas, TX 75231 (See Section 250.1830.)

J) National Association of Neonatal Nurses, Position Statement #3074 Minimum RN Staffing in the NICU (September 2021), available at: http://nann.org/about/position-statements or from the National Association of Neonatal Nurses, 8735 W. Higgins Road, Suite 300, Chicago, IL 60631 (See Section 250.1830.)

K) National Council on Radiation Protection and Measurements (NCRP), Report 49: Structural Shielding Design and Evaluation for Medical Use of X-rays and Gamma Rays of Energies up to 10 MeV (1976) and NCRP Report 102: Medical X-Ray, Electron Beam and Gamma-Ray Protection for Energies Up to 50 MeV (Equipment Design, Performance and Use) (1989), which may be obtained from the National Council on Radiation Protection and Measurements, 7910 Woodmont Ave., Suite 400, Bethesda, Maryland 20814-3095 (See Sections 250.2440 and 250.2450.)

L) DOD Penetration Test Method MIL STD 282 (2020~~2012~~): Filter Units, Protective Clothing, Gas-mask Components and Related Products: Performance Test Methods, available at: https://publishers.standardstech.com/stgnet ~~https://webstore.ansi.org/standards/dod/milstd282~~ (See Section 250.2480.)

M) National Association of Plumbing-Heating-Cooling Contractors (PHCC), National Standard Plumbing Code (2009), which may be obtained from the National Association of Plumbing-Heating-Cooling Contractors, 180 S. Washington Street, Suite 100, Falls Church, VA 22046 (703-237-8100)

N) International Building Code (2012), which may be obtained from the International Code Council, 4051 Flossmoor Road, Country Club Hills, IL 60478 (See Section 250.2420.)

O) American National Standards Institute, ANSI A117.1 (2009), Standard for Accessible and Usable Buildings, which may be obtained from the American National Standards Institute, 25 West 43rd Street, 4th Floor, New York, NY 10036 (See Section 250.2420.)

P) ASME Standard A17.1-2007, Safety Code for Elevators and Escalators, which may be obtained from the American Society of Mechanical Engineers (ASME) International, 22 Law Drive, Box 2900, Fairfield, NJ 07007-2900

Q) Accreditation Council for Graduate Medical Education, Common Program Requirements (Residency) (2022), available at: https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency_2022v2.pdf or from the Accreditation Council for Graduate Medical Education, 401 N. Michigan Ave., Suite 2000, Chicago, IL 60611 (See Section 250.315.)

R) The Joint Commission, 2022 Hospital Accreditation Standards (HAS), available at: https://store.jcrinc.com/2022-accreditation-standards-books/ or from the Joint Commission, 1515 W. 22nd St. Ste. 1300W, Oakbrook Terrace, IL 60523 (See Section 250.1035.)

S) National Quality Forum, Safe Practices for Better Health Care (2010), available at: https://www.qualityforum.org/publications/2010/04/safe_practices_for_better_healthcare_%E2%80%93_2010_update/aspx or from the National Quality Forum, 10991 14th Street NW, Suite 500, Washington DC 20005, or from www.qualityforum.org

2) Federal Government Publications

A) Department of Health and Human Services, Centers for Disease Control and Prevention, "2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" (July 2023~~May 2022~~) available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

B) Department of Health and Human Services, Centers for Disease Control and Prevention, Infection Control in Healthcare Personnel, available in two parts: "Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services" (October

25, 2019) and "Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients" (October 3, 2022~~November 5, 2021~~), both available at: https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html

C) Department of Health and Human Services, Centers for Disease Control and Prevention, "Guidelines for Environmental Infection Control in Health-Care Facilities": (July 2019), available at: https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html

D) Department of Health and Human Services, Centers for Disease Control and Prevention, Guideline for Hand Hygiene in Health Care Settings (October 25, 2002) available at: https://www.cdc.gov/infectioncontrol/guidelines/hand-hygiene/index.html

E) Department of Health and Human Services, Centers for Disease Control and Prevention, "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008", (May 2019), available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

F) Department of Health and Human Services, Centers for Disease Control and Prevention, "Core Elements of Hospital Stewardship Programs", (2019), which is available at: https://www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf, and "Implementation of Antibiotic Stewardship Core Elements at Small and Critical Access Hospitals", which is available at: https://www.cdc.gov/antibiotic-use/core-elements/small-critical.html

G) Department of Health and Human Services, Centers for Disease Control and Prevention, "Toolkit for Controlling Legionella in Common Sources of Exposure", which is available at: https://www.cdc.gov/legionella/wmp/control-toolkit/index.html

H) National Center for Health Statistics and World Health Organization, Geneva, Switzerland, "International Classification of Diseases", 11th Revision (ICD-11), (2022), available at:

https://www.who.int/standards/classifications/classification-of-diseases

I) U.S. Department of Labor, Occupational Safety and Health Administration, "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" (OSHA 3148-06R 2016), available at: https://www.osha.gov/Publications/osha3148.pdf

J) Department of Health and Human Services, United States Public Health Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "STOP SV: A Technical Package to Prevent Sexual Violence" (2016), available at: https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

K) National Research Council, Recommended Dietary Allowances 10th Edition (1989). Washington, DC: The National Academies Press. Available at: https://doi.org/10.17226/1349

3) Federal Regulations

A) 45 CFR 46.101, To What Does the Policy Apply? (October 1, 2023~~2021~~)

B) 45 CFR 46.103(b), Assuring Compliance with this Policy − Research Conducted or Supported by any Federal Department or Agency (October 1, 2023~~2021~~)

C) 42 CFR 482, Conditions of Participation for Hospitals (October 1, 2023~~2021~~)

D) 21 CFR, Food and Drugs (April 1, 2023~~2021~~)

E) 42 CFR 489.20, Basic Commitments (October 1, 2023~~2021~~)

F) 29 CFR 1910.1030, Bloodborne Pathogens (July 1, 2022~~2021~~)

G) 42 CFR 413.65(d) and (e), Requirements for a determination that a facility or an organization has provider-based status (October 1, 2023~~2021~~)

H) 42 CFR 493, Laboratory Requirements (CLIA regulations) (October 1, 2023~~2021~~)

b) All incorporations by reference of federal regulations and guidelines and the standards of nationally recognized organizations refer to the regulations, guidelines and standards on the date specified and do not include any editions or amendments subsequent to the date specified.

c) The following statutes and State regulations are referenced in this Part:

1) State of Illinois Statutes

A) Hospital Licensing Act [210 ILCS 85]

B) Illinois Health Facilities Planning Act [20 ILCS 3960]

C) Medical Practice Act of 1987 [225 ILCS 60]

D) Podiatric Medical Practice Act of 1987 [225 ILCS 100]

E) Pharmacy Practice Act [225 ILCS 85]

F) Physician Assistant Practice Act of 1987 [225 ILCS 95]

G) Illinois Clinical Laboratory and Blood Bank Act [210 ILCS 25]

H) X-Ray Retention Act [210 ILCS 90]

I) Safety Glazing Materials Act [430 ILCS 60]

J) Mental Health and Developmental Disabilities Code [405 ILCS 5]

K) Nurse Practice Act [225 ILCS 65]

L) Health Care Worker Background Check Act [225 ILCS 46]

M) MRSA Screening and Reporting Act [210 ILCS 83]

N) Hospital Report Card Act [210 ILCS 86]

O) Illinois Adverse Health Care Events Reporting Law of 2005 [410 ILCS 522]

P) Smoke Free Illinois Act [410 ILCS 82]

Q) Health Care Surrogate Act [755 ILCS 40]

R) Perinatal HIV Prevention Act [410 ILCS 335]

S) Hospital Infant Feeding Act [210 ILCS 81]

T) Medical Patient Rights Act [410 ILCS 50]

U) Hospital Emergency Service Act [210 ILCS 80]

V) Illinois Anatomical Gift Act [755 ILCS 50]

W) Illinois Public Aid Code [305 ILCS 5]

X) Substance Use Disorder Act [20 ILCS 301]

Y) ID/DD Community Care Act [210 ILCS 47]

Z) Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49]

AA) Veterinary Medicine and Surgery Practice Act of 2004 [225 ILCS 115]

BB) Alternative Health Care Delivery Act [210 ILCS 3]

CC) Gestational Surrogacy Act [750 ILCS 47]

DD) Code of Civil Procedure (Medical Studies) [735 ILCS 5/8-2101]

EE) Sexual Assault Survivors Emergency Treatment Act [410 ILCS 70]

FF) Civil Administrative Code of Illinois (Department of Public Health Powers and Duties Law) [20 ILCS 2310]

GG) AIDS Confidentiality Act [410 ILCS 305]

HH) Nursing Home Care Act [210 ILCS 45]

II) Illinois Controlled Substances Act [720 ILCS 570]

JJ) Early Hearing Detection and Intervention Act [410 ILCS 213]

KK) Home Health, Home Services, and Home Nursing Agency Licensing Act [210 ILCS 55]

LL) Health Care Violence Prevention Act [210 ILCS 160]

MM) Illinois Health Finance Reform Act [20 ILCS 2215]

NN) Fair Patient Billing Act [210 ILCS 88]

OO) Crime Victims Compensation Act [740 ILCS 45]

PP) Human Trafficking Resource Center Notice Act [775 ILCS 50]

QQ) Abandoned Newborn Infant Protection Act [325 ILCS 2]

RR) Emergency Medical Services (EMS) Systems Act [210 ILCS 50]

SS) Radiation Protection Act of 1990 [420 ILCS 40]

TT) Illinois Dental Practice Act [225 ILCS 25]

UU) Criminal Identification Act [20 ILCS 2630]

VV) Latex Glove Ban Act [410 ILCS 180]

2) State of Illinois Administrative Rules

A) Department of Public Health, Illinois Plumbing Code (77 Ill. Adm. Code 890)

B) Department of Public Health, Sexual Assault Survivors Emergency Treatment Code (77 Ill. Adm. Code 545)

C) Department of Public Health, Control of Notifiable Diseases and Conditions~~Communicable Diseases~~ Code (77 Ill. Adm. Code 690)

D) Department of Public Health, Food Code (77 Ill. Adm. Code 750)

E) Department of Public Health, Public Area Sanitary Practice Code (77 Ill. Adm. Code 895)

F) Department of Public Health, Maternal Death Review (77 Ill. Adm. Code 657)

G) Department of Public Health, Control of Sexually Transmissible Infections Code (77 Ill. Adm. Code 693)

H) Department of Public Health, Control of Tuberculosis Code (77 Ill. Adm. Code 696)

I) Department of Public Health, Health Care Worker Background Check Code (77 Ill. Adm. Code 955)

J) Department of Public Health, Language Assistance Services Code (77 Ill. Adm. Code 940)

K) Department of Public Health, Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640)

L) Health Facilities and Services Review Board, Narrative and Planning Policies (77 Ill. Adm. Code 1100)

M) Health Facilities and Services Review Board, Processing, Classification Policies and Review Criteria (77 Ill. Adm. Code 1110)

N) Department of Public Health, Private Sewage Disposal Code (77 Ill. Adm. Code 905)

O) Department of Public Health, Ambulatory Surgical Treatment Center Licensing Requirements (77 Ill. Adm. Code 205)

P) Department of Public Health, HIV/AIDS Confidentiality and Testing Code (77 Ill. Adm. Code 697)

Q) Capital Development Board, Illinois Accessibility Code (71 Ill. Adm. Code 400)

R) State Fire Marshal, Boiler and Pressure Vessel Safety (41 Ill. Adm. Code 120)

S) State Fire Marshal, Fire Prevention and Safety (41 Ill. Adm. Code 100)

T) Illinois Emergency Management Agency, Standards for Protection Against Radiation (32 Ill. Adm. Code 340)

U) Illinois Emergency Management Agency, Use of X-rays in the Healing Arts Including Medical, Dental, Podiatry, and Veterinary Medicine (32 Ill. Adm. Code 360)

V) Illinois Emergency Management Agency, Medical Use of Radioactive Material (32 Ill. Adm. Code 335)

W) Illinois Emergency Management Agency, Registration and Operator Requirements for Radiation Installations (32 Ill. Adm. Code 320)

X) Illinois Emergency Management Agency, Accrediting Persons in the Practice of Medical Radiation Technology (32 Ill. Adm. Code 401)

Y) Illinois Emergency Management Agency, General Provisions for Radiation Protection (32 Ill. Adm. Code 310)

3) Federal Statutes

A) Health Insurance Portability and Accountability Act of 1996 (110 U.S.C. 1936)

B) Emergency Medical Treatment & Labor Act (42 U.S.C. 1395dd)

4) Federal Training Materials

A) Preventing Workplace Violence in Healthcare, available at: https://www.oshatrain.org/courses/mods/776e.html

B) Workplace Violence Prevention for Nurses, available at: https://www.cdc.gov/niosh/topics/violence/

(Source: Amended at 48 Ill. Reg. _____, effective _____)

SUBPART C: THE MEDICAL STAFF

Section 250.330 Orders for Medications and Treatments

a) No medication, treatment, or diagnostic test shall be administered to a patient except on the written order of a member of the medical staff, a house staff member under the supervision of a member of the medical staff, or allied health personnel with clinical privileges recommended by the hospital medical staff and granted by the hospital governing board, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per medical staff-approved hospital policy that includes an assessment for contraindications, and medications and treatments provided to patients in a hospital outpatient setting as set forth in a policy approved by the hospital medical staff and governing board.

1) The staff-approved *influenza and pneumococcal immunization policy shall include, but not be limited to, the following:*

A) *Procedures for identifying patients age 50~~65~~ or older for influenza immunization and 65 or older for pneumococcal immunization and, at the discretion of the* hospital, *other patients at risk;*

B) *Procedures for offering immunization against influenza virus when available between September 1 and April 1, and against pneumococcal disease upon admission or discharge, to patients in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless contraindicated*; and

C) *Procedures for ensuring that patients offered immunization, or their guardians, receive information regarding the risks and benefits of vaccination.*

2) *The hospital shall provide a copy of its influenza and pneumococcal immunization policy to the Department upon request.* (Section 6.26 of the Act)

3) The outpatient medication and treatment administration policy shall include, but not be limited to, the following:

A) Procedures for verifying the credentials and scope of practice of non-medical staff members providing written orders for medications and treatment for patients under their care and management.

B) Identifying what, if any, medications or treatments should not be included in this exception.

C) A process for tracking non-medical staff members providing written orders for medication and treatments and the medications and/or treatments ordered.

4) The hospital shall provide a copy of its outpatient medication and treatment policy to the Department upon request.

b) Verbal orders shall be signed before the member of the medical staff, the house staff member, or allied health personnel with clinical privileges recommended by the hospital medical staff and granted by the hospital governing board leaves the area. Telephone orders shall be used sparingly and countersigned by the ordering practitioner or another practitioner who is responsible for the care of the patient as soon as practicable pursuant to a hospital policy approved by the medical staff, but no later than 72 hours after the order was given.

c) Members of the medical staff, house staff members, or allied health personnel with clinical privileges recommended by the hospital medical staff and granted by the hospital governing board shall give orders for medication and treatment only to the licensed, registered or certified professional persons who are authorized by law to administer or dispense the medication or treatment in the course of practicing their identified specific discipline.

d) The medical directors of the laboratory, radiology, or other diagnostic services may respectively authorize the performance of diagnostic tests and procedures at the request of other than members of the medical staff in accordance with policies approved by the medical staff and governing board.

e) The medical director of the physical therapy or rehabilitation department may authorize the provision of physical therapy or rehabilitation services or treatments at the request of other than members of the medical staff in accordance with policies approved by the medical staff and governing board.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

SUBPART G: EMERGENCY SERVICES

Section 250.710 Classification of Emergency Services

a) Each hospital, *except long-term acute care hospitals and rehabilitation hospitals identified in Section 1.3 of* the Hospital Emergency Service *Act* and in subsection

(c) of this Section (Section 1 of the Hospital Emergency Service Act), shall provide emergency services according to one of the following categories:

1) Comprehensive Emergency Treatment Services

A) At least one licensed physician shall be in the emergency department at all times.

B) Physician specialists who represent the major specialties and sub-specialties, such as plastic surgery, dermatology and ophthalmology, shall be available within minutes.

C) Ancillary services, including laboratory and x-ray, shall be staffed at all times. The pharmacy shall be staffed or on call at all times.

2) Basic Emergency Treatment Services

A) At least one licensed physician shall be in the emergency department at all times.

B) Physician specialists who represent the specialties of medicine, surgery, pediatrics and obstetrics shall be available within minutes.

C) Ancillary services, including laboratory, x-ray and pharmacy, shall be staffed or on call at all times.

3) Standby Emergency Treatment Services

A) A registered nurse on duty in the hospital shall be available for emergency services at all times.

B) A licensed physician shall be on call to the emergency department at all times.

b) All hospitals, irrespective of the category of services provided, shall provide immediate first aid and emergency care to persons requiring first aid emergency treatment on arrival at the hospital. *A hospital, in accordance with Section 1395dd(a) and 1395dd(b) of the Social Security Act, shall not delay provisions of a required appropriate medical screening examination or further medical examination and treatment for a patient in order to inquire about the individual's method of payment or insurance status.* (Section 6.34 of the Act)

c) *General acute care hospitals designated by Medicare as long-term acute care*

hospitals and rehabilitation hospitals are not required to provide hospital emergency services described in this Section or *Section 1 of* the Hospital Emergency Service *Act. Hospitals defined in this* subsection (c) *may provide hospital emergency services at their option*.

1) *Any hospital* defined in this subsection (c) *that opts to discontinue or otherwise not provide emergency services shall*:

A) *Comply with all provisions of the federal Emergency Medical Treatment and Labor Act (EMTALA)*;

B) *Comply with all provisions required under the Social Security Act*;

C) *Provide annual notice to communities in the hospital's service area about available emergency medical services; and*

D) *Make educational materials available to individuals who are present at the hospital concerning the availability of medical services within the hospital's service area*.

2) *Long-term acute care hospitals that operate standby emergency services as of January 1, 2011 may discontinue hospital emergency services by notifying the Department. Long-term acute care hospitals that operate basic or comprehensive emergency services must notify the Health Facilities and Services Review Board and follow the appropriate procedures*. (Section 1.3 of the Hospital Emergency Service Act)

3) *Any rehabilitation hospital that opts to discontinue or otherwise not provide emergency services* shall comply with subsection (c)(1), *shall not use the term "hospital" in its name or on any signage, and shall notify in writing the Department, the Health Facilities and Services Review Board, and* the Division of Emergency Medical Services and Highway Safety *of the discontinuation*. (Section 1.3 of the Hospital Emergency Service Act)

A) "Signage" means any signs or system of signs affixed to, adjacent to, or directing the public to the hospital, including but not limited to informational road signs.

B) Signage does not include materials for advertising, licensure, certification or patient referral materials.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 250.720 General Requirements

a) Each hospital shall provide adequate facilities for the provision of immediate life saving measures.

b) Policies and procedures governing the acceptance and care of emergency patients shall be established. These shall be in accordance with the category of emergency services established in the hospital. Specific policies shall be adopted and implemented in regard to rendering emergency care in the hospital's emergency department, in the hospital but away from the emergency department, and within proximity to the hospital. In developing these policies, the hospital shall take into consideration any available national or state guidelines on the standard of practice in this area. These policies shall be included as a part of any initial employee orientation/training and shall be reviewed annually with staff.

c) An appropriate record shall be maintained on each patient who presents for emergency services.

d) Appropriate supplies and equipment shall be available and ready for use.

e) This Section shall not be construed to affect hospital-patient arrangements regarding payment for care.

f) Hospitals providing obstetric services shall have a *written policy and conduct continuing education yearly* (calendar) *for providers and staff of obstetric medicine, and of the emergency department, and other staff that may care for pregnant or postpartum women. The written policy and continuing education shall include ~~yearly educational modules regarding~~ management of severe maternal hypertension and obstetric hemorrhage, addressing airway emergencies experienced during childbirth, and management of other leading causes of maternal mortality for units that care for pregnant or postpartum women*. Hospitals providing obstetric services shall *demonstrate compliance with these written policy and~~,~~ education~~, and training~~ requirements.* (Section 2310-222(b) of the Department of Public Health Powers and Duties Law) (See also Section 250.1830(n) and (o)).

g) A REH shall have an agreement with at least one licensed and Medicare-certified hospital that is a level I or level II trauma center for the referral and transfer of patients requiring emergency medical care beyond the capabilities of the REH.

h) *The use of latex gloves by* hospital staff *is prohibited. If a crisis exists that interrupts* a hospital's *ability to reliably source nonlatex gloves,* hospital staff *may use latex gloves upon a patient. However, during the crisis,* hospital staff *shall*

prioritize, to the extent feasible, using nonlatex gloves for the treatment of any patient with self-identified allergy to latex; and any patient upon whom the latex gloves are to be used who is unconscious or otherwise physically unable to communicate and whose medical history lacks sufficient information to indicate whether or not the patient has a latex allergy. (Sections 10(c) and 15 of the Latex Glove Ban Act)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

SUBPART I: NURSING SERVICE AND ADMINISTRATION

Section 250.1030 Policies and Procedures

a) For the purposes of this Section:

Health Care Worker means an individual providing direct patient care services who may be required to lift, transfer, reposition, or move a patient. A direct patient care provider is the same as a health care worker.

Safe Lifting Equipment and Accessories means mechanical equipment designed to lift, move, reposition, and transfer patients, including, but not limited to, fixed and portable ceiling lifts, sit-to-stand lifts, slide sheets and boards, slings, and repositioning and turning sheets.

Safe Lifting Team means at least 2 individuals who are trained in the use of both safe lifting techniques and safe lifting equipment and accessories, including the responsibility for knowing the location and condition of such equipment and accessories. (Section 6.25 of the Act)

b) Nursing policies and procedures shall be developed, reviewed periodically but at least once a year, and revised as necessary by nursing representatives in cooperation with appropriate representatives from administration, the medical staff, and other concerned hospital services or departments.

c) The nursing policies and procedures shall be dated to indicate the time of the most recent review or revision.

d) Written policies shall include, but not be limited to, the following:

1) Criteria pertaining to the performance of special procedures and the circumstances and supervision under which these may be performed by nursing personnel;

2) Communication and implementation of diagnostic and therapeutic orders, including verbal orders, and the responsibility and mechanism for nursing service to obtain clarification of orders when indicated;

3) Administration of medication;

4) Assignments for providing nursing care to patients;

5) Documentation in patients' records by nursing personnel;

6) Infection control, pursuant to Section 250.1100;

7) *A policy to identify, assess, and develop strategies to control risk of injury to patients and nurses and other health care workers, associated with the lifting, transferring, repositioning, or movement of a patient. The policy shall establish a process that, at a minimum, includes all of the following:*

A) *Analysis of the risk of injury to patients and nurses and other health care workers posted by the patient handling needs of the patient populations served by the hospital and the physical environment in which the patient handling and movement occurs;*

B) *Education and training of nurses and other direct patient care providers in the identification, assessment, and control of risks of injury to patients and nurses and other health care workers during patient handling and on safe lifting policies and techniques and current lifting equipment;*

C) *Evaluation of alternative ways to reduce risks associated with patient handling, including evaluation of equipment and the environment;*

D) *Restriction, to the extent feasible with existing equipment and aids, of manual patient handling or movement of all or most of a patient's weight except for emergency, life-threatening, or otherwise exceptional circumstances;*

E) *Collaboration with, and an annual report to, the nurse staffing committee;*

F) *Procedures for a nurse to refuse to perform or be involved in patient handling or movement that the nurse in good faith believes will expose a patient or nurse or other health care worker to an*

unacceptable risk of injury;

G) *Submission of an annual report to the hospital's governing body or quality assurance committee on activities related to the identification, assessment, and development of strategies to control risk of injury to patients and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a patient;*

H) *In developing architectural plans for construction or remodeling of a hospital or unit of a hospital in which patient handling and movement occurs, consideration of the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment;*

I) *Fostering and maintaining patient safety, dignity, self-determination, and choice, including the following policies, strategies, and procedures*:

i) *The existence and availability of a trained safe lifting team*;

ii) *A policy of advising patients of a range of transfer and lift options, including adjustable diagnostic and treatment equipment, mechanical lifts, and provision of a trained safe lifting team;*

iii) *The right of a competent patient, or guardian of a patient adjudicated incompetent, to choose among the range of transfer and lift options, subject to the provisions of* subsection (d)(7)(I)(v)*;*

iv) *Procedures for documenting, upon admission and as status changes, a mobility assessment and plan for lifting, transferring, repositioning, or movement of a patient, including the choice of the patient or patient's guardian among the range of transfer and lift options; and*

v) *Incorporation of such safe lifting procedures, techniques, and equipment as are consistent with applicable federal law;* (Section 6.25(b) of the Act)

8) Nursing role in other hospital services, including but not limited to services such as dietary, pharmacy, and housekeeping; and

9) Emotional and attitudinal support. (Refer to Section 250.260(b)(1).)

e) A nursing procedure manual shall be developed to provide a ready reference on nursing procedures and a basis for standardization of procedures and equipment in the hospital.

f) Copies of the nursing procedure manual shall be available on the patient care units, to the nursing staff, and to other services and departments of the hospital, including members of the medical staff and students.

g) *The use of latex gloves by* hospital staff *is prohibited. If a crisis exists that interrupts* a hospital's *ability to reliably source nonlatex gloves*, hospital staff *may use latex gloves upon a patient. However, during the crisis*, hospital staff *shall prioritize, to the extent feasible, using nonlatex gloves for the treatment of any patient with self-identified allergy to latex; and any patient upon whom the latex gloves are to be used who is unconscious or otherwise physically unable to communicate and whose medical history lacks sufficient information to indicate whether or not the patient has a latex allergy.* (Sections 10(c) and 15 of the Latex Glove Ban Act)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 250.1130 Nurse Staffing by Patient Acuity

a) As used in this Section, the following definitions apply:

"Acuity Model" – means assessment tool selected and implemented by a hospital, as recommended by a nursing care committee, that assesses the complexity of patient care needs requiring professional nursing care and skills and aligns patient care needs and nursing skills consistent with professional nursing standards.

"Direct Patient Care" – means care provided by a registered professional nurse with direct responsibility to oversee or carry out medical regimens or nursing care for one or more patients.

"Nursing-sensitive Care Performance Measure" – means data that examine nursing contributions to inpatient hospital care, including, but not limited to, the data collected and analyzed under the Hospital Report Card Act, the Illinois Adverse Health Care Events Reporting Law of 2005, and the National Database for Nursing Quality Indicators. The National Database for Nursing Quality Indicators may be accessed at

https://www.pressganey.com/products/clinical-excellence/national-database-nursing-quality-indicators. Hospitals are not required to subscribe to the database.

"Nursing Care Committee" − means a hospital-wide committee or committees of nurses whose functions, in part or in whole, contribute to the development, recommendation, and review of the hospital's nurse staffing plan established pursuant to subsection (b). (Section 10.10(b) of the Act)

"Patient Acuity" − means the complexity of patient care needs requiring the skill and care of a nurse, which is addressed when aligning nursing resources and professional practice standards as part of the patient's treatment plan.

"Registered Professional Nurse" – means a person licensed as a Registered Nurse under the Nurse Practice Act.

"Written Staffing Plan for Nursing Care Services" – means a written plan for the assignment of patient care nursing staff based on multiple nurse and patient considerations that yield minimum staffing levels for inpatient care units and the adopted acuity model aligning patient care needs with nursing skills required for quality patient care consistent with professional nursing standards. (Section 10.10(b) of the Act)

b) *Written Staffing Plan*

1) *Every hospital shall implement a written hospital-wide staffing plan, prepared by a nursing care committee or committees, that provides for minimum direct care professional registered nurse-to-patient staffing needs for each inpatient care unit, including inpatient emergency departments.*

2) *If the staffing plan prepared by the nursing care committee is not adopted by the hospital, or if substantial changes are proposed, the chief nursing officer shall either provide a written explanation to the committee of the reasons the plan was not adopted or provide a written explanation of any substantial changes made to the proposed plan prior to it being adopted by the hospital.*

3) *The written hospital-wide staffing plan shall include, but need not be limited to, the following considerations:*

A) *The complexity of complete care, assessment on patient admission, volume of patient admissions, discharges and transfers, evaluation of the progress of a patient's problems, ongoing physical assessments, planning for a patient's discharge, assessment after a change in patient condition, and assessment of the need for patient referrals;*

B) *The complexity of clinical professional nursing judgment needed to design and implement a patient's nursing care plan, the need for specialized equipment and technology, the skill mix of other personnel providing or supporting direct patient care, and involvement in quality improvement activities, professional preparation* (credentials)*, and experience;*

C) *Patient acuity and the number of patients for whom care is being provided;*

D) *The ongoing assessments of a unit's patient acuity levels and nursing staff needed, routinely made by the unit nurse manager or his or her designee;* and

E) *The identification of additional registered nurses available for direct patient care when patients' unexpected needs exceed the planned workload for direct care staff* and the process to add additional staff. (Section 10.10(c) of the Act)

F) The process for submitting the nursing care committee's recommendations to hospital; and

G) The process for providing feedback to the nursing care committee from the hospital administration regarding unresolved or ongoing issues.

4) A written staffing plan shall consider the time required for nursing staff documentation of patient care.

5) *In order to provide staffing flexibility to meet patient needs, every hospital shall identify an acuity model for adjusting the staffing plan for each inpatient care unit.*

6) *Each hospital shall implement the staffing plan and assign nursing personnel to each inpatient care unit, including inpatient emergency departments, in accordance with the staffing plan.*

A) *A registered nurse may report to the nursing care committee any variations where the nurse personnel assignment in an inpatient care unit is not in accordance with the adopted staffing plan and may make a written report to the nursing care committee based on the variations.*

B) *Shift-to-shift adjustments in staffing levels required by the staffing plan may be made by the appropriate hospital personnel overseeing inpatient care operations. If a registered nurse in an inpatient care unit objects to a shift-to-shift adjustment, the registered nurse may submit a written report to the nursing care committee.*

C) *The nursing care committee shall develop a process to examine and respond to written reports submitted under* subsections (6)(A) and (6)(B)*, including the ability to determine if a specific written report is resolved or should be dismissed.* (Section 10.10(c)(2.5) of the Act)

7) *The written staffing plan shall be posted, either by physical or electronic means, in a conspicuous and accessible location for both patients and direct care staff, as required under the Hospital Report Card Act. A copy of the written staffing plan shall be provided to any member of the general public upon request.* (Section 10.10(c)(3) of the Act)

8) In addition to the hospital providing a copy of the written staffing plan per subsection (b)(6), the hospital shall allow members of the public to schedule an appointment with the Chief Nursing Officer or their designee to review the staffing plan and address any questions.

c) *Nursing Care Committee*

1) *Every hospital shall have a nursing care committee that meets at least 6 times per year. A hospital shall appoint members of a committee* of which *at least 55% of the members are registered professional nurses providing direct inpatient care, one of whom shall be selected annually by the direct inpatient care nurses to serve as co-chair of the committee.* (Section 10.10(d)(1) of the Act)

A) The registered professional nurses on the nursing care committee shall be as broadly representative of the clinical service areas as

practically reasonable; e.g., surgery, critical care, medical surgical, obstetrics, emergency department and pediatrics.

B) When committee or nurse staff volume is not practically reasonable to include representatives from each clinical service area at any one time, the hospital may schedule for rotating representation of the hospital's clinical service areas over a defined timeframe to achieve input from all clinical service areas every three years.

C) Minutes for the nursing care committee meetings, summarizing key issues, discussions and recommendations, shall be recorded and maintained for five years.

2) *A nursing care committee shall prepare and recommend to hospital administration the hospital's written hospital-wide staffing plan. If the staffing plan is not adopted by the hospital, the chief nursing officer shall provide a written statement to the committee prior to a staffing plan being adopted by the hospital that:*

A) E*xplains the reasons the committee's proposed staffing plan was not adopted; and*

B) D*escribes the changes to the committee's proposed staffing or any alternative to the committee's proposed staffing plan.* (Section 10.10(d)(2.5) of the Act)

3) *A nursing care committee's or committees' written staffing plan for the hospital shall be based on the principles from the staffing components set forth in subsection* (b). *In particular, a committee or committees shall provide input and feedback on the following:*

A) *Selection, implementation, and evaluation of minimum staffing levels for inpatient care units.*

B) *Selection, implementation, and evaluation of an acuity model to provide staffing flexibility that aligns changing patient acuity with nursing skills required.*

C) *Selection, implementation, and evaluation of a written staffing plan incorporating the items described in* subsections (b)(1) through (b)(5). (Section 10.10(d)(3) of the Act)

i) The process for review and evaluation of the written staffing plan shall take into consideration nursing-sensitive care performance measures.

ii) The process for review and evaluation of the written staffing plan shall consider the National Quality Forum's Safe Practices for Better Healthcare.

4) The committee or committees shall *review the nurse staffing plans for all inpatient areas and current acuity tools and measures in use. The nursing care committee's review shall consider:*

A) *Patient outcomes;*

B) *Complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing;*

C) *The number of hours of nursing care provided through an inpatient hospital unit compared with the number of inpatients served by the hospital unit during a 24-hour period;*

D) *The aggregate hours of overtime worked by the nursing staff;*

E) *The extent to which actual nurse staffing for each hospital inpatient unit differs from the staffing specified by the staffing plan; and*

F) *Any other matter or change to the staffing plan determined by the committee to ensure that the hospital is staffed to meet the health care needs of patients.* (Section 10.10(d)(3)(D) of the Act)

5) System-related or clinical service area nurse staffing or patient issues identified between meetings shall be shared, reviewed and addressed at the next nurse care committee meeting.

6) *A nursing care committee must issue a written report addressing the items described in* subsections (c)(3) and (c)(4) *semi-annually. A written copy of this report shall be made available to direct inpatient care nurses by making available a paper copy of the report, distributing it electronically, or posting it on the hospital's website.* (Section 10.10(d)(4) of the Act)

7) *A nursing care committee must issue a written report at least annually to the hospital governing board that addresses items including, but not limited to:*

A) *The items described in* subsections (b)(1) through (b)(5);

B) *Changes made based on committee recommendations and the impact of* these *changes;*

C) *Recommendations for future changes related to nurse staffing* (Section 10.10(d)(5) of the Act)*;*

D) The composition of the nursing units represented by members of the nursing care committee;

E) Goals and accomplishments of the nursing care committee;

F) Outline of the current acuity tools in each inpatient and emergency department;

G) Personnel data including annual registered nurse turnover rate, current registered nurse vacancy rate, current and posted full-time or full-time equivalent registered nurse positions, and annual certified nurse aid/tech turnover and vacancy rate;

H) Number of registered nurse injuries related to patient lifting and handling as per Section 250.1030(d)(7); and

I) Number of hospital inpatient acquired pressure injuries.

8) *A Nursing care committee must annually notify the hospital nursing staff of the staff's rights under* Section 10.10 of the Act. *The annual notice must provide a phone number and an email address for staff to report noncompliance with the nursing staff's rights as described in this Section. The notice must be provided by email or by regular mail in a manner that effectively facilitates receipt of the notice.* (Section 10.10(d)(6) of the Act)

d) *Nothing in this Section shall be construed to limit, alter, or modify any of the terms, conditions, or provisions of a collective bargaining agreement entered into by the hospital.* (Section 10.10(e) of the Act)

e) *No hospital may discipline, discharge, or take any other adverse employment action against an employee solely because the employee expresses a concern or*

complaint regarding an alleged violation of this Section *or concerns related to nurse staffing.* (Section 10.10(f) of the Act)

f) *Any employee of a hospital may file a complaint with the Department regarding an alleged violation of* this Section. *The Department* will *forward notification of the alleged violation to the hospital in question within 10 business days after the complaint is filed. Upon receiving a complaint of a violation of* this Section*, the Department may take any action authorized under Section 7 or 9 of* the *Act*. (Section 10.10(g) of the Act)

g) *If a hospital demonstrates a pattern or practice of failing to substantially comply with the requirements of Section 10.10* of the Act *or the hospital's written staffing plan, the hospital shall provide a plan of correction to the Department within 60 days* after receiving notice of noncompliance. *The Department may impose fine as follows:*

1) *If a hospital fails to implement a written staffing plan for nursing services, a fine not to exceed $500 per occurrence may be imposed;*

2) *If a hospital demonstrates a pattern or practice of failing to substantially comply with a plan of correction within 60 days after the plan takes effect, a fine not to exceed $500 per occurrence may be imposed; and*

3) *If a hospital demonstrates for a second or subsequent time a pattern or practice of failing to substantially comply with a plan of correction with 60 days after the plan takes effect, a fine not to exceed $1,000 per occurrence may be imposed.* (Section 7(a-5) of the Act)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

SUBPART J: SURGICAL AND RECOVERY ROOM SERVICES

Section 250.1230 Policies & Procedures

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

b) *The use of latex gloves by* hospital staff *is prohibited. If a crisis exists that interrupts* a hospital's *ability to reliably source nonlatex gloves*, hospital staff *may use latex gloves upon a patient. However, during the crisis*, hospital staff *shall prioritize, to the extent feasible, using nonlatex gloves for the treatment of any patient with self-identified allergy to latex; and any patient upon whom the latex*

gloves are to be used who is unconscious or otherwise physically unable to communicate and whose medical history lacks sufficient information to indicate whether or not the patient has a latex allergy. (Sections 10(c) and 15 of the Latex Glove Ban Act)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

SUBPART M: FOOD SERVICE

Section 250.1610 Dietary Department Administration

a) Organization
There shall be an organized department of dietetics, and a well-definedwell defined plan of operation designed to meet the needs of the patients whether the services are centralized, decentralized, or provided under contractual agreement.

b) Staffing: Dietetic Service Director
The dietetic department shall have a full-time dietetic service directorbe directed by a full-time person who is qualified by dietetic and food service management training and experience, preferably a dietitianregistered dietitian, whose responsibilities shall include, but are not limited to, the following:

1) developing written policies and procedures to include but not necessarily be limited to:

A) responsibilities and authority for the operation;

B) standards of nutritional care for all regular and therapeutic diets including supplemental feedings;

C) medically prescribed diet orders and alterations in diets or diet schedules such as holding trays, late trays, and times for accepting diet changes;

D) patient tray identification;

E) food preparation, storage and service;

F) personal hygiene;

G) sanitation and safety;

H) ancillary dietetic services including food storage preparation and

service in kitchens and dining areas on patient care units; formula supply; vending operation; and ice making;

I) conferences--departmental and interdepartmental, clinical, executive and/or administrative;

J) training programs for personnel; and

K) patient education programs.

2) planning menus for all general and therapeutic diets in accordance with the current Recommended~~recommended Daily~~ Dietary Allowances of the Food and Nutrition Board, National Research Council, and in accordance with the principles of good dietetic management;

3) planning, organizing, directing, controlling, and evaluating all management aspects of the dietetic services including such things as budget and/or interpretations of financial reports,~~;~~ purchasing and/or requisitioning food, dietetic supplies and equipment, food costs, food storage,~~;~~ food preparation,~~;~~ food service,~~;~~ safety,~~;~~ sanitation,~~;~~ record keeping,~~;~~ personnel scheduling, and evaluating;

4) planning, implementing, and/or conducting education programs for orientation, on-the job training, in-service and continuing education on a regular, routinely scheduled basis for all dietary and other appropriate personnel, and staff development sessions for all professional staff;

5) administering all the nutritional aspects of patient care including, but not necessarily limited to:

A) taking nutrition histories and recording in patients' medical charts;

B) interviewing patients regarding food habits;

C) giving diet counseling to patients and their families; encouraging patient participation in planning their own diets;

D) participating in appropriate ward rounds and conferences, or by other methods; sharing specialized knowledge with medical and nursing staffs and other appropriate interdisciplinary team members involved in the care of the patient; and

E) consulting with patient care team(s).

c) Consultation

1) When the full-time dietetic service director, for legitimate, documented reasons, is not a dietitian~~qualified registered dietitian or qualified nutritionist~~, the hospital shall employ a dietitian~~qualified registered dietitian~~ on a part-time (minimum of 20 hours per week) or on a consulting basis. The hours of consultation in the hospital shall be dependent upon the size, needs and complexity of the hospital, and dietetic service but in no case shall there be less than a minimum of eight hours of consultation per month.

2) If consultant dietetic services are used, the consultant's visits are to be scheduled at appropriate times ~~and~~ of sufficient duration and frequency to allow for the consultant to liaise~~provide continuing liaison~~ with medical, nursing, and patient care teams,~~;~~ to advise the administrator,~~;~~ to give patient counseling,~~;~~ to give guidance to the director and staff of the dietetic service,~~;~~ to approve all menus and administrative nutritional aspects of patient care,~~;~~ to participate in development and/or revisions of dietetic policies and procedures,~~;~~ and to assist with planning and conducting orientation, in-service and continuing education programs for dietary and other appropriate personnel.

d) Staff

1) There shall be a sufficient number of properly trained and supervised dietary personnel, including a clinical dietitian(s) where warranted, competent to carry out all the functions of the dietetic service in an efficient, effective manner.

2) Dietary personnel shall be ~~so~~ scheduled and on duty to allow for the dietary department to be open and in service a minimum~~that the dietary department is open, and in service, a minimum~~ of 12 hours a day.

e) Health and Hygiene

1) Personnel shall be in good health,~~;~~ free of infections or communicable disease,~~;~~ and free of boils, infected wounds, sores, or lesions. Persons suspected of having a communicable, contagious, or infectious disease shall be subject to the requirements of~~measures outlined in~~ the Control of Notifiable Diseases and Conditions Code and the Food Code~~Department's current Regulations for the Control of Communicable Diseases (77 Ill. Adm. Code 690)" and the Department's current "Food Service Sanitation~~

~~Rules and Regulations"~~.

2) The outer clothing of all employees shall be clean and street clothing shall not be worn as outer clothing by employees while engaged in the preparation and serving of food.

3) Employees shall wear hair nets, headbands, or other effective hair restraints to prevent the contamination of food or food-contact surfaces.

4) Employees shall thoroughly wash their hands and exposed portions of their arms with soap and warm water before starting work,~~;~~ during work as ~~is~~ necessary to keep them clean,~~;~~ and after smoking, eating, drinking, or using the toilet. Employees shall keep their fingernails clean and trimmed.

5) Except where tasting food is part of the job, employees shall consume food only in designated dining areas. An area shall not be designated as a dining area if consuming food there might result in contamination of other food, equipment, utensils, or other items needing~~needed~~ protection.

6) Employees shall not use tobacco in any form while engaged in food preparation or service, nor while in equipment or utensil washing or food preparation areas. Employees shall use tobacco in any form only in designated areas. An area shall not be designated for that purpose if the use of tobacco there might result in contamination of food, equipment, utensils, or other items needing protection.

7) Employees shall handle soiled tableware in a way that avoids contamination of their hands.

8) In the event food service employees are assigned duties outside the dietetic service, these duties shall~~do~~ not interfere with the sanitation, safety, or time required for dietetic work assignments.

9) Employees shall maintain a high degree of personal cleanliness and shall conform to good hygienic practices.

10) Employees shall not *use latex gloves in the preparation and handling of food. If latex gloves must be used in the preparation of food due to a crisis that interrupts a* hospital's *ability to source nonlatex gloves, a sign shall be prominently placed at the point of order or point of purchase clearly notifying the public of the temporary change.* (Section 10(a) of the Latex Glove Ban Act)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

SUBPART O: OBSTETRIC AND NEONATAL SERVICE

Section 250.1830 General Requirements for All Obstetric Departments

a) The temperature and humidity in the nurseries and in the delivery suite shall be maintained at a level best suited for the protection of mothers and infants as recommended by the Guidelines for Perinatal Care. Chilling of the neonate shall be avoided; a non-stable neonate shall, immediately after birth, be placed in a radiant heat source that is ready to receive the infant and that allows access for resuscitation efforts. The radiant heat source shall comply with the recommendations of the Guidelines for Perinatal Care. When the neonate has been stabilized, if the mother wishes to hold her newborn, a radiant heater or pre-warmed blankets shall be available to keep the neonate warm. Stable infants shall be placed, and remain, in direct skin-to-skin contact with their mother immediately after delivery to optimally support infant breastfeeding and to promote mother/infant bonding. Personnel shall be available who are trained to use the equipment to maintain a neutral thermal environment for the neonate. For general temperature and humidity requirements, see Section 250.2480(d)(1). In general, a temperature between 72 degrees and 76 degrees and relative humidity between 35% and 60% are acceptable.

b) Linens and Laundry: Linens shall be cleaned and disinfected in compliance with the Guidelines for Perinatal Care.

1) Nursery linens shall be washed separately from other hospital linens.

2) No new unlaundered garments shall be used in the nursery.

c) Sterilizing equipment, as required in Section 250.1090, shall be available. Sterilizing equipment may be provided in the obstetric department or in a central sterilizing unit, provided that flash sterilizing equipment or adequate sterile supplies and instruments are provided in the obstetric department.

d) Accommodations and Facilities for Obstetric Patients

1) The hospital shall identify specific rooms and beds, adjacent when possible to other obstetric facilities, as obstetric rooms and beds. These rooms and beds shall be used exclusively for obstetric patients or for combined obstetric and clean gynecological service beds in accordance with Section 250.1820(g).

2) Patient rooms and beds that are adjacent to another nursing unit may be used for clean cases as part of the adjacent nursing unit. A corridor partition with doors is recommended to provide a separation between the obstetric beds and facilities and the non-obstetric rooms. The doors shall be kept closed except when in active use as a passageway.

3) Facilities shall be available for the immediate isolation of all patients in whom an infectious condition inimical to the safety of other obstetric and neonatal patients exist.

4) Labor rooms shall be convenient to the delivery rooms and shall have facilities for examination and preparation of patients. Each room used for labor, delivery and postpartum (see Section 250.1870) shall include a bathroom equipped with a toilet and a shower. The bathroom also shall include a sink, unless a sink is located in the patient room. The bathroom shall be directly accessible from the patient room without going through the corridor.

5) Delivery rooms shall be equipped and staffed to provide emergency resuscitation for infants pursuant to the recommendation of the American Academy of Pediatrics and ACOG and shall comply with the American Academy of Pediatrics/American Health Association's American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines.

6) If only one delivery room is available and in use, one labor room shall be arranged as an emergency delivery room and shall have a minimum clear floor area of 180 square feet.

7) The patient shall be kept under close observation until the patient's condition is stabilized following delivery. Observations at established time intervals shall be recorded in the patient's medical record. A recovery area shall be provided. Emergency equipment and supplies shall be available for use in the recovery area.

e) Accommodations and Facilities for Infants

1) Level I nurseries:

A) A clean nursery or nurseries shall be provided, near the mothers' rooms, with adequate lighting and ventilation. A minimum of 30 square feet of floor area for each bassinet and 3 feet between

bassinets shall be provided. Equipment shall be provided to prevent direct draft on the infants. Individual nursery rooms shall have a capacity of six to eight neonates or 12 to 16 neonates. The normal newborn infant care area in a smaller hospital shall limit room size to eight neonates, with a minimum of two rooms available to permit cohorting in the presence of infection.

B) Bassinets equipped to provide for the medical examination of the newborn infant and for the storage of necessary supplies and equipment shall be provided in a number to exceed obstetric beds by at least 20% to accommodate multiple births, extended stay, and fluctuating patient loads. Bassinets shall be separated by a minimum of 3 feet, measuring from the edge of one bassinet to the edge of the adjacent one.

C) A glass observation window shall be provided through which infants may be viewed.

D) Resuscitation equipment as described in subsection (e)(1)(E)(iii), and personnel trained to use it, shall be available in the nursery at all times.

E) Each nursery shall have necessary equipment immediately available to stabilize the sick infant prior to transfer. Equipment shall consist of:

i) A heat source capable of maintaining the core temperature of even the smallest infant at 98 degrees (an incubator, or preferably a radiant heat source);

ii) Equipment with the ability to monitor bedside blood sugar;

iii) A resuscitation tray containing equipment pursuant to the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines; and

iv) Equipment for delivery of 100% oxygen concentration, and the ability to measure delivered oxygen in fractional inspired concentrations (FI O_2) pursuant to AAP recommendations. The oxygen analyzer shall be calibrated and serviced according to the manufacturer's instructions at

least monthly by the hospital's respiratory therapy department or other responsible personnel trained to perform the task.

F) Consultation and Referral Protocols shall comply with the Regionalized Perinatal Health Care Code.

2) Level II and Level III nurseries shall comply with the Regionalized Perinatal Health Care Code. Cribs shall be separated by 4 to 6 feet to allow for ease of movement of additional personnel, and to allow space for additional equipment used in care of infants in these areas. New buildings or additions or material alterations to existing buildings that affect the Level II with Extended Neonatal Capabilities nursery shall provide at least 70 square feet of space for each infant.

3) A Level III nursery shall provide 80 to 100 square feet of space for each infant.

4) Facilities shall be available for the immediate isolation of all newborn infants who have or are suspected of having an infectious disease.

5) When an infectious condition exists or is suspected of existing, the infant shall be isolated in accordance with policies and procedures established and approved by the hospital and consistent with recommended procedures of the Guidelines for Perinatal Care and the Control of Communicable Diseases Code.

f) The personnel requirements and recommendations set forth in Subpart D apply to the operation of the obstetric department, in addition to the following:

1) Each hospital shall have a staffing plan for nursing personnel providing care for obstetric and neonatal patients. The registered nursing components of the plan shall comply with Section 250.1130 of this Part, with requirements for the level of perinatal care, as designated in accordance with the Regionalized Perinatal Health Care Code, the Guidelines for Perinatal Care, the National Association of Neonatal Nurses' (NANN) Position Statement #3074 RN Staffing in the NICU, and the following parameters:

A) Nursing supervision by a registered nurse shall be provided for the entire 24-hour period for each occupied unit of the obstetric and neonatal services. This nurse shall have education and experience in obstetric and neonatal nursing.

B) At least one registered nurse trained in obstetric and nursery care shall be assigned to the care of mothers and infants at all times. To prepare for an unexpected delivery, at least one registered nurse or LPN trained to give care to newborn infants shall be assigned at all times to the nursery with duties restricted to the care of the infants. Infants shall never be left unattended.

C) A registered nurse shall be in attendance at all deliveries and shall be available to monitor the mother's general condition and that of the fetus during labor, for at least two hours after delivery, and longer if complications occur.

D) Nursing personnel providing care for obstetric and other patients shall be instructed on a continuing basis in the proper technique to prevent cross-infection. When it is necessary for the same nurse to care for both obstetric and non-obstetric patients in the gynecologic unit, proper technique shall be followed.

E) Obstetric and neonatal department nurses providing input to the hospital's nursing care committee pursuant to Section 250.1130 shall, prior to proposing their recommendations for the hospital's written staffing plan, consider the staffing standards listed in subsection (f)(1).

F) Temporary relief from outside the obstetric and neonatal division by qualified personnel shall be permitted as necessary according to appropriate infection control policy.

G) For each shift in the obstetric department, at least one of the registered nurses or LPNs shall also have certification or experience in lactation training, pursuant to the requirements of subsection (k).

2) Nursing staff – Level I requirements for occupied units. These units shall meet the following requirements in addition to General Care Requirements in Section 250.1830(f)(1).

A) At least two nursing personnel shall be assigned per shift. One shall be a registered nurse and one shall be a registered nurse or an LPN.

B) The capability to provide neonatal resuscitation in the delivery

room shall be demonstrated by the current completion of a nationally recognized neonatal resuscitation program by medical, nursing and respiratory care staff or a hospital rapid response team, in accordance with the requirements of the Regionalized Perinatal Health Care Code.

C) Hospitals shall have the capability for continuous electronic maternal-fetal monitoring for patients, with staff available 24 hours a day, including physician and nursing, who are knowledgeable of electronic maternal-fetal monitoring use and interpretation. Physicians and nurses shall complete a competence assessment in electronic maternal-fetal monitoring every two years, in accordance with the Regionalized Perinatal Health Care Code.

3) Nursing staff – Level II requirements for occupied units. These units shall meet the requirements for Level I in subsection (f)(2). Nursery personnel may be shared with the Level I nursery as needed.

4) Nursing staff – Level II with Extended Neonatal Capabilities requirements for occupied units. In addition to the requirements in subsection (f)(3), the obstetric-newborn nursing services shall be directed by a full-time registered nurse experienced in perinatal nursing. Preference shall be given to registered nurses with a master's degree.

5) Nursing staff – Level III requirements for occupied units. These units shall meet the following requirements in addition to requirements in subsection (f)(3). Half of all neonatal intensive care direct nursing care hours shall be provided by registered nurses who have two years or more of nursing experience in a Level III NICU. All neonatal intensive care direct nursing care hours shall be provided or supervised by registered nurses who have advanced neonatal intensive care training and documented competence in neonatal pathophysiology and care technologies used in the NICU.

6) Medical personnel

A) Each hospital providing obstetric services shall have an organized obstetric staff with a chief of obstetric service. The chief's level of qualification and expertise shall be appropriate to the hospital's designated level of care. The responsibilities of the chief of obstetric services shall include the following requirements, as they relate to the care of obstetric patients:

i) General supervision of the care of the perinatal patients assigned to the unit;

ii) Establishment of criteria for admissions;

iii) Adherence to licensing requirements;

iv) Adoption, by the medical staff, of standards of practice and privileges;

v) Identification of clinical conditions and procedures requiring consultation;

vi) Arrangement of conferences, held at least quarterly, to review operations, complications and mortality;

vii) Assurance that the clinical records, consultations and reports are properly completed and analyzed; and

viii) Provision for exchange of information between medical, administrative and nursing staffs.

B) Each hospital providing pediatric services shall have an organized pediatric staff with a chief of pediatric service. The chief's level of qualification and expertise shall be appropriate to the hospital's designated level of care. The responsibilities of the chief of pediatric services shall include those listed in subsection (f)(6)(A), as they relate to the care of newborn infants.

C) Level I shall comply with the Regionalized Perinatal Health Care Code:

i) One physician shall be Chief of Obstetrical Care. The Chief of Obstetrical Care shall be a board certified or board qualified obstetrician. If this is not possible, a physician with experience and regular practice may be the Chief and be responsible for obstetrical care and available on a 24-hour basis, and a source of obstetric or maternal fetal medicine consultation shall be documented when indicated.

ii) One physician shall be Chief of Pediatric Service. The Chief of Pediatric Service shall be a board certified or board qualified pediatrician. If this is not possible, a

physician with experience and regular practice may be the Chief and be responsible for pediatric care and available on a 24-hour basis, and a source of neonatology consultation shall be documented when indicated.

D) Level II shall comply with the Regionalized Perinatal Health Care Code:

A board certified obstetrician shall be Chief of Obstetrical Care. A board certified pediatrician shall be Chief of Neonatal Care. Obstetrical anesthesia shall be directed by a board certified anesthesiologist with experience and competence in obstetrical anesthesia. Hospital staff shall also include a pathologist and an on call radiologist 24 hours a day. Specialized medical and surgical consultation shall be readily available.

E) Level II With Extended Neonatal Capabilities: Staffing shall comply with the Regionalized Perinatal Health Care Code.

F) Level III: Staffing shall comply with the Regionalized Perinatal Health Care Code.

g) Practices and procedures for care of mothers and infants:

1) The hospital shall follow procedures approved by the infection control committee for the isolation of known or suspected cases of infectious disease in the obstetric department.

2) Patients with clean obstetric complications (regardless of month of gestation), such as pregnancy-induced hypertension for observation and treatment, placenta previa for observation or delivery, ectopic pregnancy, and hypertensive heart disease in a pregnant patient, may be admitted to the obstetric department and be subject to the same requirements as any other obstetric case. (See Section 250.1820(g)(6).)

3) The physician shall determine whether a prenatal serological test for syphilis and a test for HIV have been done on each mother and the results recorded. If no tests have been done before the admission of the patients, the tests shall be performed as soon as possible pursuant to the Perinatal HIV Prevention Act. Specimens for a syphilis test may be submitted in appropriate containers to an Illinois Department of Public Health laboratory for testing without charge. Mothers shall be tested for Group B

streptococcus prior to delivery and for Hepatitis B prior to discharge of either mother or infant, pursuant to AAP recommendations.

4) No obstetric patient under the effect of an analgesic or an anesthetic, in the second stage of labor or delivery, shall be left unattended at any time.

5) Fetal lung maturity shall be established and documented prior to elective inductions and caesarean sections if the infant is at less than 39 weeks of gestation, or 38 weeks of gestation for twins. The hospital shall establish a written policy and procedure concerning the administration of oxytocic drugs.

A) Oxytocin shall be used for the contraction stress test only when qualified personnel, determined by the hospital staff and administration, can attend the patient closely. Written policies and procedures shall be available to the team members assuming this responsibility.

B) The oxytocin solution shall be administered intravenously via a controlled infusion device, using both a primary intravenous solution and a secondary oxytocin solution.

C) Oxytocin shall be used for medical induction or stimulation of labor only when qualified personnel, determined by the hospital staff and administration, can attend the patient closely. Written policies and procedures shall be available to the team members assuming this responsibility. The following shall be included in these policies:

i) An attending physician shall evaluate the patient for induction or stimulation, especially with regard to indications.

ii) The physician or other individuals starting the oxytocin shall be familiar with its effect and complications and be qualified to identify both maternal and fetal complications.

iii) A qualified physician shall be immediately available as is necessary to manage any complication effectively.

iv) During oxytocin administration, the fetal heart rate; the resting uterine tone; and the frequency, duration and intensity of contractions shall be monitored electronically

and recorded. Maternal blood pressure and pulse shall be monitored and recorded at intervals comparable to the dosage regimen; that is, at 30 to 60 minute intervals, when the dosage is evaluated for maintenance, increase or decrease. Evidence of maternal and fetal surveillance shall be documented.

6) Identification of infants:

A) While the neonate is still in the delivery room, the nurse in the delivery room shall prepare identical identification bands for both the mother and the neonate, as outlined in the hospital's policy. Wrist bands alone may be used; however, it is recommended that both wrist and ankle bands be used on the neonate. The hospital shall not use foot-printing and fingerprinting alone as methods of patient identification. The bands shall indicate the mother's admission number, the neonate's sex, the date and time of birth, and any other information required by hospital policy. Delivery room personnel shall review the bands prior to securing them on the mother and the neonate to ensure that the information on the bands is identical. The nurse in the delivery room shall securely fasten the bands on the neonate and the mother without delay as soon as the nurse has verified the information on the identification bands. The birth records and identification bands shall be checked again before the neonate leaves the delivery room.

B) If the condition of the neonate does not allow the placement of identification bands, the identification bands shall accompany the neonate and shall be attached as soon as possible, as outlined in the hospital's policy. Identification bands shall not be left unattached and unattended in the nursery.

C) When the neonate is taken to the nursery, both the delivery room nurse and the admitting nursery nurse shall check the neonate's identification bands and birth records, verify the sex of the neonate, and sign the neonate's medical record. The admitting nurse shall complete the bassinet card and attach it to the bassinet.

D) When the neonate is taken to the mother, the nurse shall check the mother's and the neonate's identification bands, verify the sex of the neonate and verify that the information on the bands is identical.

E) The umbilical cord (cords, with multiple births) shall be identified according to hospital policy (e.g., by the use of a different number of clamps) so that umbilical cord blood specimens are correctly labeled. All umbilical cord blood samples shall be labeled correctly with an indication that these are a sample of the neonate's umbilical cord blood and not the blood of the mother.

F) The hospital shall develop a newborn infant security system. This system shall include instructions to the mother regarding safety precautions designed to avoid abduction. Electronic sensor devices may be included as well.

7) Within one hour after delivery, ophthalmic ointment or drops containing tetracycline or erythromycin shall be instilled into the eyes of the newborn infant as a preventive against ophthalmia neonatorum. The eyes shall not be irrigated.

8) A single parenteral dose of vitamin K-1, water soluble to 0.5-1.0 milligrams, shall be given to the infant, shortly after birth, but usually within the first hour after delivery, as a prophylaxis against hemorrhagic disorder in the first days of life.

9) Mandatory Hearing Screening

A) *Each* hospital *shall conduct bilateral hearing screening of each newborn infant prior to discharge unless medically contraindicated or the infant is transferred to another hospital before the hearing screening can be completed.* (Section 5(a) of the Early Hearing Detection and Intervention Act)

B) *The* hospital *performing the hearing screening shall report the results of the hearing screening to the Department within 7 days after screening.*

i) *If there is no hearing screening result or an infant does not pass the hearing screening in both ears at the same time, the* hospital *shall refer the infant's parents or guardians to a health care practitioner for follow-up, and document and report the referral, including the name of the health care practitioner, to the Department in a format determined by the Department.*

ii) *For infants born outside a* hospital, *the newborn's primary care provider shall refer the patient to a* hospital *for the hearing screening to be done in compliance with the Act* and this Section *within 30 days after birth, unless a different time period is medically indicated.* (Section 5(b) of the Early Hearing Detection and Intervention Act)

10) Each infant shall be given complete individual crib-side care. The use of a common bath table is prohibited. Scales shall be adequately protected to prevent cross-infection.

11) Artificial feedings and formula changes shall not be instituted except by written order of the attending physician, pursuant to the requirements of the Hospital Infant Feeding Act.

12) Facilities for drug services. See Section 250.2130(a).

13) Newborn infants shall be transported from the delivery room to the nursery in a safe manner. Adequate support systems (heating, oxygen, suction) shall be incorporated into the transport units for infants (e.g., to x-ray). Chilling of the newborn and cross-infection shall be avoided. If travel is excessive and through other areas, special transport incubators may be required. The method of transporting infants from the nursery to the mothers shall be individual, safe and free from cross-infection hazards.

14) The stay of the mother and the infant in the hospital after delivery shall be planned to allow the identification of problems and to reinforce instructions in preparation for the infant's care at home. The mother and infant shall be carefully observed for a sufficient period of time and assessed prior to discharge to ensure that their conditions are stable. Healthy infants shall be discharged from the hospital simultaneously with the mother, or to other persons authorized by the mother, if the mother remains in the hospital for an extended stay. Follow-up shall be provided for mothers and infants discharged within 48 hours after delivery, including a face-to-face encounter with a health care provider who will assess the condition of mother and infant and arrange for intervention if problems are identified.

15) When a patient's condition permits, an infant may be transferred from an intensive care nursery to the referring nursery or to another nursery that is nearest the home and at which an appropriate level of care may be provided. Transfers shall be conducted pursuant to the Regionalized Perinatal Health Care Code.

16) The hospital shall have a policy regarding circumcisions performed by a Mohel.

17) Circumcisions shall not be performed in the delivery room or within the first six hours after birth. A physician may order and perform a circumcision when the infant is over the age of six hours and, in the physician's professional judgment, is healthy and stable.

18) The hospital shall comply with the Guidelines for Perinatal Care and Guidelines for Women's Health Care (see Section 250.160).

h) Medical Records

1) Obstetric records:

A) Adequate, accurate, and complete medical records shall be maintained for each patient. The medical records shall include findings during the prenatal period, which shall be available in the obstetric department prior to the patient's admission and shall include medical and obstetric history, observations and proceedings during labor, delivery and the postpartum period, and laboratory and x-ray findings.

B) Records shall be maintained in accordance with hospital medical records policies and procedures, including the applicable requirements of the Health Insurance Portability and Accountability Act and the minimum observations and laboratory tests outlined in Guidelines for Perinatal Care and Guidelines for Women's Health Care. The physician director of the obstetric department shall require all physicians delivering obstetric care to send copies of the prenatal records, including laboratory reports, to the obstetric unit at or before 37 weeks of gestation, including updates from that time until admission.

2) Infant records. Accurate and complete medical records shall be maintained for each infant. The medical records shall include:

A) History of maternal health and prenatal course, including mother's HIV status, if known.

B) Description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of

placenta and amniotic fluid.

C) Time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room.

D) Report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining hospital stay.

E) Physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily.

F) Documentation of infant feeding: intake, content, and amount if by formula.

G) Clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3) The hospital shall keep a record of births that contains data sufficient to duplicate the birth certificate. The requirement may be met by:

A) Retaining the yellow "hospital copy" of the birth certificate properly bound in chronological order, or

B) Retaining this copy with the individual medical record.

i) Reports

1) Each hospital that provides obstetric and neonatal services shall submit a monthly perinatal activities report to its affiliated Administrative Perinatal Center.

2) Maternal death report

A) The hospital shall submit an immediate report of the occurrence of a maternal death to the Department, in accordance with the Department's Maternal Death Review rules (77 Ill. Adm. Code 657). Maternal death is the death of any woman dying of any

cause whatsoever while pregnant or within one year after termination of the pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it was terminated. A death shall be reported regardless of whether the death occurred in the obstetric department or any other section of the hospital, or whether the patient was delivered in the hospital where death occurred, or elsewhere.

B) The filing of this report shall in no way preclude the necessity of filing a death certificate or of including the death on the Perinatal Activities Report.

3) The hospital shall comply with the laws of the State and the rules of the Department in the preparation and filing of birth, death and fetal death certificates.

4) Epidemic and communicable disease reporting

A) The hospital shall develop a protocol for the management and reporting of infections consistent with the Control of Communicable Diseases Code, the Perinatal HIV Prevention Act, Guidelines for Perinatal Care and Guidelines for Women's Health Care, and as approved by the infection control committee. These policies shall be known to obstetric and nursery personnel.

B) The hospital shall particularly address those infections specifically related to mothers and infants, including but not limited to, methicillin-resistant Staphylococcus Aureus occurring in infants under 61 days of age, ophthalmia neonatorum, and perinatal hepatitis B infection.

j) Infant Feeding Policy

1) For the purposes of this subsection (j):

A) *Baby-Friendly Hospital Initiative means the voluntary program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) that recognizes hospitals that meet certain evaluation criteria regarding the promotion of breastfeeding.*

B) *Infant Nutrition Resource means breastfeeding education and infant formula safety and preparation.*

2) *Infant Feeding Policy Required*

A) *Every hospital that provides birthing services must adopt an infant feeding policy that promotes breastfeeding. In developing the policy, a hospital shall consider guidance provided by the Baby-Friendly Hospital Initiative*.

B) *An infant feeding policy adopted under* this Section *shall include guidance on the use of formula for medically necessary supplementation, if preferred by the mother, or when exclusive breastfeeding is contraindicated for the mother or for the infant*.

3) *Communication of Policy. A hospital shall routinely communicate the infant feeding policy to staff in the hospital's obstetric and neonatal areas, beginning with hospital staff orientation. The hospital shall also ensure that the policy and infant nutrition resources are posted in a conspicuous place in the hospital's obstetric or neonatal area or on the hospital's Internet or Intranet web site or on the Internet or Intranet web site of the health system of which the hospital is a part. The hospital shall make copies of the policy available to the Department upon request.*

4) *Application of Policy. A hospital's infant feeding policy adopted under* the Hospital Infant Feeding *Act must apply to all mother-infant couplets in the hospital's obstetric and neonatal areas*. (Sections 5 through 20 of the Hospital Infant Feeding Act)

k) Breast Milk and Formula

1) Pursuant to the requirements of subsection (j), the hospital shall provide the mother with information regarding lactation, the nutritional benefits of breast milk, and lactation support organizations within the area. The hospital staff shall include, at a minimum, lactation support staff with certification or experience in lactation training. The lactation support staff shall attend continuing education in relation to lactation counseling and training, consistent with hospital policy. At least one lactation support staff shall be on duty at all times in the obstetric department.

2) Pursuant to the requirements of subsection (j), the hospital shall have a policy for the preparation of formula by hospital staff when hospital-prepared formula is needed in place of commercially prepared formula. Adequate space, equipment and procedures for processing, handling and storing commercially-prepared formula shall be provided.

A) All hospitals providing obstetric or pediatric services that prepare their own formula shall provide a well-ventilated and well-lighted formula room, which shall be adequately supervised and used exclusively for the preparation of formulas.

B) Equipment shall include hand-washing facilities with hot and cold running water with knee, foot or elbow controlled valves; a double-section sink for washing and rinsing bottles; facilities for storing cleaning equipment, refrigeration facilities; utensils in good condition for preparation of formulas; cupboard and work space and a work table; an autoclave and a supply of individual formula bottles, nipples and protecting caps, adequate to prepare a 24-hour supply of formula and water for each infant. Procedures shall be established by the hospital and enforced.

3) *A hospital shall provide information and instructional materials to parents of each newborn, upon discharge from the hospital, regarding the option to voluntarily donate milk to non-profit milk banks that are accredited by the Human Milk Banking Association of North America or its successor organization.*

A) *The materials shall be provided free of charge and shall include general information regarding non-profit milk banking practices and contact information for area nonprofit milk banks that are accredited by the Human Milk Banking Association of North America.*

B) *The information and instructional materials described in* subsection (k)(3) *may be provided electronically.*

C) Hospitals may obtain *free and suitable information on voluntary milk donation from the Human Milk Banking Association of North America, or its successor organization, or its accredited members.* (Section 11.9 of the Act)

l) Visiting Policy

1) The visiting requirements set forth in Subpart B shall apply to obstetric departments, except as modified in this subsection (l).

2) Each obstetric department shall have a visiting policy that complies with the Guidelines for Perinatal Care and is approved by the hospital's

infection control committee.

3) The visiting policy shall cover all programs in the obstetric department.

4) The visiting policy shall comply with the hospital's infection control policy and shall include signage instructing visitors to wash their hands.

m) Infant Abduction Policies
Every hospital shall demonstrate to the Department that the following have been adopted:

1) *Procedures designed to reduce the likelihood that an infant patient will be abducted from the hospital. The procedures may include, but need not be limited to, architectural plans to control access to infant care areas, video camera observation of infant care areas, and procedures for identifying hospital staff and visitors.*

2) *Procedures designed to aid in identifying allegedly abducted infants who are recovered. The procedures may include, but need not be limited to, foot-printing infants by staff who have been trained in that procedure, photographing infants, and obtaining and retaining blood samples for genetic testing.* (Section 6.15 of the Act)

n) Staff Continuing Education Policies and Requirements.

1) Hospitals shall have a *written policy and conduct continuing education yearly* (calendar) *for providers and staff of obstetric medicine and of the emergency department and other staff that may care for pregnant or postpartum women. The written policy and continuing education shall include ~~yearly educational modules regarding~~management of severe maternal hypertension and obstetric hemorrhage, addressing airway emergencies experienced during childbirth, and management of other leading causes of maternal mortality for units that care for pregnant or postpartum women.*

2) Hospitals shall *demonstrate compliance* by annually submitting a copy of the facility's *written policy and~~,~~ education~~, and training~~ requirements* to the hospital's Administrative Perinatal Center. (Section 2310-222(b) of the Department of Public Health Powers and Duties Law)

o) Hospitals *shall incorporate best practices for timely identification and assessment of all pregnant and postpartum women for common pregnancy or postpartum complications in the emergency department and for care provided by the* hospital

throughout the pregnancy and postpartum period, to be *provided* to the hospital *by the Department, in consultation with the Illinois Perinatal Quality Collaborative, into the written policy* required in subsection (n). (Section 2310-222(d) of the Department of Public Health Powers and Duties Law)

(Source: Amended at 48 Ill. Reg. _____, effective _____)