CHAPTER 133 HOSPITAL LICENSING RULES 03/02/06 PROPOSAL REVISIONS

1. Rulemaking Process Timeline
October 5-6, 2006 Council Meeting
Last day to submit to Office of General Counsel is Friday, July 21, 2006
The attached Rulemaking Process Timeline has a 30 day comment period; however, due to the length of these rules, they will have a 60 day comment period. A public hearing will be scheduled and held during the comment period.

Rulemaking Process Timeline Oc...

2. Repeal existing rules. (**Nance Stearman, Marc Connelly agrees**)

3. The Texas Medical Board is working on rules related to physician reporting of Niche Hospital ownership. There is crossover between our two agencies in the hospital licensing rules; therefore this issue should be resolved prior to proposal of the hospital licensing rules. **(Kathy Perkins)**

niche BME rules.doc niche_hosp_owner_report.doc Ch199-Sec.5-Notice of Ownership of Niche

4. SUBCHAPTER A: GENERAL PROVISIONS
§133.2 Definitions
(6) Available--On the premises and sufficiently free of other duties to enable the individual to respond rapidly to an emergency situation.
Might consider changing to: "…enable the individual to rapidly perform hands-on care in an emergency situation."
Prevents the argument of, "I did respond rapidly by giving instructions on the phone." **(Carol Vetter, department agrees)**

04/18/06 stakeholder meeting:

- SUBCHAPTER A: GENERAL PROVISIONS

§133.2 Definitions
(6) Available--On the premises and able to rapidly perform hands-on care in an emergency situation.

- Search rules for the terms "available", "immediately available" and "on call" for accuracy. Since available referred to services, equipment, manuals, supplies, space, procedures, parking, access, list, records, reports and documentation, "When referring to on-site personnel" added.

5. Observation beds
A number of hospitals have been cited by the department for keeping outpatients in observation for longer than 24 hours. The Medicare Conditions of participation allow an outpatient to be kept in observation for a total time of 48 hours, and they deny payment to a hospital for those patients who have been admitted as inpatients and thereafter changed to observation status. The hospital licensing rules should be revised to allow an observation patient to be kept in an outpatient bed beyond the 24-hour outpatient maximum for an additional time period. **[Texas Hospital Association (THA)]**

THA recommended language:
SUBCHAPTER A: GENERAL PROVISIONS
§133.2 Definitions
(41) Outpatient--An individual who presents for diagnostic or treatment services for an intended length of stay of less than 24 hours; provided, however, that an individual who requires continued observation may be considered as an outpatient for a period of time not to exceed an additional 24 hours.

04/18/06 stakeholder meeting:
§133.2 Definitions

(41) Outpatient--An individual who presents for diagnostic or treatment services for an intended length of stay of less than 24 hours; provided, however, that an individual who requires continued observation may be considered as an outpatient for a period of time not to exceed a total of 48 hours.

6. Accredited hospitals are not routinely surveyed and do not comply with §133.21(c)(2). Non-accredited hospitals are routinely surveyed and do comply with §133.21(c)(2). If we retain this rule, we need to enforce it consistently. Or, should this rule be modified or deleted? **(Jane Guerrero)**
SUBCHAPTER B: HOSPITAL LICENSE
§133.21 General
(c) Scope of hospital license.
(2) A hospital license shall not include off-site outpatient facilities.

04/18/06 stakeholder meeting: Retain current rule language. Hospitals may have businesses, such as an imaging center or ambulatory surgical center that are not part of the licensed hospital.

7. Disclosure of ownership interest *(proposed sec's. 133.22 (a) (8); 133.23 (b) (1) (E) (i)-(v))*
The issue concerns whether the proposals meet the intent of recent ownership-disclosure legislation. The first provision relates to initial licensure, and would require an applicant for a hospital license to disclose the name and social security number of any individual who owns a 5 percent or greater interest in the hospital. Senate Bill 872 requires a physician to disclose any ownership interest in a niche hospital. House Bill 3357 requires an application for a hospital license to contain the name and social number of any individual who has an ownership interest of more than 25 percent in a corporate applicant.

The second provision (sec. 133.23 (b) (1) (E) (i)-(v)) relates to renewal licensure. It would track the disclosure provisions applicable to initial licensure, above, with the addition of a requirement that the hospital applicant disclose the name and license numbers of any physicians who have a financial interest either in the hospital or in any entity that has an ownership interest in the hospital. At the least, it seems that the additional physician-disclosure requirement in the renewal licensure provision should also be added to the initial licensure provision. **(THA)**

The department agrees to add to proposed rule 133.22(a)(8) new section (E) the names and license numbers of any physicians licensed by the Texas Medical Board who have a financial interest in the applicant or any entity which has an ownership interest in the applicant.

04/18/06 stakeholder meeting: Add definition of niche hospital as in SB 872. Use the exact language from HB 3357 and SB 872 in application and issuance of initial and renewal licenses.

8. §133.41(a) Anesthesia services. There are inconsistencies between the ambulatory surgical centers and hospital licensing rules in relation to nurses and anesthesia. This may be appropriate because the settings of these facilities are different, but the issue needs discussion with stakeholders. **(Kathy Perkins)**

04/18/06 stakeholder meeting: Add the language from the ambulatory surgical center rules as applicable.
06/16/06 THA comments: §133.41(a) Anesthesia services revised.

9. Administration of anesthesia by anesthesiology assistants *(§133.41 (a) (1)*
The question has been raised whether the rules should be revised specifically to address the administration of anesthesia by anesthesiology assistants. *See* proposed and current sec. 133.41 (a) (1). The Medicare conditions of participation allow anesthesiology assistants to administer anesthesia if they are under the supervision of an anesthesiologist who is immediately available if needed. *See* 42 C.F.R. § 482.52 (a) (5). **(THA)**

See:
http://www.tmb.state.tx.us/rules/guidelines/gfaa.php
http://www.tmb.state.tx.us/rules/guidelines/aasjd.doc

The department has drafted the following language:
SUBCHAPTER C: OPERATIONAL REQUIREMENTS
§133.41. Hospital Functions and Services.

(a) Anesthesia services.

(1) Organization and staffing.

(E) an anesthesiologist assistant.

(i) An anesthesiologist assistant shall be a graduate of a medical school-based anesthesiologist's assistant educational program that is accredited by the Committee on Allied Health Education and Accreditation, and includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

(ii) An anesthesiologist assistant shall maintain current certification by the National Commission for Certification of Anesthesiologist Assistants.

(iii) An anesthesiologist assistant shall maintain current certification in Advanced Cardiac Life Support.

(iv) If anesthesia is administered by an anesthesiologist assistant, the governing body shall adopt, implement and enforce policies concerning the granting of clinical privileges to anesthesiologist assistants, including policies relating to the application process, reasonable qualifications for privileges, and the process for renewal, modification, or revocation of privileges.

(v) An anesthesiologist assistant shall work under the direction of an anesthesiologist who holds a current unrestricted license to practice medicine in the state of Texas, is engaged full time in the medical specialty of anesthesiology, and is certified by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists in anesthesiology.

(vi) An anesthesiologist assistant shall administer anesthesia under the direct supervision of a qualified anesthesiologist. For general anesthesia, direct supervision means direct line of sight in the same room. For topical anesthesia, local anesthesia, regional anesthesia, minimal sedation, moderate sedation or analgesia, and deep sedation of analgesia, direct supervision means immediately available. Except under emergency circumstances, the supervising anesthesiologist shall not concurrently direct more that four anesthesia services or simultaneously supervise more than a combination of four certified registered nurse anesthetists, anesthesiologist assistants, or anesthesiology residents.

(vii) If anesthesia is administered by an anesthesiologist assistant, the supervising anesthesiologist shall inform patients that they will receive anesthesiology care in the team mode, which includes the use of anesthesiologist assistants, and that the physician may not be present in the operating room at all times but must be present in the operating suite. If the patient does not consent to anesthesia administered by an anesthesiologist assistant, anesthesia shall be administered by a qualified anesthesiologist, a physician other than an anesthesiologist, a dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law or a certified registered nurse anesthetist.

04/18/06 stakeholder meeting: Add anesthesiologist assistant (AA) to the list of those who may administer anesthesia. Use the Texas Medical Board guidelines in the rules. The anesthesiologists will object to the department's addition of the requirement for supervision of the anesthesiologist assistant by a qualified anesthesiologist to be direct line of sight in the same room for general anesthesia, as this will negate assigning an anesthesiologist assistant to administer general anesthesia. If the anesthesiologist must supervise by direct line of sight in the same room, they may as well administer the anesthesia themselves.
05/30/06 Texas Association of Nurse Anesthetists (TANA) letter received 05/30/06: Do not include AA in this rule revision.
06/09/06 Timothy Goodrich email: Do not require direct line of sight in the same room supervision for general anesthesia, and reword the option of refusing care from AAs to other members of the anesthesia care team.
06/16/06 THA comments: §133.41(a) Anesthesia services revised.
06/23/06 American Academy of Anesthesiologist Assistants comments: Do not require direct line of sight in the same room supervision for general anesthesia. Support THA revision.

10. (a) Administration of anesthesia services by a CRNA *(proposed sec's. 133.41 (a) (1) (D))*
The issue concerns the proposed rule's apparent conflict with the Medicare Conditions of Participation. The proposed rule allows a CRNA to administer anesthesia "in accordance with the Nursing Practice Act and the rules . . .". The Medicare conditions of participation require "the supervision of the operating practitioner or of an anesthesiologist who is immediately available. . .". *See* 42 C.F.R. § 482.52 (a) (4). The earlier departmental draft required supervision by the operating physician or anesthesiologist. The department's earlier language should be retained. **(THA)**

(b) I suggest a change in wording to make it clear that the anesthesia department is to be supervised by a physician, not the individual anesthesia service (similar to CNAP's comments on the ASC rules). We actually prefer the word "department" because that cannot be mistaken. However, based on wording in the Medicare CoPs and the wording in the remaining sections of the rules, the following would be acceptable and may avoid some of the confusion that exists.

(a) Anesthesia services. If the hospital furnishes anesthesia services, these services shall be provided in a well-organized manner. The anesthesia service shall be under the direction of a qualified physician and the**[. The anesthesia]** service is responsible for all anesthesia administered in the hospital.

I have no idea if the BNS suggested changing §133.41 (a) (1) (D) regarding the practice of CRNAs. Carol was the BNE staff member involved in our workgroup, and I do not know is she shared the draft with the same staff members who wrote the response to the ASC rules or not. If not, I assume that the staff will notice when these rules are proposed and will comment in a similar fashion as they did in Comment 3 in responding to the proposed ASC rules. Therefore it would seem reasonable to go ahead and change the language in paragraph (D) at the top of page 17 to be consistent with the language that will be included in the ASC rules.

(1) a certified registered nurse anesthetist practicing in accordance with the Nursing Practice Act and the rules and regulations promulgated by the Board of Nurse Examiners.

OR

(2) a certified registered nurse anesthetist practicing in accordance with the Nursing Practice Act and the rules and regulations promulgated by the Board of Nurse Examiners for the State of Texas, to whom the ordering of the drugs and devices necessary to administer an anesthetic or an anesthesia-related service has been delegated by the operating surgeon or an anesthesiologist. **(Lynda Woolbert)**

04/18/06 stakeholder meeting: Use Lynda Woolbert's (2) recommendation.
05/30/06 Lynda Woolbert email and TANA 05/05/06 letter received 05/30/06: change "an anesthesiologist" to "other physician".
06/16/06 THA comments: §133.41(a) Anesthesia services revised.

11. Responsibility of governing body *(proposed sec's. 133.41 (f) (4) (F); 133.22 (a))*
The issue concerns the scope of the governing body's responsibility to implement and enforce hospital policies and procedures, and the scope of the department's oversight of the board's responsibility. The first section would require the governing body to be responsible for ensuring that any policies and procedures it adopts are implemented and enforced. This would mean, for example, that a participating hospital's failure to follow a JCAHO standard (e.g., adoption of the National Patient Safety Goals) could be considered a violation of the hospital licensing rules – even though the rules contained no reference to the JCAHO standard. Similarly, the administrative penalty provisions of the rules [sec. 133.22 (a)] would be expanded to allow the department to assess an administrative penalty against a hospital for violating policies and procedures adopted by its governing body. Both provisions should be modified by adding the phrase "to implement the requirements of this chapter" after the phrase "governing body." This would narrow the scope of the responsibility and oversight to compliance with the hospital licensing rules alone. **(THA)**

The department disagrees. The governing body is responsible for the organization, management, control, and operation of the hospital. The hospital licensing rules are minimum standards. The governing body must be accountable for all services provided and policies and procedures adopted to provide these services.

04/18/06 stakeholder meeting: Accept THA's recommendation.

12. Search document to ensure all policies are required to be adopted, implemented and enforced. **(Nance Stearman)**
Example:
SUBCHAPTER C: OPERATIONAL REQUIREMENTS
§133.41 Hospital Functions and Services
(g) Infection control.
(1) Organization and policies.
(C) There shall be a written policy for reporting all reportable diseases to the local health authority or the Infectious Disease Epidemiology and Surveillance Division, Texas Department of Health, 1100 West 49th Street, Austin, TX 78756-3199, in accordance with Chapter 97 of this title (relating to Communicable Diseases).

04/18/06 stakeholder meeting: Accept recommendation.

13. Used infrequently at §133.41 (o) (3) (B) (iii) needs to be defined or deleted. **(Nance Stearman)**
SUBCHAPTER C: OPERATIONAL REQUIREMENTS
§133.41 Hospital Functions and Services
(o) Nursing services.
(3) Drugs and biologicals.
(B) All orders for drugs and biologicals shall be in writing and signed by the individual responsible for the care of the patient as specified under subsection (f)(6)(A) of this section. When telephone or oral orders must be used, they shall be:
(iii) used infrequently.

04/18/06 stakeholder meeting: This is the same language that is in the Medicare conditions of participation. Language in the licensing rules should be the same, if possible. This has not been a significant problem. Don't change current rule.

14. Timely manner is a non-enforceable term. Too vague. **(Carol Vetter)** Should be defined. **(Marc Connelly)**
SUBCHAPTER C: OPERATIONAL REQUIREMENTS
§133.41 Hospital Functions and Services
(r) Quality assessment and performance improvement **[assurance]**.
(3) **[(2)]** Medically-related patient care services.
(A) Discharge planning shall be initiated in a timely manner.

04/18/06 stakeholder meeting: Change to (A) Discharge planning shall be completed prior to discharge.

15. HB 1718 amended Subchapter B, Chapter 241, Health and Safety Code by adding Section 241.0262. The amendment specified that the licensed vocational nurses and surgical technologists assisting in circulatory duties shall be under the "direct" supervision of a qualified registered nurse "circulator". **(Nance Stearman)**

The department recommends the following language:
SUBCHAPTER C: OPERATIONAL REQUIREMENTS
§133.41 Hospital Functions and Services
(v) Surgical services.

(1) Organization and staffing.
(C) Circulating duties in the operating room shall be performed by qualified RNs. In accordance with approved medical staff policies and procedures, LVNs and surgical technologists may assist in circulatory duties under the direct supervision of a qualified RN circulator who is immediately available to respond to emergencies.

04/18/06 stakeholder meeting: Accept recommendation. Change "shall" to "must" as in bill.
06/16/06 THA comments: Deleted who is immediately available to respond to emergencies.

16. Transfer provisions *(proposed sec's. 133.44 (c) (4) (A) (ii) and §133.44 (c) (4) (B) (i)*
The issue whether the rules should prohibit non-RNs (such as physician assistants) from assessing a patient's condition, reporting it to a physician, and signing a verbal transfer order from a physician (sec. 133.44 (c) (6) (C)). Prohibiting other qualified medical personnel such as physician assistants from assessing a patient, discussing the assessment with a physician and signing a transfer order could be particularly onerous in rural hospitals and other areas with manpower shortages. These provisions should be revised to allow appropriately trained medical personnel to provide assessment, reporting and transfer as long as the actions are within the scope of their licensure. **(THA, the department agrees to change a registered nurse to hospital staff member)**

04/18/06 stakeholder meeting: Change RNs to RNs, PAs or other qualified medical personnel as established by the governing body.

17. Transfer provisions *(proposed sec 133.44 (c) (6) (C)*
The issue is whether transfers should occur only for medical reasons (sec. 133.44 (c) (4)). The current rules allow for transfers based on reasons other than medical ones (such as those transfers based in contract or those based on certain statutory requirements). The proposed rule would prohibit any transfer except one based on medical reasons. The exceptions should be replaced in the rule**. (THA)**

The department disagrees. This paragraph is special requirements related to the transfer of patients who have emergency medical conditions. The paragraph containing requirements for transfer of patients who do not have emergency medical conditions has been deleted. All of that language has been moved to §133.44(b). The proposed rule does not prohibit any transfer except one based on medical reasons.

04/18/06 stakeholder meeting: Marc Allen Connelly will review and email Nance Stearman with outcome.
06/16/06 THA comments: Agree. Phrase added.

18. The hospital licensing law requires the rules to "provide that patient transfers between hospitals be accomplished through policies that result in medically appropriate transfers from physician to physician and from hospital to hospital . . ." (emphasis added). This language seems to require the direct involvement of a transferring physician. **THA** recommends that the existing phrase "and transferring physician" be retained in draft §133.44 (c) (6) (D).

04/18/06 stakeholder meeting: Accept recommendation.

19. I thought we were using the terms "substantiated" and "not substantiated," and not "validated." **(Carol Vetter, the department agrees)**
Subchapter F. Inspection and Investigation Procedures.
§133.101. Inspection and Investigation Procedures.
(b) Complaint investigations.
(5) Following the investigation of a complaint, the department shall notify the complainant if the complaint was ~~validated~~ substantiated and if regulatory violations were identified.

04/18/06 stakeholder meeting: Accept recommendation. Also changed at §133.41(o)(2)(I)(i)(II)(-c-).

20. Subchapter G. Enforcement.
§133.121. Enforcement Action.
We had worked on 25 TAC: 134 rules for about 3 years and the goal was that 133 would be modeled after 134. **(Carol Vetter, the department agrees)**

04/18/06 stakeholder meeting: Accept recommendation.

21. Adequate beds in the emergency department *(proposed sec's §133.161 (f) and §133.163 (f)*
Members have raised concerns whether certain general hospitals have adequate facilities to address emergency care. The suggestion has been made that the department consider requiring a general hospital to have a certain number of beds in the emergency department in relation to the bed size of the hospital. THA has not yet adopted a formal position on this issue; the Policy Committee on EMS and Trauma will consider the issue at its next meeting. **(THA)**

04/18/06 stakeholder meeting: THA will provide input on this.
06/16/06 THA comments: The department is requesting THA to conduct a survey of all licensed hospitals to determine the fiscal impact of the new provision, so this can be discussed prior to adding the new provision to the rules. Department will conduct the survey. Rule added.
07/21/06: Rule deleted.

22. Spatial and equipment requirements for various suites
The issue concerns whether the proposed new spatial and equipment requirements for the following suites will impose additional costs for new construction or renovation. **(THA)**
Gerard Van de Werken response:
The requirements are only for new or renovations. Submittal of plans have already reflected the increases by the hospitals themselves wanting the larger foot prints. Work group members from hospitals did not see a problem with the increases.

Significant revisions of current rules regarding suites:
- Emergency suite (sec. 133.163 (f) – starting pg. 111) and holding or observation room/area (sec. 133.163(f)(1)(B) – starting pg. 114)

Gerard Van de Werken response:
This is "when language". This is the rule when the hospital provides that service. It is NOT a requirement. Since 1998 rule set more and more hospitals are providing this service.
- Employees suite (sec. 133.163 (g) – starting pg. 120)

Gerard Van de Werken response:
The work group felt that this is a requirement so general staff have a place to change and store valuables and to have an opportunity to clean-up and change if necessary. The AIA guidelines required the employee suite and the 1985 HLS required as well but the language in the 1998 changed slightly. The new language is readdressing the requirement.
- Nursing unit (sec. 133.163 (s) – starting pg. 146)

Gerard Van de Werken response:
Spatial requirements increase mirrors the AIA guidelines and JCAHO has adopted the guidelines as their criteria. HLR and AIA guidelines in most cases mirror the special requirements since 1985.

- Obstetrical suite – neonatal critical care unit (NCCU) (sec. 133.163 (t) (1) (O) – starting pg. 158)

Gerard Van de Werken response:
Spatial requirements increase mirrors the AIA guidelines and JCAHO has adopted the guidelines as their criteria. HLR and AIA guidelines in most cases mirror the special requirements since 1985.

- Obstetrical suite – service areas – triage room (sec. 133.163 (t) (1) (Q) (xxi) – starting pg. 163)

Gerard Van de Werken response:
This is "when language". This is the rule when the hospital provides that service. It is NOT a requirement. Since 1998 rule set more and more hospitals are providing this service.

- Outpatient suite (sec. 133.163 (u) – starting pg. 166)

Gerard Van de Werken response:
Language has changed primarily so that outpatient service can be provided through out the hospital instead of one indefinable location, otherwise criteria stayed the same. A lot of again "when provided language".

- Outpatient suite – multiple-bed holding/observation room/area (sec. 133.163 (u) (1) (C) (5) – pg. 168)

Gerard Van de Werken response:
This is "when language". This is the rule when the hospital provides this service. It is NOT a requirement. Since 1998 rule set more and more hospitals are providing this service. Criteria of spatial requirement had to be established. This is a minimum square foot area and holds true with other similar requirements throughout the hospital licensing rules.

- Outpatient suite – multiple-bed/gurney preoperative/recovery patient station (sec. 133.163 (u) (1) (F) – starting pg. 169)

Gerard Van de Werken response:
This is "when language". This is the rule when the hospital provides this service. It is NOT a requirement. Since 1998 rule set more and more hospitals are providing this service. Criteria of spatial requirement had to be established. This is a minimum square foot area and holds true with other similar requirements throughout the hospital licensing rules.

- Special procedure suite (sec. 133.163 (cc) – starting pg. 188)

Gerard Van de Werken response:
Again when a hospital provides a special procedure suite it has to be defined. Actually the spatial requirements have been reduced in some procedural rooms. Spatial requirements increase mirrors the AIA guidelines and JCAHO has adopted the guidelines as their criteria. HLR and AIA guidelines in most cases mirror the spatial requirements since 1985.

<u>Rules proposed to regulate new types of suites:</u>

- Intermediate care suite (sec. 133.163 (ee) – starting pg. 204)

Gerard Van de Werken response:
This is "when language". This is the rule when the hospital provides that service. It is NOT a requirement. Since 1998 rule set more and more hospitals are providing this service.

- Universal care suite (sec. 133.163 (ff) – starting pg. 208)

Gerard Van de Werken response:
This is "when language". This is the rule when the hospital provides that service. It is NOT a requirement. Since 1998 rule set more and more hospitals are providing this service.

04/18/06 stakeholder meeting: Maintain proposed rules. Reorder suites in alpha.

23. Working through the many challenges of Hurricane Rita also brought up issues that should be addressed in the hospital licensing rules, such as emergency power and supplies. However, these issues are complicated and need stakeholder discussion. **(Kathy Perkins)**

DISASTER PREPAREDNESS

1) add requirement to submit emergency contact name and phone number
2) add definition for EMSystem
3) add requirement to use and update EMSystem
4) add requirement for a generator large enough to heat and cool the hospital onsite or available by secondary source within 24 hours.
5) increase fuel requirement from 24 hours to 36 hours

1) Subchapter B: Hospital License
§133.21 General.
(g) Changes which affect the license.
(2) A hospital shall notify the department in writing at the time of the occurrence of any of the following:
<u>(D) change in the emergency contact name and phone number.</u>

The application will be modified to include this item.

2), 3) and 4) §133.45 Miscellaneous Policies and Protocols.
(c) Disaster preparedness.
(1) Policy. A hospital shall adopt, implement, and enforce a written policy for **[publicly known natural]** disaster preparedness for the reception, treatment, and disposition of casualties. The written policy shall:
(D) include the requirement to use the EMSystem and update bed availability as required.
(E) include the requirement to have a generator that is large enough to heat and cool the hospital onsite or available by secondary source within 24 hours.
(2) EMSystem.
(A) Definition. The EMSystem is a database that combines realtime communication of bed availability with the ability to analyze trends and efficiently manage hospital resources.
(B) Bed availability updates shall be performed in the EMSystem:
(i) routinely every 24 hours; and
(ii) immediately prior to declaring diversion or closed to emergency management services (EMS) status for any of the medical care capabilities the hospital advertises to the public as being available; and
(iii) every two hours while on diversion or closed to EMS status for any of the medical care capabilities the hospital advertises to the public as being available; and
(iv) as requested by the department during a public health emergency or state declared disaster.
(3) Generator. In the event of loss of power the hospital shall have a generator that is large enough to heat and cool the facility onsite or available by secondary source within 24 hours.

5) §133.162 New Construction Requirements.
(d) Building design and construction requirements.
(5) General electrical requirements.
(M) Emergency electric service. A Type I essential electrical system shall be provided in each hospital in accordance with requirements of NFPA 99; NFPA 101, and National Fire Protection Association 110, Standard for Emergency and Standby Power Systems, 2002 **[1999]** edition.

(i) When the emergency and standby power systems require a fuel source with tank, the fuel storage capacity tank shall have enough fuel for a period of 36 hours.

04/18/06 stakeholder meeting: The department needs to research other software packages to use rather than the EMSystem. The generator and fuel requirements will be very expensive.
05/30/06: Per Kathy Perkins, include the rule changes for notification of a change in the emergency contact and use of the EMSystem, but don't include the rule changes for a generator or fuel.

24. Matt Wall, THA, will email Nance Stearman with recommended language for exception to §133.41(e)(2)(B), §133.41(e)(2)(C) and §133.163(f).

06/16/06 THA comments: Agree. Phrase added.

RECOMMENDATIONS MADE AFTER 04/18/106 STAKEHOLDER MEETING

1. I have a suggestion for hospital licensing rules for renal disease services. There are acute care hospitals that provide inpatient dialysis services to their patients. As you well know, there are no rules that address any part of dialysis procedures in the current hospital rules. It would be a positive step to add rules for water treatment and dialysis equipment in the hospital setting. I don't think we would need to start from scratch. The water treatment and equipment rules in the outpatient dialysis setting (ESRD) could be adapted. (117.32 – 117.33) Another concern with the hospital dialysis patients includes the prevention of Hepatitis B. Again, the applicable sections of the ESRD rules (117.34 (d)(2)) could be adapted. **(Martha Elliott and internal stakeholders agree)**