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OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 76

SPECIAL HEALTH CARE FACILITIES

Ambulatory Surgical Centers ASC

333-076-0101
Definitions
As used in OAR chapter 333, division 76 unless the context requires otherwise, the following definitions apply:
(1) "Ambulatory Surgical Center" (ASC) means:
(a) A facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.
(b) Ambulatory surgical center does not mean:
(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or
(B) A portion of a licensed hospital designated for outpatient surgical treatment.
(2) "Authentication" means verification that an entry in the patient medical record is genuine.
(3) "~~"~~CMS"~~"~~ means Centers for Medicare and Medicaid Services.
(4) "~~"~~Certified ambulatory surgical center"~~"~~ means a facility that is licensed by the Division and is deemed as meeting the Medicare Conditions of Participation for ambulatory surgical services, 42 CFR 416, Subpart C.
(5) "Certified Nurse Anesthetist" (CRNA) means a registered nurse certified by the Council on Certification of Nurse Anesthetists and licensed by the Oregon State Board of Nursing (OSBN).
(6) "Certified Nursing Assistant" (CNA) means a person who is certified by the Oregon State Board of Nursing (OSBN) to assist licensed nursing personnel in the provision of nursing care.
(7~~6~~) "~~"~~Conditions of Participation"~~"~~ mean the applicable federal regulations that ASCs are required to comply with in order to participate in the federal Medicare and Medicaid programs.
(8~~7~~) "~~"~~Conscious sedation"~~"~~ means an induced controlled state of minimally depressed consciousness in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.
(9~~8~~) "~~"~~Deemed"~~"~~ means a health care facility that has been inspected by an approved accrediting organization and has been approved by the CMS as meeting CMS Conditions of Participation.
(10~~9~~) "~~"~~Deep sedation"~~"~~ means an induced controlled state of depressed consciousness in which the patient experiences a partial loss of protective reflexes, as evidenced by the inability to

respond purposefully either to physical stimulation or to verbal command but the patient retains the ability to independently and continuously maintain an airway.
(110) "“Direct ownership"” has the meaning given the term ‘ownership interest’ in 42 CFR 420.201.
(121) "Division" means the Public Health Division of the Oregon Health Authority.
(132) "“Financial interest"” means a five percent or greater direct or indirect ownership interest.
(143) "“General anesthesia"” means an induced controlled state of unconsciousness in which the patient experiences complete loss of protective reflexes, as evidenced by the inability to independently maintain an airway, the inability to respond purposefully to physical stimulation, or the inability to respond purposefully to verbal command.
(154) "Governing body" means the body or person legally responsible for the direction and control of the operation of the facility.
(165) "Health Care Facility" (HCF) has the meaning given the term in ORS 442.015.
(176) "Health Care Facility Licensing Law" means ORS 441.015-441.990 and rules thereunder.
(187) "“High complexity non-certified”" means a facility that is licensed by the Division, is not deemed as meeting the Medicare Conditions of Participation for ambulatory surgical services, 42 CFR 416, Subpart C, and performs surgical procedures involving deep sedation or general anesthesia.
(198) "Hospital" has the meaning given that term in ORS 442.015.
(2019) "“Indirect ownership"” has the meaning given the term ‘indirect ownership interest’ in 42 CFR 420.201.
(210) "Licensed" means that the person or facility to whom the term is applied is currently licensed, certified or registered by the proper authority to follow his or her profession or vocation within the State of Oregon, and when applied to a health care facility means that the facility is currently and has been duly and regularly licensed by the Division.
(221) "Licensed Nurse" means a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).
(232) "Licensed Practical Nurse" (LPN) means a person licensed under ORS chapter 678 to practice practical nursing.
(243) "“Local anesthesia"” means the administration of an agent that produces a transient and reversible loss of sensation in a circumscribed portion of the body.
(254) "“Moderate complexity non-certified"” means a facility licensed by the Division, is not deemed as meeting the Medicare Conditions of Participation for ambulatory surgical services, 42 CFR 416, Subpart C, and performs procedures requiring not more than conscious sedation.
(265) "New construction" means a new building or an addition to an existing building.
(276) "NFPA" means National Fire Protection Association.
(287) "Nursing staffAssistant" means a person certified as meeting the educational requirements established by the Oregon State Board of Nursing (OSBN) as a licensed nurse (RN), licensed practical nurse (LPN) or nursing assistant (CNA). Responsibilities shall be limited to functions included in a course curricula approved by OSBN.
(298) "Patient audit" means review of the medical record and/or physical inspection of a patient.
(3029) "Person" means an individual, a trust or estate, or a partnership or corporation (including associations, joint stock companies and insurance companies, a state or a political subdivision or instrumentality including a municipal corporation).

(310) "Physician" means a person licensed under ORS chapter 677 to practice medicine by the Oregon Medical Board.
(321) "Podiatrist" means a person licensed under ORS chapter 677 to practice podiatry.
(332) "Podiatry" means the diagnosis or the medical, physical or surgical treatment of ailments of the human foot, except treatment involving the use of a general or spinal anesthetic unless the treatment is performed in a hospital certified in the manner described in subsection (2) of ORS 441.055 and is under the supervision of or in collaboration with a physician licensed to practice medicine by the Oregon Medical Board. "Podiatry" does not include the administration of general or spinal anesthetics or the amputation of the foot.
(343) "Registered Nurse" (RN) means a person licensed as a Registered Nurse under ORS chapter 678.
Stat. Auth.: ORS 441.025 & 441.057
Stats. Implemented: ORS 441.015-ORS 441.065, 441.020, 441.025, 441.057, 441.098, & 442.015

333-076-0135
Nursing Services
(1) An RN shall be responsible for the nursing care provided to the patients.
(2) The number and types of nursing personnel, including RNs, LPNs, and CNAs nursing and surgical technologistsassistants shall be based on the needs of the patients and the types of services performed.
(3) At least one RN and one other nursing staff member shall be on duty at all times patients are present.
(4)(a) For purposes of this rule, "circulating nurse" means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of operating room team members during surgery.
(b) The duties of a circulating nurse performed in an operating room of a certified or high complexity non-certified ambulatory surgical center shall be performed by a registered nurse licensed under ORS 678.010-678.410.
(c) In any case requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient or procedure.
(d) Nothing in this rule precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.
(45) Nurses who supervise the recovery area shall have current training in resuscitation techniques and other emergency procedures.
Stat. Auth.: ORS 441.025 & 441.057
Stats. Implemented: ORS 441.025, 441.057, 441.162, & 678.362

333-076-0137
Surgery Services

(1) For purposes of this rule:
(a) "Circulating nurse" means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of the operating room team members during surgery.
(b) "Rural or medically underserved community" means a geographic area of Oregon that is 10 or more miles from the geographic center of a population center of 40,000 or more individuals.
(c) "Surgical technology" means intraoperative surgical patient care that involves:
(A) Preparing an operating room for surgical procedures by ensuring that surgical equipment is functioning properly and safely;
(B) Preparing an operating room and the sterile field for surgical procedures by preparing sterile supplies, instruments and equipment using sterile techniques;
(C) Anticipating the needs of a surgical team based on knowledge of human anatomy and pathophysiology and how those fields relate to the surgical patient and the patient's surgical procedure; and
(D) Performing tasks as directed in an operating room, including:
(i) Passing instruments, equipment or supplies;
(ii) Sponging or suctioning of an operative site;
(iii) Preparing and cutting suture material;
(iv) Transferring fluids or drugs;
(v) Handling specimens;
(vi) Holding retractors and other equipment;
(vii) Applying electrocautery to clamps on bleeders;
(viii) Connecting drains to suction apparatus;
(ix) Applying dressings to closed wounds; and
(x) Assisting in counting supplies and instruments, including sponges and needles.
(2) An ASC, regardless of classification, shall comply with this rule.
(3) An ASC shall have operating rooms that conform to the applicable requirements in OAR 333-076-0185.
(4) An ASC's operating rooms must be supervised by an experienced registered nurse or doctor of medicine or osteopathy.
(5) The duties of a circulating nurse performed in an operating room of an ASC shall be performed by a registered nurse licensed under ORS 678.010 through 678.410. In all cases requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient or procedure.
(6) Nothing in section (5) precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.
(7) In order for a person to practice surgical technology at an ASC, the ASC governing body shall ensure that the following provisions are met by the individual:
(a) Documentation showing that the person has completed a training program for surgical technologists in a branch of the armed forces of the United States or in the United States Public Health Service Commissioned Corp and completes 16 hours of continuing education as described in section (11) of this rule every two years; or

(b) Completion of a surgical technology education program accredited by the Commission on Accreditation of Allied Health Education Program (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES) and certification as a surgical technologist issued by the National Board of Surgical Technology and Surgical Assisting (NBSTSA); or
(c) Documentation that a person has practiced surgical technology at least two years between January 1, 2014 and January 1, 2017 in a hospital, ambulatory surgical center or as an employee of a federal government agency or institution and completes 16 hours of continuing education as described in section (11) of this rule every two years.
(8) Notwithstanding subsection (7)(b), an ASC may allow a person who is not certified by the NBSTSA to practice surgical technology at the hospital for 12 months after the person completes an educational program accredited by the CAAHEP or ABHES.
(9) An ASC located in a rural or medically underserved community may allow a person to practice surgical technology at the ASC who does not meet the requirements specified in section (7) of this rule while the person is attending an educational program accredited by the CAAHEP or ABHES. Such persons are exempt from these educational requirements for three years from the date on which the person began practicing at the ASC.
(10) These rules do not prohibit a licensed practitioner from performing surgical technology if the practitioner is acting within the scope of the practitioner's license and an ASC allows the practitioner to perform such duties.
(11)(a) The continuing education requirements described in subsections (7)(a) and (7)(c) shall:
(A) Consist of 16 hours every two years;
(B) Be tracked by the surgical technologist and is subject to audit by the ASC in which the person is practicing; and
(C) Be relevant to the medical-surgical practice of surgical technology.
(b) Continuing education may include but is not limited to:
(A) Continuing education credits approved by the Association for Surgical Technologist;
(B) Healthcare sponsored conferences, forums, seminars, symposiums or workshops;
(C) Online distance learning courses;
(D) Live lectures at national conferences; or
(E) College courses.
(12) An ASC shall conduct a random audit of a representative sample of the surgical technologists employed by the ASC every two years to verify compliance with educational requirements.
Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.025, 678.362 & OL 2015, ch. 373

~~**HOSPITALS, GENERALLY**~~

DIVISION 500

HOSPITAL DEFINITIONS, APPLICATION AND RENEWAL PROCEDURES, FEES, FACILITY CLOSURE

333-500-0045
Submission of Plans

(1) A hospital proposing to make alterations or additions to an existing facility or to construct a new facility shall, before commencing such alteration, addition or new construction, submit plans and specifications to the Division for preliminary inspection and approval or recommendations with respect to compliance with Division rules and compliance with National Fire Protection Association standards when the facility is also to be Medicare or Medicaid certified.
(2) Submissions shall comply with OAR chapter 333, division 675. Plans should also be submitted to the local building division having authority for review and approval in accordance with state building codes.
Stat. Auth.: ORS 441.025, ORS 441.060
Stats. Implemented: ORS 441.025, ORS 441.060

DIVISION 505

HOSPITAL ORGANIZATION AND MANAGEMENT

333-505-0005
Governing Body Responsibility
(1) In a multi-hospital system, one governing body may oversee multiple hospitals.
(2) The governing body of a hospital shall be responsible for the operation of the hospital, the selection of the medical staff and the quality of care rendered in the hospital. The governing body shall ensure that:
(a) All health care personnel for whom a state license or registration is required are currently licensed or registered;
(b) Qualified individuals allowed to practice in the hospital are credentialed and granted privileges consistent with their individual training, experience and other qualifications;
(c) Procedures for granting, restricting and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law;
(d) It has an organized medical staff responsible for reviewing the professional practices of the hospital for the purpose of reducing morbidity and mortality and for the improvement of patient care;
(e) A physician is not denied medical staff privileges at the facility solely on the basis that the physician holds medical staff membership or privileges at another health care facility;
(f) Licensed podiatric physicians and surgeons are permitted to use the hospital in accordance with ORS 441.063;
(g) All hospital employees and health care practitioners granted hospital privileges have been tested for tuberculosis in compliance with OAR 333-505-0080; and
(h) A notice, in a form specified by the Division, summarizing the provisions of ORS 441.162, 441.166, 441.168, 441.174, 441.176, 441.178, 441.192 is posted in a place where notices to employees and applicants are customarily displayed.
(3) A hospital may grant privileges to nurse practitioners in accordance with ORS 441.064 and subject to hospital rules governing credentialing~~admissions~~ and staff privileges.
(a) Privileges granted to nurse midwife nurse practitioners, if any, must be consistent with privileges granted to other medical staff and include:
(A) Admitting privileges that do not require a nurse midwife nurse practitioner to co-admit a patient with a physician who is a member of the medical staff; and

(B) Voting rights.
(b) A~~The~~ hospital may refuse to grant privileges to nurse practitioners only upon the same basis that privileges are refused to other licensed health care practitioners.
(4) A hospital shall require that every patient admitted shall be and remain under the care of a member of the medical staff as specified under the medical staff by-laws.
Stat. Auth: ORS 441.025
Stats. Implemented: ORS 441.055 and 441.064

333-505-0007
Health Care Practitioner ~~Physician~~ Credentialing~~, Hospitals, Health Care Service Contractors~~
Each hospital shall comply with the ~~and~~ health care practitioner and telemedicine provider ~~service contractor shall use the Oregon Practitioner c~~Credentialing requirements~~Application and the Oregon Practitioner Recredentialing Application adopted pursuant to ORS 442.805 and~~ in accordance with OAR chapter 409, division 045~~-0000~~.
Stat. Auth.: ORS 441.056 ~~442.807~~
Stats. Implemented: ORS 441.056 & ORS 441.222~~442.805~~

333-505-0030
Organization, Hospital Policies
(1) As used in this rule, "lay caregiver" means:
(a) In paragraph (4)(b)(A), an individual who, at the request of a patient, agrees to provide aftercare to the patient in the patient's residence.
(b) In paragraph (4)(b)(B), which applies to patients that are hospitalized for mental health treatment:
(A) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient;
(B) For a patient who is 14 years of age or older, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675.
(2~~1~~) A hospital's internal organization shall be structured to include appropriate departments and services consistent with the needs of its defined community.
(3~~2~~) A hospital shall adopt and maintain clearly written definitions of its organization, authority, responsibility and relationships.
(4~~3~~) A hospital shall adopt, maintain and follow written patient care policies that include but are not limited to:
(a) Admission and~~,~~ transfer ~~and discharge~~ policies that address:
(A) Types of clinical conditions not acceptable for admission;
(B) Constraints imposed by limitations of services, physical facilities or staff coverage;
(C) Emergency admissions;
(D) Requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; such policies and procedures shall address informed consent of minors in accordance with provisions in ORS 109.610, 109.640, 109.670, and 109.675;
(E) Requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures and ensuring that the information provided is accurate and documented appropriately in accordance with these rules and ORS 441.098; and
(F) A process for the internal transfer of patients from one level or type of care to another.~~;~~

(bG) Discharge and termination of services policies that address:; and
(AH) For patients who identify a lay caregiver to provide aftercare, development of a discharge pPlannning for continuity of patient care following discharge including but not limited to.:
(i) Assessment of the patient's ability for self-care;
(ii) Opportunity for both the patient and lay caregiver to participate in discharge planning;
(iii) Instructions or training provided to the patient and lay caregiver, prior to discharge, for the lay caregiver to provide assistance with activities of daily living, medical or nursing tasks such as wound care, administering medications, or the operation of medical equipment, or other assistance relating to the patient's condition; and
(iv) Notification of the lay caregiver that patient is being discharged or transferred.
(B) For patients hospitalized for mental health treatment, requirements that the hospital:
(i) Encourage the patient to sign an authorization form allowing for the disclosure of information that is necessary for a lay caregiver to participate in the patient's discharge planning and to provide appropriate support measures to the patient;
(ii) Assess the patient's risk of suicide with input from the patient's lay caregiver, if applicable;
(iii) Assess the long-term needs of the patient which include but are not limited to:
(I) Community-based services;
(II) Capacity for self-care; and
(III) Appropriate patient care where patient resided at time of admission;
(iv) Develop a process to coordinate the patient's care and transition the patient to outpatient treatment that may include community-based providers, peer support, lay caregivers or other individuals who can implement the patient's care plan; and
(v) Schedule a follow-up appointment for no later than seven days after discharge. If a follow-up appointment cannot be scheduled within seven days, the hospital must document why.
(cb) Patient rights;
(dc) Housekeeping;
(ed) All patient care services provided by the hospital;
(fe) Maintenance of the hospital's physical plant, equipment used in patient care and patient environment; and
(gf) Treatment or referral of acute sexual assault patients in accordance with ORS 147.403;. and
(h) Identification of patients who could benefit from palliative care in order to provide information and facilitate access to appropriate palliative care in accordance with Oregon Laws 2015, chapter 789.
(5) Discharge policies developed in accordance with paragraph (3)(b)(A) of this rule must be publically available and:
(a) Must specify requirements for documenting who is designated by the patient as the lay caregiver and details of the discharge plan;
(b) May incorporate established evidence based practices;
(c) Must ensure that discharge planning is appropriate to the needs and acuity of the patient and the abilities of the lay caregiver;
(d) Must not delay a patient's discharge or transfer to another facility; and
(e) Must not require the disclosure of protected health information without obtaining a patient's consent as required by state and federal laws.
(64) In addition to the policies described in section (3) of this rule, a hospital shall, in accordance with the Patient Self-Determination Act, 42 CFR 489.102, adopt policies and procedures that

require (applicable to all capable individuals 18 years of age or older who are receiving health care in the hospital):
(a) Providing to each adult patient, including emancipated minors, not later than five days after an individual is admitted as an inpatient, but in any event before discharge, the following in written form, without recommendation:
(A) Information on the rights of the individual under Oregon law to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care;
(B) Information on the policies of the hospital with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;
(C) A copy of the directive form set forth in ORS 127.531, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form."; and
(D) The name of a person who can provide additional information concerning the forms for directives.
(b) Documenting in a prominent place in the individual's medical record whether the individual has executed a directive.
(c) Compliance with Oregon law relating to directives for health care.
(d) Educating the staff and the community on issues relating to directives.
(7~~5~~) A hospital's transfer agreements or contracts shall clearly delineate the responsibilities of parties involved.
(8~~6~~) Patient care policies shall be evaluated triennially and rewritten as needed, and presented to the governing body or a designated administrative body for approval triennially. Documentation of the evaluation is required.
(9~~7~~) A hospital shall have a system, described in writing, for the periodic evaluation of programs and services, including contracted services.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 147.025, ~~&~~ 441.025 & OL 2015 ch. 263, OL 2015 ch. 466, and OL 2015 ch. 789

333-505-0050
Medical Records
(1) A medical record shall be maintained for every patient admitted for care in a hospital.
(2) A legible reproducible medical record shall include, but is not limited to (as applicable):
(a) Admitting identification data including date of admission.
(b) Chief complaint.
(c) Pertinent family and personal history.
(d) Medical history, physical examination report and provisional diagnosis as required by OAR 333-510-0010.
(e) Admission notes outlining information crucial to patient care.
(f) All patient admission, treatment, and discharge orders.
(A) All patient orders shall be initiated, dated, timed and authenticated by a licensed health care practitioner in accordance with section (7) of this rule.
(B) Documentation of verbal orders shall include:
(i) The date and time the order was received;

(ii) The name and title of the health care practitioner who gave the order; and
(iii) Authentication by the authorized individual who accepted the order, including the individual's title.
(C) Verbal orders shall be dated, timed, and authenticated promptly by the ordering health care practitioner or another health care practitioner who is responsible for the care of the patient.
(D) For purposes of this rule, a verbal order includes but is not limited to an order given over the telephone.
(g) Clinical laboratory reports as well as reports on any special examinations. (The original report shall be recorded in the patient's medical record.)
(h) X-ray reports bearing the identification of the originator of the interpretation.
(i) Consultation reports when such services have been obtained.
(j) Records of assessment and intervention, including graphic charts and medication records and appropriate personnel notes.
(k) Discharge planning documentation in accordance with OAR 333-505-0030(5)(a).
(~~lk~~) Discharge summary including final diagnosis.
~~(l) Discharge order.~~
(m) Autopsy report if applicable.
(n) Such signed documents as may be required by law.
(o) Informed consent forms that document:
(A) The name of the hospital where the procedure or treatment was undertaken;
(B) The specific procedure or treatment for which consent was given;
(C) The name of the health care practitioner performing the procedure or administering the treatment;
(D) That the procedure or treatment, including the anticipated benefits, material risks, and alternatives was explained to the patient or the patient's representative or why it would have been materially detrimental to the patient to do so, giving due consideration to the appropriate standards of practice of reasonable health care practitioners in the same or a similar community under the same or similar circumstances;
(E) The manner in which care will be provided in the event that complications occur that require health services beyond what the hospital has the capability to provide;
(F) The signature of the patient or the patient's legal representative; and
(G) The date and time the informed consent was signed by the patient or the patient's legal representative.
(p) Documentation of the disclosures required in ORS 441.098.
(3) A medical record of a surgical patient shall include, in addition to other record requirements, but is not limited to:
(a) Preoperative history, physical examination and diagnosis documented prior to operation.
(b) Anesthesia record including preanesthesia assessment and plan for anesthesia, records of anesthesia, analgesia and medications given in the course of the operation and postanesthetic condition.
(c) A record of operation dictated or written immediately following surgery and including a complete description of the operation procedures and findings, postoperative diagnostic impression, and a description of the tissues and appliances, if any, removed. When the dictated operative report is not placed in the medical record immediately after surgery, an operative progress note shall be entered in the medical record after surgery to provide pertinent information for any individual required to provide care to the patient.

(d) Postanesthesia recovery progress notes.
(e) Pathology report on tissues and appliances, if any, removed at the operation.
(4) An obstetrical record for a patient, in addition to the requirements for medical records, shall include but is not limited to:
(a) The prenatal care record containing at least a serologic test result for syphilis, Rh factor determination, and past obstetrical history and physical examination.
(b) The labor and delivery record, including reasons for induction and operative procedures, if any.
(c) Records of anesthesia, analgesia, and medications given in the course of delivery.
(5) A medical record of a newborn or stillborn infant, in addition to the requirement for medical records, shall include but is not limited to:
(a) Date and hour of birth; birth weight and length; period of gestation; sex; and condition of infant on delivery (Apgar rating is recommended).
(b) Mother's name and hospital number.
(c) Record of ophthalmic prophylaxis or refusal of same.
(d) Physical examination at birth and at discharge.
(e) Progress and nurse's notes including temperature; weight and feeding data; number, consistency and color of stools; urinary output; condition of eyes and umbilical cord; condition and color of skin; and motor behavior.
(f) Type of identification placed on infant in delivery room;
(g) Newborn hearing screening tests in accordance with OAR 333-020-0130.
(6) A patient’s emergency room, outpatient and clinic records, in addition to the requirements for medical records, shall be maintained and available to the other professional services of the hospital and shall include but are not limited to:
(a) Patient identification.
(b) Admitting diagnosis, chief complaint and brief history of the disease or injury.
(c) Physical findings.
(d) Laboratory and X-ray reports (if performed), as well as reports on any special examinations. The original report shall be authenticated and recorded in the patient's medical record.
(e) Diagnosis.
(f) Record of treatment, including medications.
(g) Disposition of case with instructions to the patient.
(h) Signature or authentication of attending physician.
(i) A record of the pre-hospital report form (when patient is brought in by ambulance) shall be attached to the emergency room record.
(7) All entries in a patient's medical record shall be dated, timed and authenticated.
(a) Authentication of an entry requires the use of a unique identifier, including but not limited to a written signature or initials, code, password, or by other computer or electronic means that allows identification of the individual responsible for the entry.
(b) Systems for authentication of dictated, computer, or electronically generated documents must ensure that the author of the entry has verified the accuracy of the document after it has been transcribed or generated.
(8) The following records shall be maintained ~~and kept permanently~~ in written or computerized form for the time period specified:
(a) Permanent:
(A~~a~~) Patient's register, containing admissions and discharges;

(Bb) Patient's master index;
(Cc) Register of all deliveries, including live births and stillbirths;
(Dd) Register of all deaths; and
(Ee) Register of operations.;
(b) Seven years:
(Af) Register of outpatients (seven years); and
(Bg) Emergency room register (seven years).; and
(ch) Blood banking register shall be retained for (20 years).
(9) The completion of the medical record shall be the responsibility of the attending qualified member of the medical staff. Any licensed health care practitioner responsible for providing or evaluating the service provided shall complete and authenticate those portions of the record that pertain to their portion of the patient's care. The appropriate individual shall authenticate the history and physical examination, operative report, progress notes, orders and the summary. In a hospital using interns, such orders must be according to policies and protocols established and approved by the medical staff. An authentication of a licensed health care practitioner on the face sheet of the medical record does not suffice to cover the entire content of the record:
(a) Medical records shall be completed by a licensed health care practitioner and closed within four weeks following the patient's discharge.
(b) If a patient is transferred to another health care facility, transfer information shall accompany the patient. Transfer information shall include but is not limited to:
(A) The name of the hospital from which they were transferred;
(B) The name of physician or other health care practitioner to assume care at the receiving facility;
(C) The date and time of discharge;
(D) The current medical findings;
(E) The current nursing assessment;
(F) Current medical history and physical information;
(G) Current diagnosis;
(H) Orders from a physician or other licensed health care practitioner for immediate care of the patient;
(I) Operative report, if applicable;
(J) TB test, if applicable; and
(K) Other information germane to patient's condition.
(c) If the discharge summary is not available at time of transfer, it shall be transmitted to the new facility as soon as it is available.
(10) Diagnoses and operations shall be expressed in standard terminology. Only abbreviations approved by the medical staff may be used in the medical records.
(11) Medical records shall be filed and indexed. Filing shall consist of an alphabetical master file with a number cross-file. Indexing is to be done according to diagnosis, operation, and qualified member of the medical staff, using a system such as the International or Standard nomenclature systems.
(12) Medical records are the property of the hospital. The medical record, either in original, electronic or microfilm form, shall not be removed from the hospital except where necessary for a judicial or administrative proceeding. Treating and attending physicians shall have access to medical records. When a hospital uses off-site storage for medical records, arrangements must be

made for delivery of these records to the hospital when needed for patient care or other hospital activities. Precautions must be taken to protect patient confidentiality.
(13) Authorized personnel of the Division shall be permitted to review medical records and patient registers as necessary to determine compliance with health care facility licensing laws.
(14) Medical records shall be kept for a period of at least 10 years after the date of last discharge. Original medical records may be retained on paper, microfilm, electronic or other media.
(15) Medical records shall be protected against unauthorized access, fire, water and theft.
(16) If a hospital changes ownership, all medical records in original, electronic or microfilm form shall remain in the hospital and it shall be the responsibility of the new owner to protect and maintain these records.
(17) If a hospital closes, its medical records and the registers required under section (8) of this rule may be delivered and turned over to any other hospital in the vicinity willing to accept and retain the same as provided in section (12) of this rule. A hospital which closes permanently shall follow the procedure for Division and public notice regarding disposal of medical records under OAR 333-500-0060.
(18) All original clinical records or photographic or electronic facsimile thereof, not otherwise incorporated in the medical record, such as X-rays, electrocardiograms, electroencephalograms, and radiological isotope scans shall be retained for seven years after a patient's last exam date~~discharge~~ if professional interpretations of such graphics are included in the medical records. Mammography images shall be retained for 10 years after a patient's last exam date.
(19) If a qualified medical record practitioner, RHIT (Registered Health Information Technician) or RHIA (Registered Health Information Administrator) is not the Director of the Medical Records Department, periodic and at least annual consultation must be provided by a qualified medical records consultant, RHIT/RHIA. The visits of the medical records consultant shall be of sufficient duration and frequency to review medical record systems and assure quality records of the patients. The contract for such services shall be made available to the Division.
(20) A current written policy on the release of medical record information including a patient's access to his or her medical record shall be maintained in the medical records department.
(21) A hospital is not required to keep a medical record in accordance with this rule for a person referred to a hospital ancillary department for a diagnostic procedure or health screening by a private physician, dentist, or other licensed health care practitioner acting within his or her scope of practice.
(22) Pursuant to ORS 441.059, the rules of a hospital that govern patient access to previously performed X-rays or diagnostic laboratory reports shall not discriminate between patients of chiropractic physicians and patients of other licensed health care practitioners permitted access to such X-rays and diagnostic laboratory reports.
(23) Nothing in this rule is meant to prohibit or discourage a hospital from maintaining its records in electronic form.
Stat. Auth: ORS 441.025
Stats. Implemented: ORS 441.025

DIVISION 510

PATIENT CARE AND NURSING SERVICES IN HOSPITALS

333-510-0030

Nursing Services
(1) The hospital shall provide a nursing service department, which provides 24-hour onsite registered nursing care, 7 days per week.
(2) The nursing services department shall be under the direction of a nurse executive who is a registered nurse, licensed to practice in Oregon.
(3) All nursing personnel shall maintain current certification in cardiopulmonary resuscitation.
~~(4) For the purposes of these rules, "circulating nurse" means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of the operating room team members during surgery.~~
~~(5) The duties of a circulating nurse performed in an operating room of a hospital shall be performed by a registered nurse licensed under ORS 678.010 through 678.410. In all cases requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient or procedure.~~
~~(6) Nothing in this section precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.~~
Stat. Auth.: ORS 413.042, 441.02~~5~~5
Stats. Implemented: ORS 441.025~~160 - 441.192~~

DIVISION 515

HOSPITAL ENVIRONMENTAL AND MAINTENANCE SERVICES

333-515-0030
Safety and Emergency Precautions
(1) A hospital shall:
(a) Have a physical plant and overall hospital environment that is developed and maintained in such a manner that the safety and well-being of patients are provided for.
(b) Have telephone or another communication method to summon help in case of fire or other emergency.
(c) Comply with ORS chapter 479, its implementing rules, and all other requirements of the State Fire Marshal.
(d) Have emergency power facilities that are tested monthly and are in readiness at all times for use in the delivery, operating and emergency rooms, nurseries and other areas as required in NFPA 99 and the National Electrical Code.
(2) In collaboration with local emergency medical services, a~~A~~ hospital shall develop, maintain, update, train, and exercise an emergency plan for the protection of all individuals in the event of an emergency, in accordance with OAR chapter 837, division-040. ~~A hospital shall have developed an emergency plan and shall have submitted a summary of the plan to the Authority by February 1, 2010. A hospital that applies for licensure after October 1, 2009, is required to submit an emergency plan with its application.~~

(a) A hospital shall conduct at least two drills every year to demonstrate that employees have practiced their specific duties and assignments, as outlined in the emergency preparedness plan. A hospital shall document the drills.
(b) An emergency plan shall:
(A) Include the contact information for the hospital's local emergency management.
(B) Address all applicable hazards that may include, but are not limited to, the following:
(i) Chemical emergencies;
(ii) Dam failure;
(iii) Earthquakes;
(iv) Fire;
(v) Flood;
(vi) Hazardous material;
(vii) Heat;
(viii) Hurricane;
(ix) Landslide;
(x) Nuclear power plant emergency;
(xi) Pandemic;
(xii) Terrorism; or
(xiii) Thunderstorms.
(C) Address the provision of sufficient supplies for patients and staff to shelter in place for a minimum of four days under the following conditions:
(i) Extended power outage;
(ii) No running water;
(iii) Replacement of food or supplies is unavailable; and
(iv) Staff members do not report to work as scheduled.
(D) Address evacuation, including:
(i) Identification of individual positions' duties while vacating the building, transporting, and housing residents;
(ii) Method and source of transportation;
(iii) Planned relocation sites;
(iv) Method by which each patient will be identified by name and facility of origin by people unknown to them;
(v) Method for tracking and reporting the physical location of specific patients until a different entity resumes responsibility for the resident; and
(vi) Notification to the Division about the status of the evacuation.
(E) Address the clinical and medical needs of the patients, including provisions to provide:
(i) Storage of and continued access to medical records necessary to obtain care and treatment of patients, and the use of paper forms to be used for the transfer of care or to maintain care on-site when electronic systems are not available;
(ii) Continued access to pharmaceuticals, medical supplies and equipment, even during and after an evacuation; and
(iii) Alternative staffing plans to meet the needs of the patients when scheduled staff members are unavailable. Alternative staffing plans may include, but are not limited to, on-call staff, the use of travelers, the use of management staff, or the use of other emergency personnel.
(c) A hospital shall ensure that its emergency plan is available to Division staff during licensing and certification surveys.

(d) A hospital shall re-evaluate and revise its emergency plan as necessary or when there is a significant change in the facility or population of the hospital.
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 441.0255
Stats. Implemented: ORS 441.0255 & 442.015

333-515-0050
Submission of Plans
(1) Any party proposing to make certain alterations or additions to an existing subject health care facility or to construct new facilities shall, before commencing such alteration, addition or new construction, submit plans and specifications to the Public Health Division, for preliminary inspection and approval or recommendations with respect to compliance with Health Division rules and for compliance to National Fire Protection Association standards when the facility is also to be Medicare- or Medicaid-certified. Submissions shall be in accord with rules of the Licensing Plans Review Program, OAR Chapter 333, Division 675-0000 through 0040. Plans should also be submitted to the local building division having authority for review and approval in accordance with state building codes.
Stat. Auth.: ORS 441.060
Stats. Implemented: ORS 441.060

333-515-0060
Exceptions to Rules (All Subject HCFs)
(1) While all subject health care facilities are required to maintain continuous compliance with the Authority's rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications or the conducting of pilot projects or research. Requests for exceptions to the rules must be:
(a) Submitted to the Authority in writing; and
(b) Identify the specific rule for which an exception is requested; and
(c) The special circumstances relied upon to justify the exception; and
(d) What alternatives were considered, if any and why alternatives (including compliance) were not selected; and
(e) Demonstrate that the proposed exception is desirable to maintain or improve the health and safety of the patients, to meet the individual and aggregate needs of patients, and will not jeopardize patient health and safety; and
(f) The proposed duration of the exception.
(2) Upon finding that the facility has satisfied the conditions of this rule, the Authority may grant an exception.
(3) The facility may implement an exception only after written approval from the Authority.
Stat. Auth.: ORS 441.060
Stats. Implemented: ORS 441.060

DIVISION 520

HOSPITALS, GENERALLYHOSPITAL SERVICES

Hospital Services

333-520-0020
Dietary Services
(1) All hospitals, regardless of classification, shall comply with this rule.
(2) A hospital shall:
(a) Have an organized dietary department, directed by qualified personnel, that conforms to the requirements in OAR 333-150-0000, the Food Sanitation Rules.
(b) Employ supportive personnel competent to carry out the functions of the dietary service, including a full-time director with overall supervisory responsibility for the dietary service and who is:
(A) A qualified dietitian who is registered by the Commission on Dietetic Registration of the American Dietetic Association;
(B) A person who has received a baccalaureate or higher degree with major studies in food, nutrition, diet therapy or food service management and has at least one year of supervisory experience in a health care dietetic service, and participates in continuing education related to the dietetic profession;
(C) A graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association;
(D) A graduate of a state approved course that provides 90 or more hours of classroom instruction in food service supervision and has one year's experience as a supervisor in a health care institution; or
(E) Has training and experience in food service supervision and management in a military service equivalent in content to one of the above criteria for qualifying.
(c) Contract with a dietician with the qualifications listed in paragraph (2)(b)(A~~B~~) of this rule, if the Director is not a qualified dietitian under paragraph (2)(b)(A) of this rule, and:
(A) Consult at least quarterly with the contractor;
(B) Have on file a contract signed by the consultant and the hospital administrator stating the relationship of the consultant to the hospital, services to be provided, length of contract, terms and hours; and
(C) Require the contractor to submit quarterly reports to the hospital administrator and the committee, council or other reviewing body designated by the hospital as having responsibility for dietary services that include:
(i) The date(s) of visit(s) and length of time spent on premises;
(ii) Staff members seen;
(iii) Services performed;
(iv) Action taken on previous reports;
(v) Problems identified; and
(vi) Recommended action and distribution of the report.
(d) Require the on-site visits of the Consulting Dietitian to be of sufficient duration and frequency to review dietetic systems and assure quality food to the patient.
(e) Provide dietetic services to patients in accordance with a written order by the responsible physician, or other health care practitioner authorized within the scope of his or her professional

license, and record appropriate dietetic information in the patient's medical record including the following:
(A) Timely and periodic assessments of the patient's nutrient intake and tolerance to the prescribed diet modification, including the effect of the patient's appetite and food habits on food intake;
(B) A description of the diet instructions given to the patient or family and assessment of their diet knowledge;
(C) A description or copy of the diet information forwarded to another institution upon patient discharge; and
(D) Nutritional care follow-up with the patient's health care practitioner or a health care agency.
(f) Regularly review and evaluate the quality and appropriateness of nutritional care provided by the dietetic service including the nutritional adequacy of all menus.
(g) Ensure that the Dietetic Service is represented on hospital committees concerned with nutritional care.
(h) Serve food that has an appetizing appearance, is palatable, is served at proper temperature and is cooked and served in such a way as to retain the nutrient value of food.
(i) Restrict admittance to the kitchen area to those who must enter to perform assigned duties.
(j) Develop written procedures for cleaning equipment and work areas and enforce those procedures.
Stat. Auth.: ORS 441.025~~5 & 442.015~~
Stats. Implemented: ORS 441.025~~5 & 442.015~~

333-520-0050
Surgery Services
(1) For purposes of this rule:
(a) "Circulating nurse" means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of the operating room team members during surgery.
(b) "Rural or medically underserved community" means a geographic area of Oregon that is 10 or more miles from the geographic center of a population center of 40,000 or more individuals.
(c) "Surgical technology" means intraoperative surgical patient care that involves:
(A) Preparing an operating room for surgical procedures by ensuring that surgical equipment is functioning properly and safely;
(B) Preparing an operating room and the sterile field for surgical procedures by preparing sterile supplies, instruments and equipment using sterile techniques;
(C) Anticipating the needs of a surgical team based on knowledge of human anatomy and pathophysiology and how those fields relate to the surgical patient and the patient's surgical procedure; and
(D) Performing tasks as directed in an operating room, including:
(i) Passing instruments, equipment or supplies;
(ii) Sponging or suctioning of an operative site;
(iii) Preparing and cutting suture material;
(iv) Transferring fluids or drugs;
(v) Handling specimens;

(vi) Holding retractors and other equipment;
(vii) Applying electrocautery to clamps on bleeders;
(viii) Connecting drains to suction apparatus;
(ix) Applying dressings to closed wounds; and
(x) Assisting in counting supplies and instruments, including sponges and needles.
(2~~1~~) General hospitals are required to comply with this rule. A low occupancy acute care or mental or psychiatric hospital shall comply with this rule if it offers surgery services.
(3~~2~~) A hospital that provides surgical services shall have operating rooms that conform to the applicable requirements in OAR chapter 333, division 535.
(4~~3~~) A hospital's operating rooms must be supervised by an experienced registered nurse or doctor of medicine or osteopathy.
(5) The duties of a circulating nurse performed in an operating room of a hospital shall be performed by a registered nurse licensed under ORS 678.010 through 678.410. In all cases requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient or procedure.
(6) Nothing in section (5) precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.
(7) In order for a person to practice surgical technology at a hospital, the hospital's governing body shall ensure that the following provisions are met by the individual:
(a) Documentation showing that the person has completed a training program for surgical technologists in a branch of the armed forces of the United States or in the United States Public Health Service Commissioned Corp and completes 16 hours of continuing education as described in section (11) of this rule every two years; or
(b) Completion of a surgical technology education program accredited by the Commission on Accreditation of Allied Health Education Program (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES) and certification as a surgical technologist issued by the National Board of Surgical Technology and Surgical Assisting (NBSTSA); or
(c) Documentation that a person has practiced surgical technology at least two years between January 1, 2014 and January 1, 2017 in a hospital, ambulatory surgical center or as an employee of a federal government agency or institution and completes 16 hours of continuing education as described in section (11) of this rule every two years.
(8) Notwithstanding subsection (7)(b), a hospital may allow a person who is not certified by the NBSTSA to practice surgical technology at the hospital for 12 months after the person completes an educational program accredited by the CAAHEP or ABHES.
(9) A hospital located in a rural or medically underserved community may allow a person to practice surgical technology at the hospital who does not meet the requirements specified in section (7) of this rule while the person is attending an educational program accredited by the CAAHEP or ABHES. Such persons are exempt from these educational requirements for three years from the date on which the person began practicing at the hospital.
(10) These rules do not prohibit a licensed practitioner from performing surgical technology if the practitioner is acting within the scope of the practitioner's license and a hospital allows the practitioner to perform such duties.
(11)(a) The continuing education requirements described in subsections (7)(a) and (7)(c) shall:

(A) Consist of 16 hours every two years;
(B) Be tracked by the surgical technologist and is subject to audit by the hospital in which the person is practicing; and
(C) Be relevant to the medical-surgical practice of surgical technology.
(b) Continuing education may include but is not limited to:
(A) Continuing education credits approved by the Association for Surgical Technologist;
(B) Healthcare sponsored conferences, forums, seminars, symposiums or workshops;
(C) Online distance learning courses;
(D) Live lectures at national conferences; or
(E) College courses.
(12) A hospital shall conduct a random audit of a representative sample of the surgical technologists employed by the hospital every two years to verify compliance with educational requirements.
Stat. Auth.: ORS 441.0255, OL 2015 ch. 373
Stats. Implemented: ORS 441.0255, & 442.015 , 678.362 & OL 2015 ch. 373

DIVISION 525

SPECIALTY HOSPITALS

333-525-0000
Mental or Psychiatric Hospital
A hospital classified as mental or psychiatric shall:
(1) Be devoted primarily to the diagnosis and treatment of mentally ill persons.
(2) Have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning, including:
(a) A clinical director, service chief, or equivalent who:
(A) Is qualified to provide the leadership required for an intensive treatment program;
(B) Meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry;
(C) Monitors and evaluates the quality and appropriateness of services and treatment provided by the medical staff; and
(D) Supervises inpatient psychiatric services.
(b) Doctors of medicine or osteopathy and other appropriate professional personnel available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a licensed hospital.
(c) A director of psychiatric nursing services who:
(A) Is a registered nurse with a master's degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing Accrediting Commission, or the Commission on Collegiate Nursing Education, or is qualified by education and experience in the care of the mentally ill; and

(B) Demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.
(d) Registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient.
(e) The availability of a registered professional nurse 24 hours each day.
(f) The availability of staff to provide other psychological services to meet the needs of the patients.
(g) A director of social services who:
(A) Has a master's degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill; and
(B) Monitors and evaluates the quality and appropriateness of social services furnished.
(h) At least one staff member with a master's degree in social work if the director of social services does not have such a degree.
(i) Social service staff with responsibilities that include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.
(j) Qualified therapists, support personnel, and consultants adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.
(k) In a satellite as defined in OAR 333-500-0010(46)(b), the prompt availability of at least one psychiatrist to provide emergency psychiatric services or other psychiatric services to meet the needs of the patients 24 hours each day in person or using telemedicine technology.
(3) Have a therapeutic activities program that is appropriate to the needs and interests of patients and directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.
(4) Maintain medical records in a manner that permits determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized. A patient's medical record shall include:
(a) The patient's legal status;
(b) The provisional or admitting diagnosis, including the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
(c) The reasons for admission as stated by the patient or others significantly involved;
(d) The social service records, including reports of interviews with patients, family members, and others, including an assessment of home plans and family attitudes, and community resource contacts as well as a social history;
(e) When indicated, a complete neurological examination recorded at the time of the admission physical examination;
(f) Documentation of all active therapeutic efforts; and

(g) A discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.
(5) Have a psychiatrist perform a psychiatric evaluation of each patient that:
(a) Is completed within 60 hours of admission;
(b) Includes a medical history;
(c) Contains a record of mental status;
(d) Notes the onset of illness and the circumstances leading to admission;
(e) Describes attitudes and behavior;
(f) Estimates intellectual functioning, memory functioning, and orientation; and
(g) Includes an inventory of the patient's assets in descriptive, not interpretative, fashion.
(6) Develop a written individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities that includes:
(a) A substantiated diagnosis;
(b) Short-term and long-range goals;
(c) The specific treatment modalities utilized;
(d) The responsibilities of each member of the treatment team; and
(e) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.
(7) Ensure that progress notes are recorded by:
(a) The doctor of medicine or osteopathy responsible for the care of the patient; and
(b) Nurses, social workers and, when appropriate, others significantly involved in active treatment modalities.
(8) The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.
(9) Provide discharge planning in accordance with OAR 333-505-0030(5)(a).
(10) Comply with the applicable rules of the Authority, Addictions and Mental Health Division, including OAR chapter 309, divisions 31 and 33.
Stat. Auth.: ORS 441.025~~5 & 442.015~~
Stats. Implemented: ORS 441.025~~5~~

DIVISION 535

NEW CONSTRUCTION AND ALTERATIONS OF EXISTING HOPSITALS

Building Requirements for General Hospitals

333-535-0061
Psychiatric Patient Care Units and Rooms
(1) The design of inpatient psychiatric patient care units shall be supportive of the types of psychiatric therapies provided for patients and their psychiatric care needs. Interior finishes,

lighting and furnishings shall, to the extent practicable, reflect a residential rather than an institutional setting with an emphasis on natural light and exterior views while not compromising patient privacy and safety design. Inpatient psychiatric patient care units shall include patient rooms meeting the requirements of section (4) of this rule and service areas meeting the requirements of section (5) of this rule.
(2) Patient and Staff Safety Assessment. The hospital psychiatric care staff and the hospital administration, in consultation with the project architects, shall develop a Patient and Staff Safety Assessment that addresses security and safety design features and devices. A copy of this Assessment shall accompany construction documents submitted to the Licensing Plans Review Program. The Patient and Staff Safety Assessment shall include at least the following elements:
(a) A statement explaining the psychiatric population groups served;
(b) A discussion of the capability for staff visual supervision of patient ancillary areas and corridors;
(c) A discussion of the risks to patients, including self-injury, and the project solutions employed to minimize such risks;
(d) A discussion of building features and equipment, including items which may be used as weapons, that is intended to minimize risks to patients, staff and visitors;
(e) A statement explaining how potentially infectious patients will be managed; and
(f) A discussion of outdoor areas used by patients. Discussion must include, but is not limited to, the number of patients each outdoor area will serve at one time, staffing, security and shifts.
(3) Except as permitted under OAR 333-500-0065, every hospital classified as mental or psychiatric and other hospitals, regardless of classification, that provide psychiatric services, shall have at least one psychiatric seclusion~~holding~~ room which meets the requirements of section (7) of this rule and OAR 309-033-0727~~0(3)(e)~~.
(4) Psychiatric patient care rooms shall comply with the requirements of OAR 333-535-0025, except as follows:
(a) A nurse call system is not required. If included, provisions shall be made for easy removal or covering of call buttons;
(b) Patient toilets shall not have bed pan flushing devices;
(c) Hand-washing stations are not required in patient rooms;
(d) Visual privacy in multi-bed rooms (for example~~e.g.~~, cubicle curtains) is not required;
(e) Each patient room shall be provided a private toilet room and hand-washing station. Grab bars are only required in rooms required to be accessible to the disabled;
(f) All hardware shall have tamper-resistant fasteners; and
(g) Patient rooms shall comply with the requirements of section (6) of this rule.
(5) Psychiatric patient care unit service areas shall comply with the requirements of OAR 333-535-0025, except as follows:
(a) A secured storage area shall be provided for patients' belongings that are determined to be potentially harmful;
(b) A secured storage station will be provided for storing law enforcement weapons prior to officers entering the patient care unit;
(c) The medication station shall include provision against unauthorized access;
(d) Between meal nourishment(s) facilities within the unit shall be one, or a combination of the following:
(A) A nourishment station;

(B) A kitchenette, designed for patient use, with a sink and a keyed switch or other acceptable method for staff control of any heating and cooking devices; or
(C) A kitchen service within the unit that includes a hand washing station, storage space, refrigerator and facilities for full meal preparation. A keyed switch or other acceptable method for staff control of any heating and cooking devices is required.
(e) All storage spaces within the psychiatric patient care unit shall be secured from patient access;
(f) A bathtub or shower shall be provided for every six beds not otherwise served by bathing facilities within the patient rooms. Bathing facilities shall be designed and located for patient safety, convenience, privacy and shall comply with section (6) of this rule;
(g) A separate charting area shall be provided with provisions for visual and acoustical privacy. Viewing windows to permit observation of patient areas by the charting nurse or physician may be used if the arrangement is such that patient files cannot be read from outside the charting area. Viewing windows shall meet the requirements of subsection (6)(g) of this rule;
(h) At least two separate social spaces, one appropriate for noisy activities and one for quiet activities shall be provided. The combined area shall be at least 40 square feet per patient with each space being at least 120 square feet in size. These spaces may be shared by dining activities;
(i) Space for group therapy shall be provided. This space may be combined with the quiet space required by subsection (5)(h) of this rule when the unit accommodates 12 or fewer patients and when at least 225 square feet of closed private space is available for group therapy activities;
(j) Securable patient laundry facilities with an automatic washer and dryer and secured space for chemicals shall be provided;
(k) Each psychiatric patient care unit shall include, or have close access to, a soiled utility room that meets the requirements of OAR 333-535-0260(5) or a soiled holding room. A soiled holding room shall meet all the requirements of a soiled utility room except that a clinical sink may be omitted;
(l) The following elements shall also be provided, but shall be permitted to serve several nursing units and may be on a different floor if conveniently located to the unit for routine use:
(A) Space requirements. Examination rooms shall have a minimum floor area of 120 square feet, excluding space for vestibule, toilets, and closets. The room shall contain a hand-washing station, storage facilities and a surface for charting. In existing psychiatric facilities exam rooms may continue to be 80 square feet excluding space for vestibules, toilets and closets;
(B) Separate consultation room(s), lockable from the outside. Each consultation room shall have a minimum floor space of 100 square feet and shall be provided at a room-to-bed ratio of one consultation room for every 12 psychiatric beds. The room(s) shall be designed for acoustical and visual privacy and be constructed to achieve a level of voice privacy of 50 STC;
(C) Separate space for patient therapy/multipurpose use. The greater of at least 300 square feet or at least 15 square feet per patient shall be provided. The space shall include a hand-washing station, work counter(s), storage and space for displays and may serve more than one psychiatric patient care unit. However, when a psychiatric patient care unit contains less than 12 beds, the therapy and other functions may be performed within the noisy activities area required by subsection (5)(h) of this rule if at least an additional 10 square feet per patient is provided; and
(D) A conference and treatment planning room, for use by psychiatric patient care unit staff, constructed to achieve a level of voice privacy of 50 STC.
(m) Outside area shall be provided for all patients. The area shall be discussed as part of the Functional Program per subsection (2)(f) of this rule.

(6) Patient and staff safety features, security and safety devices shall not, to the extent practicable, be presented in a manner to attract or invite tampering by patients. Design, finishes and furnishings shall be designed and installed to minimize the opportunity for patients to cause injury to themselves or others. Special design considerations for prevention of self injury and injury to staff and others shall include:
(a) Visual control of nursing unit corridors, passive activity areas and outdoor areas shall be provided;
(b) Hidden alcoves are prohibited;
(c) Non-patient areas, including staff support rooms, mechanical and electrical spaces shall be secured from patients;
(d) Door closers and door and cabinet hardware, including hinges in patient areas, shall be designed to prevent attachment of other articles and to limit possible patient or staff injury;
(e) Doors to patient toilet and shower rooms shall not swing into the room. These doors shall either not be lockable from within the room or shall be provided with privacy locks that can be opened by staff with a key or tool. Hardware shall be designed to preclude patients from tying the door closed;
(f) Furnishings, movable equipment and accessories shall be addressed by the Patient and Staff Safety Assessment required by section (2) of this rule;
(g) Windows, including interior and exterior glazing, shall be non-operable and shall be of break-resistant material and ~~(i.e., will not shatter)~~. Window sills, curtains and blinds shall be constructed to prevent attachment of other articles;
(h) Curtains and blinds shall be constructed to break-away with a vertical load of greater than 40 pounds;
(i) Ceilings in patient bedrooms, toilet and shower rooms shall be of continuous bonded construction. T-bar ceilings with lay-in tiles are not allowed;
(j) The ceiling and air distribution devices, lighting fixtures, sprinkler heads, smoke detectors, and other appurtenances shall be designed and installed to be tamper resistant, non-breakable, prevent the attachment of other articles and to limit possible patient or staff injury in patient rooms, toilet and shower rooms;
(k) Flooring base in patient rooms, toilet and shower rooms shall be installed to preclude removal by patients;
(l) Shower, bath, toilet and sink plumbing fixture hardware and accessories, including grab bars and toilet paper holders, shall prevent attachment of other articles and removal by patients. Shut-offs under patient sinks shall be covered and secured to prevent patient access;
(m) Grab bars, if provided, shall be contiguous to the wall so that nothing can pass between the edge of the rail and the wall;
(n) Toilet flush valves shall be recessed or of the push button type;
(o) Hand-washing station faucet hardware shall be recessed or of the push button type to preclude patient or staff injury;
(p) Shower curtains, if provided, shall have a breakaway maximum of 40 pounds and be supported on curtain tracks attached or flush to the ceiling. Shower curtains shall not be permitted where facilities accommodate children whose weight is close to, or within the breakaway weight limits;
(q) Shower heads shall be sloped or otherwise designed to prevent attachment of other articles;
(r) Fire extinguisher cabinets and fire alarm pull stations shall be located or installed to prevent inappropriate use;

(s) Electrical outlets in patient areas shall be of a ground fault interrupter type ("GFI") or shall be protected by GFI breakers at electrical panels;
(t) Patient mirrors shall be non-breakable and shatterproof;
(u) Medical gas outlets, if provided, shall be located or installed to prevent patient access;
(v) All devices attached to walls, ceilings and floors and all door and window hardware shall be tamper resistant and be securely fastened with tamper proof screws;
(w) All exit door hardware shall have concealed rods, if any are used, and they shall not be removable by patients. Door closure and panic bars, if provided, shall not allow attachment of other articles;
(x) Time delay closers shall not be used on locked doors; and
(y) Outdoor areas shall be secured in accordance with the Patient and Staff Safety Assessment required by section (2) of this rule.
(7) Psychiatric SeclusionHolding Rooms. Psychiatric seclusion holding rooms shall comply with the following requirements:
(a) As required by section (3) of this rule, and except as permitted by OAR 333-500-0065, each hospital classified as general or psychiatric shall have at least one psychiatric seclusionholding room. A minimum of one psychiatric seclusionholding room is required for every 24 psychiatric beds or fraction thereof. The rooms shall be proximate to a nurses' station. Each room shall be for only one patient and shall be at least 80 square feet in size. The design of the room shall prevent patient hiding and minimize the potential for escape and self injury;
(b) Psychiatric seclusionholding rooms shall meet the requirements of section (6) of this rule;
(c) Outside room corners, door hardware protrusions and other projections shall be avoided to minimize points for possible patient injury;
(d) No items shall be attached to the walls and there shall be no exposed curtains, drapes, rods or furniture, except a portable bed which can be removed if necessary. Beds that are securely fastened to the floor are allowable but must have no sharp protrusions, such as bed posts or corners;
(e) Wall and other room finish materials shall be securely constructed to resist attempts at intentional damage;
(f) Exposed pipes or electrical wiring is prohibited. Electrical outlets, if provided, shall be permanently capped or covered with a metal shield that opens with a key and shall be circuited and controllable from outside the room. Ceiling lights shall be unbreakable and shall be either recessed or surface mounted;
(g) Room construction shall contain no readily combustible materials (for examplei.e., wood or vinyl wall covering surfaces). If the room interior is padded with combustible materials, such materials shall meet the requirements of the National Fire Protection Association (NFPA) 101 Code as enforced by the State Fire Marshal;
(h) Sprinkler heads shall be of a recessed pop-down type and shall have a breakaway strength of under 80 pounds;
(i) A toilet and hand-washing station that meets the requirements of section (6) of this rule shall be available for patient use but shall not be located within the room;
(j) The door to the room shall open outward and shall include a viewing window of shatterproof glass or plastic through which the entire room may be viewed from the outside before entering; and
(k) The door to the room shall be lockable from the outside and shall include tamper-proof hardware. The lock must release with initiation of the fire alarm, sprinkler flow or power failure

as required for controlled egress in accordance with the Oregon Structural Specialty Code and NFPA 101 Code as enforced by the appropriate building codes agency and fire marshal.
(8) Child and Adolescent Psychiatric Units. The requirements of sections (1) through (6) of this rule, and of section (7) of this rule if a psychiatric seclusion~~holding~~ room is provided, shall apply to child and adolescent psychiatric units, except as follows:
(a) The environment of the unit shall reflect the age, social and developmental needs of children and adolescents, including space to accommodate family and other caregivers;
(b) At least one single occupancy timeout room shall be provided;
(c) An outdoor activity area shall be provided with a minimum of 50 square feet per patient but not less than 400 total square feet;
(d) Child and adolescent care units shall be physically and visually separate from one another and from adult care units; and
(e) Showers. Shower curtains shall not be permitted in child adolescent care units.
(9) Geriatric, Alzheimer and Other Dementia Units. The requirements of sections (1) through (6) of this rule, and of section (7) of this rule if a psychiatric seclusion~~holding~~ room is provided, shall apply to geriatric, Alzheimer and other dementia units, except as follows:
(a) Single patient rooms shall be at least 120 square feet in size. Multiple patient rooms shall provide at least 80 square feet per patient exclusive of closets, vestibules and bathroom facilities and allow for a minimum of 3 feet between beds;
(b) A nurse call system meeting the requirements of section (6) of this rule shall be provided. Provisions shall be made for the removal or covering of call button outlets as required by the Patient Safety Assessment. Call cords or strings in excess of six inches shall not be permitted;
(c) Handrails shall be provided on both sides of corridors used by patients. These handrails shall be contiguous with the wall so that nothing may pass between the rail and wall;
(d) Doors to patient rooms and patient ancillary use areas shall be a minimum of 3 feet 8 inches in clear width;
(e) Slip resistant flooring surfaces shall be provided in all bathing rooms; and
(f) Secure storage for wheelchairs shall be provided in a location readily accessible to the unit.
(10) Forensic Psychiatric Units. The requirements of sections (1) through (6) of this rule shall apply to forensic psychiatric units, except as follows:
(a) Security vestibules or sally ports are required at the unit entrance;
(b) Additional treatment areas, police and courtroom space, and special security considerations shall be provided in accordance with the Patient and Staff Safety Assessment; and
(c) Children and adolescents shall be separated from one another as defined by the Functional Program. Children and adolescents shall also be physically and visually separate from adult care units.
Stat. Auth.: ORS ~~441.025 &~~ 441.060
Stats. Implemented: ORS ~~441.025 &~~ 441.060

333-535-0080
Emergency Department
(1) ~~General.~~ Hospitals offering emergency patient care services shall include facilities required under section (2) of this rule. If outpatient clinical services are to be included as a part of the Emergency Department, elements under OAR 333-535-0085 shall also be provided.
(a) Except as permitted under OAR 333-500-0065, every hospital classified as mental or psychiatric and any other hospital, regardless of classification, that provides psychiatric services

shall have at least one psychiatric seclusion~~holding~~ room that meets the requirements of section (7) of OAR 333-535-0061 and 309-033-0727~~0(3)(e)~~.
(2) Hospitals providing emergency services shall include the following:
(a) Entrance located on the same level and proximate to the emergency department, sheltered from the weather, and with provision for ambulance and disabled pedestrian access. Emergency entrance location shall be marked by a lighted sign. The emergency access shall be paved to permit discharge of patients from automobiles and ambulances. Temporary parking convenient to the entrance shall be provided;
(b) A reception, triage and control area conveniently located near the entrance, waiting area(s), and treatment room(s). The control station(s) shall be located to permit staff observation and control of access to treatment areas, pedestrian and ambulance entrances and public waiting area;
(c) Public waiting space with toilet facilities, public telephone, and drinking fountain;
(d) Examination and Treatment room(s):
(A) Space requirements. Each examination room shall have a minimum clear floor area of 120 square feet exclusive of toilets, waiting area and casework.
(B) Each examination room shall contain an examination light, medication storage, work counter, a hand-washing station, medical gas outlets per Table 5 (OAR 333-535-0300), electrical outlets above floor level to accommodate required equipment, suction, and space for storage of emergency equipment such as emergency treatment trays, defibrillator, cardiac monitor, and resuscitator.
(C) Treatment cubicles:
(i) Where treatment cubicles are in open multiple-bed areas, each cubicle shall have a minimum of 80 square feet of clear floor space with a minimum of 5 feet between beds and shall be separated from adjoining cubicles by curtains.
(ii) Hand-washing stations shall be provided at a rate of one per four treatment cubicles.
(e) Trauma/cardiac rooms for emergency procedures, including emergency surgery shall have:
(A) At least 250 square feet of clear floor space.
(B) Additional square footage and cubicle curtains for privacy shall be provided to accommodate more than one patient at a time in the trauma room.
(C) Cabinets and emergency supply shelves, image readers, examination lights, and counter space for writing in each room.
(D) Provisions in each room for monitoring equipment.
(E) Storage provided for immediate access to protective attire for infection control.
(F) Doorways leading from the ambulance entrance to the cardiac trauma room shall be a minimum of 5 feet wide to simultaneously accommodate stretchers, equipment, and personnel.
(G) Medical gas outlets shall equal that required of an operating room in Table 5, OAR 333-535-0300;
(f) Provisions for orthopedic and cast work. There shall be storage for orthopedic supplies including but not limited to: splints, traction hooks, portable image readers~~,~~ or exam lights~~, etc~~. These provisions may be in a separate room(s) or in a treatment room. If a sink is used for the disposal of plaster of paris, a plaster trap shall be provided. The amount of clear floor space for this area shall be dependent on the Functional Program, procedures planned and the equipment needed;

(g) Scrub stations or hand-washing stations located in or adjacent to each trauma or orthopedic room;
(h) Provisions for infection control and for the handling of a patient requiring isolation in accordance with the hospital's ICRA. If so determined by the hospital's ICRA, the emergency department waiting area and triage areas shall require special measures to reduce the risk of airborne infection transmission. These measures may include enhanced general ventilation and air disinfection similar to inpatient requirements for airborne infection isolation rooms;
(i) Communication center with related equipment shall be convenient to the control station(s), nursing station and have radio, telephone, and intercommunication systems;
(j) Access to radiology and laboratory services;
(k) Storage area out of line of traffic for stretchers and wheelchairs with access from emergency entrances;
(l) Staff work and charting area(s). This may be combined with reception and control area or located within the treatment room;
(m) Storage out of traffic and under staff control for general medical/surgical emergency supplies, medications and equipment such as a ventilator, defibrillator, pumps, patient monitoring, portable image readers and splints;
(n) Soiled utility room or area per OAR 333-535-0260(5) containing clinical sink, work counter, a hand-washing station, waste receptacle, and linen receptacle;
(o) Patients' toilet room convenient to treatment room(s) that shall include a nurse call device or other approved alternative to summon staff; and
(p) Security station. Where dictated by the Functional Program, a security station system shall be located near the emergency entrances and triage/reception area.
(A) Accommodation for hospital security staff, police officers and monitoring equipment, for example, ~~eg. S~~silent alarms, panic buttons, intercom systems~~,~~ or visual monitoring devices~~, etc~~.
(B) Located near emergency entrance and triage/reception area.
[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 441.025 & 441.060
Stats. Implemented: ORS 441.025 & 441.060

333-535-0110
Surgical Facilities
A surgical unit shall consist of but not be limited to facilities as follows for exclusive use of the surgery department, unless otherwise noted:
(1) The number of operating rooms and recovery beds and the sizes of the service areas shall be based on the expected surgical workload. The surgical suite shall be located and arranged to prevent non-related traffic through the suite. Also see OAR 333-535-0300 for mechanical rules and 333-535-0310 for electrical rules which apply;
(2) Certain rules of this section differ dependent upon the type of surgical procedures performed. These are classified as one of the following three categories:
(a) Unrestricted areas for Minor Surgical and Diagnostic Procedures: Unrestricted areas include a central control point established to monitor the entrance of patients, personnel, and materials. Street clothes are permitted in this area and traffic is not limited. Minor procedures are those that

conform to the criteria listed in paragraphs (2)(a)(A) through (D) of this rule based on an assessment of the patient. These procedures are non-invasive and require no general anesthetic.
(A) Anesthesia is limited to local anesthesia or conscious sedation;
(B) Procedure time (duration) is less than two hours;
(C) Procedure is non-invasive with low risk for infection; and
(D) Patient assessment indicates no special risks for cardiorespiratory complications.
(b) Semi-restricted areas include the following:
(A) The peripheral support areas of the surgical suite, and storage areas for clean and sterile supplies, work areas for storage and processing of instruments, and corridors leading to the restricted areas of the surgical suites; and
(B) Traffic in this area is limited to authorized personnel and patients. Personnel are required to wear surgical attire and cover all head and facial hair.
(c) Restricted areas for Major Surgical and Diagnostic Procedures are those which exceed the criteria described for Minor Surgical and Diagnostic Procedures in OAR 333-535-0110(2)(a). Restricted areas include the following:
(A) The operating and procedure rooms, the clean core, and scrub sink areas.
(B) Where surgical attire, hair coverings, and masks are required due to the presence of open sterile supplies, scrubbed people or similar circumstances.
(3) Operating Rooms:
(a) One or more operating rooms shall be provided. Each operating room shall provide a system for emergency communication with the surgical control station which can be operated without use of the hands, but which is not foot operated. No plumbing fixtures or open drains shall be provided in operating rooms except as stipulated in subsection (3)(d). Each operating room shall have a minimum clear area as follows:
(A) Existing operating rooms shall have not less than 360 square feet exclusive of fixed cabinets and built-in shelves. The minimum dimension shall be 18 feet between fixed cabinets and built-in shelves. At least one i~~I~~mage reader~~s for handling at least two films at the same time~~ shall also be provided.
(B) In new construction, operating rooms shall have a minimum clear area of 400 square feet exclusive of fixed or wall-mounted cabinets and built-in shelves, with a minimum of 20 feet clear dimension between fixed cabinets and built-in shelves. At least one i~~I~~mage reader~~s for handling at least four films at the same time~~ shall also be provided.
(b) Operating room(s) for orthopedic surgery, when provided, shall in addition to meeting subsection (a) of this section, have enclosed storage space for splints and traction equipment. Storage may be outside the operating room but must be located for convenient access. If plaster of paris is used for cast work, also provide a plaster sink outside the operating room, but within the operating suite.
(c) Operating rooms for cardiovascular surgery, when provided, shall provide appropriate plumbing connections in both the cardiovascular operating room and pump room and shall in addition to meeting subsection (a) of this section, provide a minimum clear area as follows:
(A) Existing facilities shall have not less than 400 square feet exclusive of fixed cabinets and built-in shelves with a minimum of 20 feet clear dimension between fixed cabinets and built-in shelves; and

(B) In new construction, rooms for cardiovascular, orthopedic, neurological, and other special procedures or combination of procedures such as cardiac catheterization lab and surgery that require additional personnel ~~and/~~or large equipment shall have, in addition to the above requirements for general operating rooms, a minimum clear area of 600 square feet with a minimum room dimension of 20 feet clear dimension exclusive of fixed or wall-mounted cabinets and built-in shelves.
(d) Operating rooms for surgical cystoscopic and surgical endoscopic procedures and operating rooms dedicated to eye surgery, when provided, shall meet requirements of subsection (a) of this section, but clear area of the room shall be as follows:
(A) Existing facilities shall have not less than a minimum of 250 square feet exclusive of fixed cabinets and built-in shelves.
(B) In new construction, rooms for surgical cystoscopic and other endourologic procedures shall have a minimum clear area of 350 square feet exclusive of fixed or wall-mounted cabinets and built-in shelves, with a minimum of 15 feet clear dimension between fixed cabinets and built-in shelves. If cystoscopy rooms are used for procedures other than cystoscopy, provisions must be made to allow cleaning and sealing of any floor drains, and such procedures must be included in the hospital's written infection control policy.
(e) Operating rooms for minor surgical procedures, as defined in section (2) of this rule, shall meet requirements of subsection (a) of this section, except that clear area of the room shall be a minimum of 200 square feet exclusive of fixed cabinets and built-in shelves and minimum dimensions do not apply. Film illuminators are required only if procedures involve the use of X-rays.
(f) Despite requirements under subsections (a) through (e) of this section, needs for some procedures may require additional clear operating room space, and special plumbing and mechanical features. Such specialized operating rooms are not addressed by subsections (a) through (e) of this section, and are the responsibility of the hospital and their design consultants.
(4) Service areas: Services, except the enclosed soiled utility room mentioned in subsection (f) of this section and the housekeeping closet in subsection (q) of this section, may be shared with obstetrical facilities if the Functional Program and project design reflect this concept. Service areas, when shared with delivery rooms, shall be arranged to avoid the need for patients or staff to pass between the operating room and the delivery room areas. (See also obstetrical rules under OAR 333-535-0120.) The following services shall be provided:
(a) Control station located to permit visual observation of all traffic into and within the suite;
(b) Administrative and administrative support space in accord with the hospital's program needs;
(c) Sterilizing facility(ies) with high speed autoclave(s) for emergency use. Other facilities for processing and sterilizing reusable instruments~~, etc.,~~ may be located in another hospital department such as Central Services. Immediate access to sterilizing facilities is not required where only disposable supplies, instruments and equipment are used. Sterilization equipment shall conform to the Oregon Boiler and Pressure Vessel Specialty Code, ORS 480.525(1)(e);
(d) Medication storage and distribution facilities. Provisions shall be made for storage and preparation of medications administered to patients. A refrigerator and storage system meeting the requirements of Oregon Board of Pharmacy rules, OAR chapter 855, division 41 shall be provided. A hand-washing station shall be provided in or accessible to each area or room;

(e) Scrub facilities. For major surgical procedures, two scrub facilities shall be provided near the entrance to each operating room. Two scrub positions may serve two operating rooms if both are located adjacent to the entrance of each operating room. For minor surgical procedures, a scrub sink or a hand-washing station shall be provided in or accessible to each room. This sink shall be equipped with fittings usable without the use of hands;
(f) Soiled utility room. An enclosed soiled utility room for the exclusive use of the surgical suite staff or soiled holding room that is part of a system within the building for the collection and disposal of soiled material shall be provided. The soiled utility room shall contain a clinical sink or equivalent flushing type fixture, work counter, sink equipped for hand-washing, waste receptacle, and linen receptacle. When a soiled holding room is used, the clinical sink and work counter may be omitted from that room. (Also see subsection (g) of this section for fluid waste disposal facilities.) Soiled utility or holding areas shall not have direct connection with operating rooms or other sterile activities. The maximum travel distance to soiled utility or holding rooms shall be not more than six rooms or 180 feet;
(g) Fluid waste disposal facilities. These shall be located convenient to, but not connected with, the operating rooms. A clinical sink or equivalent equipment in a soiled utility room or in a soiled holding room would meet this standard if convenient for use. When the surgical program does not include procedures with substantial liquid or solid wastes (for example, ~~e.g.~~ minor eye surgery), a clinical sink is not required;
(h) Clean utility room or a clean supply room. A clean utility room is required when clean materials are assembled within the surgical suite prior to use. A clean utility room shall contain work counter, a hand-washing station, and space for clean and sterile supplies. If the Functional Program defines a system for the storage and distribution of clean and sterile supplies in a clean supply room, the counter and sink may be omitted. The clean workroom or supply room may be shared with the delivery suite when provisions for joint use are included in the hospital's infection control policy and arrangement allows for direct access from both surgery and delivery suites. (See also obstetrical rules under OAR 333-535-0120.);
(i) Medical gas storage facilities. Storage of bulk medical gases shall be provided outside or inside the facility. Provisions shall be made for additional separate storage of reserve gas cylinders to complete at least one day's procedures. Storage facilities shall be in compliance with National Fire Protection Association (NFPA) 99;
(j) Anesthesia workroom. Inhalation anesthesia workroom for cleaning, testing, and storing anesthesia equipment shall contain a work counter and sink. Provisions shall be made for separated storage of clean and holding of soiled items. When facilities for cleaning and testing are available elsewhere in the building or the surgical program does not involve substantial anesthesia, a separate utility room is not required;
(k) Anesthesia storage. Anesthesia storage facilities shall be provided for anesthesia-related materials stored within the surgery suite;
(l) Equipment storage room(s) for equipment and supplies used in surgical suite. Ten percent of the surgical suite shall be devoted to equipment storage space. See OAR 333-535-0270 for storage requirements;
(m) Staff clothing change areas. Appropriate areas shall be provided for male and female personnel including orderlies, technicians, nurses and doctors working within the surgical suite.

Each area shall contain lockers, showers, toilets, hand-washing stations, and space for donning scrub attire. In surgical suites providing general anesthesia and invasive surgical procedures, these areas shall be arranged to encourage a traffic pattern so that personnel entering from outside the surgical suite can change and move directly into the surgical suite. Showers are not required in suites limited to minor procedures;
(n) Pre-surgical waiting area. In facilities with two or more operating rooms, a room or separate area shall be provided to accommodate stretcher patients waiting for surgery. This may be adjoining the post anesthesia recovery area and be serviced by the same staff nurse when feasible. The area shall be located to allow for nursing supervision and emergency communications;
(o) Storage areas for portable equipment used in surgery, such as portable X-ray unit, stretchers, fracture tables, warming devices~~,~~ or auxiliary lamps~~, etc~~. These areas shall not infringe on the width of exit corridors;
(p) Lounge, toilet facilities, and dictation and report preparation space for surgical staff. These facilities shall be provided in hospitals having three or more operating rooms and shall be located to permit use without leaving the surgical suite. A toilet room shall be provided near the recovery room(s);
(q) Housekeeping closet. A closet containing a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite;
(r) For major procedures, an area for preparation and examination of frozen sections. This may be part of the general laboratory if the system and procedures provide immediate results that will not unnecessarily delay the completion of surgery;
(s) Ice machine to supply ice for patient use and treatments;
(t) Provisions for refrigerated blood bank storage when major procedures are included; and
(u) Post anesthesia care unit for major surgical procedures. Each recovery unit shall be designed to provide:
(A) A medication distribution station, hand-washing stations (at a rate of one sink per four beds), nurses' station with charting facilities and clinical sink. Provisions for bedpan cleaning, storage space for stretchers, supplies and equipment shall be closely available.
(B) Clearance space of at least 5 feet between patient beds and 4 feet between sides of beds and adjacent walls.
(C) Patient privacy such as cubicle curtains.
(D) Provisions shall be made for isolation of infectious patients, although a separate isolation room is not mandated. At least one door to a recovery unit shall access directly from the surgical suite without crossing uncontrolled common hospital corridors. Separate and additional recovery space may be necessary to accommodate surgical outpatients, where applicable but is not required.
(5) Separate Hospital Licensed Outpatient Surgical Facilities. The following additional features shall be provided when an outpatient surgical facility is outside the inpatient hospital building or remote from the inpatient suite:
(a) Visual privacy shall be provided for registration, preparation, examination and recovery. Audible privacy shall be provided during registration;

(b) Provisions shall be made for patient examination, interview, testing and preparation prior to surgery;
(c) Outpatient surgical facilities not part of an inpatient hospital structure shall meet the requirements of the Oregon Structural Specialty Code and the NFPA 101 and 99; and
(d) Outpatient surgery change areas. If the Functional Program defines an outpatient surgery component as part of the inpatient surgical suite, facilities shall be provided where outpatients may change from street clothing into hospital gowns and be prepared for surgery. This would include facilities for waiting, storage of clothing, toilets, and space for gowning. Separate clothes changing areas are not required when sufficient pre-operative holding cubicles are available;
(e) Phase 1 recovery. If the facility provides outpatient surgery, rooms or cubicles for postanesthesia care and recovery shall be provided. At least 3 feet shall be provided at each side of each bed or recovery lounge chair and at the foot of each bed as needed for circulation of staff and gurneys and wheelchairs. Recovery spaces shall be observable from a nursing station. Provide hand wash stations at a rate of one sink per six recovery beds; and
(f) Phase 2 recovery spaces. Dedicated recovery spaces or a dedicated recovery lounge shall be provided in facilities where the surgical program includes patients who do not require postanesthesia recovery or who have completed postanesthesia recovery, but need additional time for observation by staff prior to leaving the facility. Access to toilet facilities shall be provided.
(g) Administrative and public areas. The following shall be provided:
(A) A patient and visitor waiting room or area and information and reception desk or counter;
(B) Public telephone or other phone(s) usable by patients and visitors;
(C) Space(s) for private interviews relating to social services, credit and admission;
(D) Office space(s) for business transactions, records, and administrative and professional staff, and space and equipment for medical records dictating, recording and retrieving. These shall be separate from public and patient areas with provisions for confidentiality of records;
(E) Secure storage for staff clothing and personal effects; and
(F) General storage for administrative supplies.
(6) Dental operations: Dental surgery facilities not part of a multi-specialty surgical unit shall meet the requirements of sections (1) through (4) of this rule. Operating rooms dedicated to dental surgery shall also conform to the following:
(a) Operating rooms used for invasive maxillofacial and reconstructive dental procedures with general anesthesia shall meet the rules of an operating room for major surgical procedures, except that room size shall be a minimum of 250 square feet; and
(b) Operating rooms for extractions and minor operative procedures within limited anesthesia or conscious sedation shall provide a minimum of 132 square feet of clear space and include the following features:
(A) Four feet or more of clear space at one side of the dental chair and a clear access route for a stretcher or gurney; and
(B) Mechanical and electrical features of a minor surgical procedure room according to OAR 333-535-0300 and 333-535-0310.
[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 441.025 & 441.060
Stats. Implemented: ORS 441.025 & 441.060