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Fast-Track Regulation Agency Background Document

Agency name	Virginia Board of Health
Virginia Administrative Code (VAC) citation(s)	12 VAC5-410-10 <i>et seq.</i>
Regulation title(s)	Regulations for the Licensure of Hospitals in Virginia
Action title	Amend Regulations to Conform to Ch. 433 of the 2019 Acts of Assembly
Date this document prepared	August 28, 2019

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations*.

Brief Summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

Ch. 433 of the 2019 Acts of Assembly amended and reenacted Va. Code § 32.1-134.01 to add perinatal anxiety to the list of information hospitals are required to make available to maternity patients, the father of the infant, and other relevant family members or caretakers such patients' release. The existing list of information from that Code section is not currently included in the hospital regulations and the Board is using this action to conform to the requirements of Va. Code § 32.1-134.01. The Board is also using this action to correct a spelling error in 12VAC5-410-441.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

“Board” means the Virginia State Board of Health.

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

The Board of Health approved these fast track amendments for the Regulations for the Licensure of Hospitals in Virginia on December 12, 2019.

Mandate and Impetus

Please identify the mandate for this regulatory change, and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, board decision, etc.). For purposes of executive branch review, “mandate” has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), “a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part.”

As required by Virginia Code § 2.2-4012.1, please also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track process.

Ch. 433 of the 2019 Acts of Assembly amended and reenacted Va. Code § 32.1-134.01 to add perinatal anxiety to the list of information hospitals are required to make available to maternity patients, the father of the infant, and other relevant family members or caretakers such patients’ release. The existing list of information from that Code section is not currently included in the hospital regulations.

As the rulemaking is being utilized to conform to the statutes and no new requirements are being developed, it is expected to be noncontroversial.

Legal Basis

Please identify (1) the agency or other promulgating entity, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency or promulgating entity’s overall regulatory authority.

Va. Code § 32.1-12 gives the Board the responsibility to make, adopt, promulgate, and enforce such regulations as may be necessary to carry out the provisions of Title 32.1 of the Code of Virginia. Va. Code § 32.1-127 requires the Board to adopt regulations that include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities.

Purpose

Please explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

This regulation is being amended due to the changes to Va. Code § 32.1-143.01. The Board is required by Va. Code § 32.1-127 to promulgate regulations for the licensure of hospitals in order to protect the health, safety, and welfare of citizens receiving care in hospitals. The goal of the regulatory change is to conform the regulations to the statutes. It is intended to increase maternity patients' knowledge and awareness regarding of certain information that protects the health, safety, and welfare of new mothers and their infants.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

12VAC5-410-441: A new subdivision is added to require the provision of information pursuant to Va. Code § 32.1-134.01.

Issues

Please identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

As the action is being used to conform the regulations to existing requirements in the statutes, there are no advantages or disadvantages to the public, the agency, or the Commonwealth.

Requirements More Restrictive than Federal

Please identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

There are no requirements in this proposal that exceed applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Please identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or

regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

No other state agency is particularly affected.

Localities Particularly Affected

No locality is particularly affected.

Other Entities Particularly Affected

The 106 licensed inpatient hospitals and 63 outpatient surgical hospitals will be required to comply with the provision.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, please identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Please keep in mind that this is change versus the status quo.

Impact on State Agencies

<i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	None.
<i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	None.
<i>For all agencies:</i> Benefits the regulatory change is designed to produce.	None.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	None.
Benefits the regulatory change is designed to produce.	None.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory	Licensed inpatient hospitals and licensed outpatient surgical hospitals.
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change. If no other entities will be affected, include a specific statement to that effect.	
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million.	106 inpatient hospitals and 63 outpatient surgical hospitals. Three of the outpatient surgical hospitals are estimated to meet the definition of "small business"
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	As all licensed hospitals are required to comply with the Code of Virginia, there are no projected costs for compliance with the regulatory change.
Benefits the regulatory change is designed to produce.	The regulatory change is designed to conform the regulations to the Code of Virginia.

Alternatives

Please describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no viable alternatives to conform the regulations to the statutes. As the requirement to provide information on perinatal anxiety is already present in statute, there are no additional costs for small businesses associated with compliance with the regulation.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

The Board is required to regulate the licensure of hospitals consistent with the provisions of Article 1 (Va. Code § 32.1-127 *et seq.*) of Chapter 5, Title 32.1 of the Code of Virginia and promulgating regulation is the

least burdensome method to conform the Regulations for the Licensure of Hospitals in Virginia (12VAC5-410) to the statutes.

Public Participation

If an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register; and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

Detail of Changes

Please list all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation.

If the regulatory change will be a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory change. Delete inapplicable tables.

If the regulatory change is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below. Please include citations to the specific section(s) of the regulation that are changing.

For changes to existing regulation(s), please use the following chart:

Current section number	Current requirement	Change, intent, rationale, and likely impact of new requirements
441	<p>12VAC5-410-441. Obstetric service requirements; medical direction; physician consultation and coverage; nurse staffing and coverage; policies and procedures.</p> <p>A. he governing body shall appoint a physician as medical director of the organized obstetric service who meets the qualifications specified in the medical staff bylaws.</p> <p>1. If the medical director is not a board certified obstetrician or board eligible in obstetrics, the hospital shall have a written agreement with one or more board-certified or board-eligible obstetricians to provide consultation on a 24-hour basis. Consultation may be by telephone.</p> <p>2. The duties and responsibilities of the medical director of obstetric services shall include but not be limited to:</p>	<p>Change: The Board is proposing the following change:</p> <p>12VAC5-410-441. Obstetric service requirements; medical direction; physician consultation and coverage; nurse staffing and coverage; policies and procedures.</p> <p>A. he The governing body shall appoint a physician as medical director of the organized obstetric service who meets the qualifications specified in the medical staff bylaws.</p> <p>1. If the medical director is not a board certified obstetrician or board eligible in obstetrics, the hospital shall have a written agreement with one or more board-certified or board-eligible obstetricians to provide consultation</p>

<p>a. The general supervision of the quality of care provided patients admitted to the service;</p> <p>b. The establishment of criteria for admission to the service;</p> <p>c. The adherence to standards of professional practices and policies and procedures adopted by the medical staff and governing body;</p> <p>d. The development of recommendations to the medical staff on standards of professional practice and staff privileges;</p> <p>e. The identification of clinical conditions and medical or surgical procedures that require physician consultation; and</p> <p>f. Arranging conferences, at least quarterly, to review obstetrical surgical procedures, complications and infant and maternal mortality and morbidity. Infant mortality and morbidity shall be discussed jointly between the obstetric and newborn service staffs.</p> <p>B. A physician with obstetrical privileges capable of arriving on-site within 30 minutes of notification shall be on a 24-hour on-call duty roster.</p> <p>C. A physician with obstetrical privileges shall be accessible for patient treatment within 10 minutes during the administration of an oxytocic agent to an antepartum patient.</p> <p>D. A physician or a certified nurse-midwife, under the supervision of a physician with obstetrical privileges, shall be in attendance for each delivery. Physician supervision of the nurse-midwife shall be in compliance with the regulations of the Boards of Nursing and Medicine.</p> <p>E. A physician shall be in attendance during all high-risk deliveries. High-risk deliveries shall be defined by the obstetric service medical staff.</p> <p>F. A physician or a nurse skilled in neonatal cardiopulmonary resuscitation (CPR) shall be available in the hospital at all times.</p> <p>G. A current roster of physicians, with a delineation of their obstetrical, newborn, pediatric, medical and surgical staff privileges,</p>	<p>on a 24-hour basis. Consultation may be by telephone.</p> <p>2. The duties and responsibilities of the medical director of obstetric services shall include but not be limited to:</p> <p>a. The general supervision of the quality of care provided patients admitted to the service;</p> <p>b. The establishment of criteria for admission to the service;</p> <p>c. The adherence to standards of professional practices and policies and procedures adopted by the medical staff and governing body;</p> <p>d. The development of recommendations to the medical staff on standards of professional practice and staff privileges;</p> <p>e. The identification of clinical conditions and medical or surgical procedures that require physician consultation; and</p> <p>f. Arranging conferences, at least quarterly, to review obstetrical surgical procedures, complications and infant and maternal mortality and morbidity. Infant mortality and morbidity shall be discussed jointly between the obstetric and newborn service staffs.</p> <p>B. A physician with obstetrical privileges capable of arriving on-site within 30 minutes of notification shall be on a 24-hour on-call duty roster.</p> <p>C. A physician with obstetrical privileges shall be accessible for patient treatment within 10 minutes during the administration of an oxytocic agent to an antepartum patient.</p> <p>D. A physician or a certified nurse-midwife, under the supervision of a physician with obstetrical privileges, shall be in attendance for each delivery. Physician supervision of the nurse-midwife shall be in compliance with the regulations of the Boards of Nursing and Medicine.</p> <p>E. A physician shall be in attendance during all high-risk deliveries. High-risk deliveries shall be defined by the obstetric service medical staff.</p>
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<p>shall be posted at each nurses' station in the obstetric suite and in the emergency room.</p> <p>H. A copy of the 24-hour on-call duty schedule, including the list of on-call consulting physicians, shall be posted at each nurses' station in the obstetric suite and in the emergency room.</p> <p>I. An occupied unit of the obstetrics service shall be supervised by a registered nurse 24 hours a day.</p> <p>J. If the postpartum unit is organized as a separate nursing unit, staffing shall be based on a formula of one nursing personnel for every six to eight obstetric patients. Staffing shall include at least one registered nurse for the unit for each duty shift.</p> <p>K. If the postpartum and general care newborn units are organized as combined rooming-in or modified rooming-in units, staffing shall be based on a formula of one nursing personnel for every four mother-baby units. The rooming-in units shall be staffed at all times with no less than two nursing personnel each shift. At least one of the two nursing personnel on each shift shall be a registered nurse.</p> <p>L. A registered nurse shall be in attendance at all deliveries. The nurse shall be available on-site to monitor the mother's general condition and that of the fetus during labor, at least one hour after delivery, and longer if complications occur.</p> <p>M. Nurse staffing of the labor and delivery unit shall be scheduled to ensure that the total number of nursing personnel available on each shift is equal to one half of the average number of deliveries in the hospital during a 24-hour period.</p> <p>N. At least one of the personnel assigned to each shift on the obstetrics unit shall be a registered nurse. At no time when the unit is occupied shall the nursing staff on any shift be less than two staff members.</p> <p>O. Patients placed under analgesia or anesthesia during labor or delivery shall be under continuous observation by a registered nurse or a licensed practical nurse for at least one hour after delivery.</p>	<p>F. A physician or a nurse skilled in neonatal cardiopulmonary resuscitation (CPR) shall be available in the hospital at all times.</p> <p>G. A current roster of physicians, with a delineation of their obstetrical, newborn, pediatric, medical and surgical staff privileges, shall be posted at each nurses' station in the obstetric suite and in the emergency room.</p> <p>H. A copy of the 24-hour on-call duty schedule, including the list of on-call consulting physicians, shall be posted at each nurses' station in the obstetric suite and in the emergency room.</p> <p>I. An occupied unit of the obstetrics service shall be supervised by a registered nurse 24 hours a day.</p> <p>J. If the postpartum unit is organized as a separate nursing unit, staffing shall be based on a formula of one nursing personnel for every six to eight obstetric patients. Staffing shall include at least one registered nurse for the unit for each duty shift.</p> <p>K. If the postpartum and general care newborn units are organized as combined rooming-in or modified rooming-in units, staffing shall be based on a formula of one nursing personnel for every four mother-baby units. The rooming-in units shall be staffed at all times with no less than two nursing personnel each shift. At least one of the two nursing personnel on each shift shall be a registered nurse.</p> <p>L. A registered nurse shall be in attendance at all deliveries. The nurse shall be available on-site to monitor the mother's general condition and that of the fetus during labor, at least one hour after delivery, and longer if complications occur.</p> <p>M. Nurse staffing of the labor and delivery unit shall be scheduled to ensure that the total number of nursing personnel available on each shift is equal to one half of the average number of deliveries in the hospital during a 24-hour period.</p> <p>N. At least one of the personnel assigned to each shift on the obstetrics unit shall be a registered nurse. At no time when the unit is occupied shall the nursing staff on any shift be less than two staff members.</p> <p>O. Patients placed under analgesia or anesthesia during labor or delivery shall be under continuous observation by a registered</p>
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<p>P. To ensure adequate nursing staff for labor, delivery, and postpartum units during busy or crisis periods, duty schedules shall be developed in accordance with the following nurse/patient ratios:</p> <ol style="list-style-type: none"> 1. 1:1 to 2 Antepartum testing 2. 1:2 Laboring patients 3. 1:1 Patients in second stage of labor 4. 1:1 Ill patients with complications 5. 1:2 Oxytocin induction or augmentation of labor 6. 1:2 Coverage of epidural anesthesia 7. 1:1 Circulation for cesarean delivery 8. 1:6 to 8 Antepartum/postpartum patients without complications 9. 1:2 Postoperative recovery 10. 1:3 Patients with complications, but in stable condition 11. 1:4 Mother-newborn care <p>Q. Student nurses, licensed practical nurses and nursing aides who assist in the nursing care of obstetric patients shall be under the supervision of a registered nurse.</p> <p>R. At least one registered nurse trained in obstetric and neonatal care shall be assigned to the care of mothers and infants at all times.</p> <p>S. At least one member of the nursing staff on each shift who is skilled in cardiopulmonary resuscitation of the newborn must be immediately available to the delivery suite.</p> <p>T. All nursing personnel assigned to the obstetric service shall have orientation to the obstetrical unit.</p> <p>U. The governing body shall adopt written policies and procedures for the management of obstetric patients approved by the medical and nursing staff assigned to the service.</p> <ol style="list-style-type: none"> 1. The policies and procedures shall include, but not be limited to, the following: 	<p>nurse or a licensed practical nurse for at least one hour after delivery.</p> <p>P. To ensure adequate nursing staff for labor, delivery, and postpartum units during busy or crisis periods, duty schedules shall be developed in accordance with the following nurse/patient ratios:</p> <ol style="list-style-type: none"> 1. 1:1 to 2 Antepartum testing 2. 1:2 Laboring patients 3. 1:1 Patients in second stage of labor 4. 1:1 Ill patients with complications 5. 1:2 Oxytocin induction or augmentation of labor 6. 1:2 Coverage of epidural anesthesia 7. 1:1 Circulation for cesarean delivery 8. 1:6 to 8 Antepartum/postpartum patients without complications 9. 1:2 Postoperative recovery 10. 1:3 Patients with complications, but in stable condition 11. 1:4 Mother-newborn care <p>Q. Student nurses, licensed practical nurses and nursing aides who assist in the nursing care of obstetric patients shall be under the supervision of a registered nurse.</p> <p>R. At least one registered nurse trained in obstetric and neonatal care shall be assigned to the care of mothers and infants at all times.</p> <p>S. At least one member of the nursing staff on each shift who is skilled in cardiopulmonary resuscitation of the newborn must be immediately available to the delivery suite.</p> <p>T. All nursing personnel assigned to the obstetric service shall have orientation to the obstetrical unit.</p> <p>U. The governing body shall adopt written policies and procedures for the management of obstetric patients approved by the medical and nursing staff assigned to the service.</p> <ol style="list-style-type: none"> 1. The policies and procedures shall include, but not be limited to, the following: <ol style="list-style-type: none"> a. Criteria for the identification and referral of high-risk obstetric patients;
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	<p>a. Criteria for the identification and referral of high-risk obstetric patients;</p> <p>b. The types of birthing alternatives, if offered, by the hospital;</p> <p>c. The monitoring of patients during antepartum, labor, delivery, recovery and postpartum periods with or without the use of electronic equipment;</p> <p>d. The use of equipment and personnel required for high-risk deliveries, including multiple births;</p> <p>e. The presence of family members or chosen companions during labor, delivery, recovery, and postpartum periods;</p> <p>f. The reporting, to the Department of Health, of all congenital defects;</p> <p>g. The care of patients during labor and delivery to include the administration of Rh O(D) immunoglobulin to Rh negative mothers who have met eligibility criteria. Administration of RH O(D) immunoglobulin shall be documented in the patient's medical record;</p> <p>h. The provision of family planning information, to each obstetric patient at time of discharge, in accordance with § 32.1-134 of the Code of Virginia;</p> <p>i. The use of specially trained paramedical and nursing personnel by the obstetrics and newborn service units;</p> <p>j. A protocol for hospital personnel to use to assist them in obtaining public health, nutrition, genetic and social services for patients who need those services;</p> <p>k. The use of anesthesia with obstetric patients;</p> <p>l. The use of radiological and electronic services, including safety precautions, for obstetric patients;</p> <p>m. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in aseptic containers, dated, stored under refrigeration and consumed or disposed of within 24 48 hours of collection if the</p>	<p>b. The types of birthing alternatives, if offered, by the hospital;</p> <p>c. The monitoring of patients during antepartum, labor, delivery, recovery and postpartum periods with or without the use of electronic equipment;</p> <p>d. The use of equipment and personnel required for high-risk deliveries, including multiple births;</p> <p>e. The presence of family members or chosen companions during labor, delivery, recovery, and postpartum periods;</p> <p>f. The reporting, to the Department of Health, of all congenital defects;</p> <p>g. The care of patients during labor and delivery to include the administration of Rh O(D) immunoglobulin to Rh negative mothers who have met eligibility criteria. Administration of RH O(D) immunoglobulin shall be documented in the patient's medical record;</p> <p>h. The provision of family planning information, to each obstetric patient at time of discharge, in accordance with § 32.1-134 of the Code of Virginia;</p> <p>i. The use of specially trained paramedical and nursing personnel by the obstetrics and newborn service units;</p> <p>j. A protocol for hospital personnel to use to assist them in obtaining public health, nutrition, genetic and social services for patients who need those services;</p> <p>k. The use of anesthesia with obstetric patients;</p> <p>l. The use of radiological and electronic services, including safety precautions, for obstetric patients;</p> <p>m. The management of mothers who utilize breast milk with their newborns. Breast milk shall be</p>
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<p>breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use;</p> <p>n. Staff capability to perform cesarean sections within 30 minutes of notice;</p> <p>o. Emergency resuscitation procedures for mothers and infants;</p> <p>p. The treatment of volume shock in mothers;</p> <p>q. Training of hospital staff in discharge planning for identified substance abusing, postpartum women and their infants; and</p> <p>r. Written discharge planning for identified substance abusing, postpartum women and their infants. The discharge plans shall include appropriate referral sources available in the community or locality for mother and infants such as:</p> <p>(1) Substance abuse treatment services; and</p> <p>(2) Comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 USC § 1471 et seq.</p> <p>(3) The discharge planning process shall be coordinated by a health care professional and shall include, to the extent possible:</p> <p>(a) The father of the infant; and</p> <p>(b) Any family members who may participate in the follow-up care of the mother or infant.</p> <p>The discharge plan shall be discussed with the mother and documented in the medical record.</p> <p>2. The obstetric service shall adopt written policies and procedures for the use of the labor, delivery and recovery rooms (LDR)/Labor, delivery, recovery and postpartum rooms (LDRP) that include, but are not limited to the following:</p>	<p>collected in aseptic containers, dated, stored under refrigeration and consumed or disposed of within 24 48 hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use;</p> <p>n. Staff capability to perform cesarean sections within 30 minutes of notice;</p> <p>o. Emergency resuscitation procedures for mothers and infants;</p> <p>p. The treatment of volume shock in mothers;</p> <p>q. Training of hospital staff in discharge planning for identified substance abusing, postpartum women and their infants; and</p> <p>r. Written discharge planning for identified substance abusing, postpartum women and their infants. The discharge plans shall include appropriate referral sources available in the community or locality for mother and infants such as:</p> <p>(1) Substance abuse treatment services; and</p> <p>(2) Comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 USC § 1471 et seq.</p> <p>(3) The discharge planning process shall be coordinated by a health care professional and shall include, to the extent possible:</p> <p>(a) The father of the infant; and</p> <p>(b) Any family members who may participate in the follow-up care of the mother or infant.</p> <p>The discharge plan shall be discussed with the mother and documented in the medical record-; and</p> <p><u>s. The provision of information pursuant to § 32.1-134.01 of the Code of Virginia about the</u></p>
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	<p>a. The philosophy, goals and objectives for the use of the LDR/LDRP rooms;</p> <p>b. Criteria for patient eligibility to use the LDR/LDRP rooms;</p> <p>c. Identification of high-risk conditions which disqualify patients from use of the LDR/LDRP rooms;</p> <p>d. Patient care in LDR/LDRP rooms, including but not limited to, the following;</p> <p>(1) Defining vital signs, the intervals at which they shall be taken, and requirements for documentation; and</p> <p>(2) Observing, monitoring, and assessing the patient by a registered nurse, certified nurse midwife, or physician;</p> <p>e. The types of analgesia and anesthesia to be used in LDR/LDRP rooms;</p> <p>f. Specifications of conditions of labor or delivery requiring transfer of the patient from LDR/LDRP rooms to the delivery room;</p> <p>g. Specification of conditions requiring the transfer of the mother to the postpartum unit or the newborn to the nursery;</p> <p>h. Criteria for early or routine discharge of the mother and newborn;</p> <p>i. The completion of medical records;</p> <p>j. The presence of family members or chosen companions in the delivery room or operating room in the event that the patient is transferred to the delivery room or operating room;</p> <p>k. The number of visitors allowed in the LDR/LDRP room, and their relationship to the mother; and</p> <p>l. Infection control, including, but not limited to, gowning and attire to be worn by persons in the LDR/LDRP room, upon leaving it, and upon returning.</p>	<p><u>incidence of postpartum blues, perinatal depression, and perinatal anxiety; information to increase awareness of shaken baby syndrome and the dangers of shaking infants; and information about safe sleep environments for infants that is consistent with current information from the American Academy of Pediatrics.</u></p> <p>2. The obstetric service shall adopt written policies and procedures for the use of the labor, delivery and recovery rooms (LDR)/Labor, delivery, recovery and postpartum rooms (LDRP) that include, but are not limited to the following:</p> <p>a. The philosophy, goals and objectives for the use of the LDR/LDRP rooms;</p> <p>b. Criteria for patient eligibility to use the LDR/LDRP rooms;</p> <p>c. Identification of high-risk conditions which disqualify patients from use of the LDR/LDRP rooms;</p> <p>d. Patient care in LDR/LDRP rooms, including but not limited to, the following;</p> <p>(1) Defining vital signs, the intervals at which they shall be taken, and requirements for documentation; and</p> <p>(2) Observing, monitoring, and assessing the patient by a registered nurse, certified nurse midwife, or physician;</p> <p>e. The types of analgesia and anesthesia to be used in LDR/LDRP rooms;</p> <p>f. Specifications of conditions of labor or delivery requiring transfer of the patient from LDR/LDRP rooms to the delivery room;</p> <p>g. Specification of conditions requiring the transfer of the mother to the postpartum unit or the newborn to the nursery;</p> <p>h. Criteria for early or routine discharge of the mother and newborn;</p>
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