LCB File No. R130-99

PROPOSED REGULATION OF THE STATE BOARD OF HEALTH

NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the State Board of Health will hold public hearing and act on amendments to Nevada Administrative Code (NAC) 449 and 652. **The hearing is scheduled to begin at 9:00 a.m. on Thursday, October 7, 1999, at the Grant Sawyer Building, Room 4410, 555 E. Washington Avenue, Las Vegas, Nevada.**

PROPOSED REGULATIONS FOR FACILITIES FOR THE TREATMENT OF IRREVERSIBLE RENAL DISEASE

Currently, there are no regulations for state licensure of Facilities for the Treatment of Irreversible Renal Disease. The proposed regulations will fill that gap.

The proposed regulations will affect all areas of service in the Facility for the Treatment of Irreversible Renal Disease. They will incorporate patient rights, minimum standards for space, equipment, water treatment and reuse, and sanitary and hygienic conditions, patient care and treatment, home dialysis, qualifications of staff, training, clinical records, and evaluation of quality.

The adoption of the proposed regulations should not create an economic or operational impact on licensed facilities because they parallel federal requirements that all facilities for the treatment of irreversible renal disease have been following.

The proposed regulations will have a beneficial impact for the public by providing licensing standards for recipients of renal dialysis that are consistent with current standards of practice.

The adoption of the proposed regulations will have no economic impact on the Bureau of Licensure and Certification because the proposed regulations parallel federal regulations that the agency has surveyed under contract with the Health Care Financing Administration.

The proposed regulations do not duplicate the regulations of other state or local government entities. They parallel federal regulations of the Health Care Financing Administration 42 C.F.R. 405.2102 through 405.2171, inclusive.

The proposed regulations contain several sections that are more stringent than the federal regulations: Requirements for Tuberculosis testing for employees, fire protection, training curriculum, bacteriologic testing of product water, and water system requirements.

The proposed regulations do not change existing fees or add additional fees.

PROVISION OF HOSPICE CARE

The proposed changes are necessitated by the passage of Senate Bill 382 that eliminated the word "Freestanding" from the statutory definition of facility for hospice care. This change allows a hospice program to be part of an existing medical facility.

The specific Nevada Administrative Code (NAC) regulations that are affected are: NAC 449.016, NAC 449.0181, NAC 449.0187, NAC 449.01225, NAC 449.016(1)(g), NAC 449.016(2)(h), NAC 449.0172, NAC 449.0181, NAC 449.0187, NAC 449.0187(8), and NAC 449.0188.

There will be no adverse effects on the business of hospice care. In fact, there will be a beneficial effect due to the fact that a hospice program could now occupy part of an existing medical facility rather than incur the expense of building a freestanding facility.

There will be no increased cost to the Bureau of Licensure and Certification. The changes to the regulations do not effect the time required to conduct licensure surveys.

These regulations do not overlap any other existing state regulations. The regulations are somewhat similar to the Medicare requirements for hospice care at 42 CFR 418.50 – 418.100. The federal regulations are more stringent.

The proposed changes to the regulations do not establish any new fees or increase existing fees.

FACILITIES FOR MODIFIED MEDICAL DETOXIFICATION AND FEES

The 1999 legislature established under NRS 449.0151 another facility type, facility for modified medical detoxification. "Facility for modified medical detoxification " means a facility that provides 24-hour medical monitoring of treatment and detoxification in a manner which does not require that the service be provided in a licensed hospital. The proposed regulations are necessary to license this medical facility type.

The proposed regulations establish consistency in the areas of Governing Body, Administration, Drug and Alcohol treatment program following the Bureau of Alcohol and Drugs programmatic guidelines, health and safety areas, and minimal nursing, pharmacy and, medication administration standards.

These proposed regulations will benefit the businesses because the businesses will be able to provide a higher level of detoxification services, as defined by American Society of Additive Medicine, to the public.

The public will have more opportunities to access a higher level of detoxification services for alcohol and drug addictions.

There will be no cost to the Bureau of Licensure and Certification for enforcement. Fees will be established for initial licensure and renewal licensure to be paid by the facilities. These fees will cover BLC's costs.

There is some duplication from the accreditation process by the Bureau of Alcohol and Drug abuse. The duplicated regulations are necessary to assure all programmatic aspects are met to assure that the public is receiving detoxification services that meet state and national standards.

The regulations do not duplicate or overlap any federal regulations.

Since this is a new facility type that will be licensed, there will be an initial licensure and annual renewal licensure fee for the facility. This fee covers the cost to the BLC for the survey processes and the clerical aspects.

HOMES FOR INDIVIDUAL RESIDENTIAL CARE AND FEES

During the 1999 Legislature, Senate Bill 163 was introduced, supported and passed because of concern for residents that were being cared for in homes for individual residential care. Until the passage of SB 163 these homes, with less than three residents were required to be registered by the bureau. However, there are no regulations for these homes to follow. Section 1 of NRS 449.249 has directed the Nevada State Board of Health to adopt minimal standards for licensing these homes that provide for care and sanitation to prevent the abuse, neglect and exploitation of the residents.

The minimal regulations were developed to prevent abuse, neglect and exploitation of residents in individual residential care and ensure that these resident's needs are met in a clean and sanitary environment.

The anticipated effect on the registered homes and individual residential care, is that each home will have consistent minimal standards to follow assuring consistently better care and understanding by the provider.

It is anticipated that the proposed regulations will provide a greater degree of protection for persons that live in homes for individual residential care.

The increased cost to the agency will be funded by establishing a minimal initial and renewal licensing fee for homes for individual residential care. The fee will be kept to a minimum for the home.

The proposed regulations do not overlap/duplicate other state or federal regulations. The proposed regulations do not have a counterpart in the code of federal regulations.

The regulation will establish a new fee for initial licensure and annual renewal. This fee will be kept to a minimum.

BUSINESSES THAT PROVIDE REFERRALS TO RESIDENTIAL FACILITIES FOR GROUPS AND FEES

Assembly Bill 373 requires a person to obtain a license from the board to operate a business that provides referrals to residential facilities for groups.

These regulations were developed to protect residents and their families by ensuring that people making referrals meet licensing standards and are confined to specific ways they can establish fees.

It is anticipated that the regulations will ensure that persons making referrals meet licensing standards and are prepared to assess a resident and assist with an appropriate placement. The regulations also determine the way fees can be charged. It is anticipated that these regulations will benefit the public using referral agencies.

The increased cost to the agency will be funded by establishing a minimal initial and renewal licensing fee for referral agencies.

The proposed regulations do not overlap/duplicate other state or federal regulations. The proposed regulations do not have a counterpart in the code of federal regulations.

The regulations will establish a new fee for initial licensure and annual renewal for referral agencies.

MEDICAL LABORATORIES AND FEES

Changes are needed to align regulations with statute as stated in Senate Bill 7 and establish fees associated with compliance verification for Senate Bill 7 and Assembly Bill 470.

Laboratory Assistant qualifications will be modified to reference those qualifications stated in Senate Bill 7. Permissible testing for laboratory assistants will be expanded to include all tests classified as waived. Fees will be established to cover costs associated with compliance verification of testing in out patient centers as permitted by Senate Bill 7. The ability to recover costs associated with the survey of out of state laboratories as required by Assembly bill 470 will be established.

No anticipated effects on medical laboratories. No anticipated effect on the public. No cost to the Health Division. No duplication of state or local regulations. No overlap of federal regulations. Regulations are not more stringent than federal regulations.

An initial fee of $100 is established for each out patient center of a licensed laboratory that performs testing along with a $50 biennial renewal fee.

RESIDENTIAL FACILITIES FOR TWO OR FEWER

Assembly Bill 373 requires that by January 1, 2000, homes for individual residential care in Counties of more than 100,000 either become licensed as residential facilities for groups or cease to operate. These facilities must comply with all statutory requirements for residential facilities for groups. The minimal regulations written for these facilities provide for care and sanitation to prevent abuse, neglect and exploitation of the elderly.

The minimal regulations were developed to prevent abuse, neglect and exploitation of residents and ensure that residents' needs are met in a clean and sanitary environment.

The anticipated effect on these facilities is that some facilities may have difficulty in meeting the requirements and therefore cease operation. Others may meet the requirements and provide a more professional setting for residents.

It is anticipated that the proposed regulations will provide a greater degree of protection for persons that live in residential facilities for groups licensed for two or fewer. It is anticipated that because of the proposed regulations some facilities may choose to close and therefore make options more limited for the elderly.

The increased cost to the agency will be funded by the licensing and renewal fees collected from these facilities.

The proposed regulations do not duplicate/overlap federal regulations.
The proposed regulations do not have a counterpart in the code of federal regulations.

The proposed regulations do incorporate state regulations. NAC 449.190, NAC 449.193, NAC 449.196 section 1 (a), (b) and (e), NAC 449.202, NAC 449.205, NAC 449.231, NAC 449.268 and NAC 449.269 will apply to residential facilities for two only.

The regulations determine that these facilities will be required to pay the fees established for residential facilities for groups.

Members of the public may make oral comments at this meeting. Persons wishing to submit written testimony or documentary evidence in excess of two typed, 8-1/2" x 11" pages must submit the material to the Board's Secretary by September 22, 1999.

Secretary, State Board of Health
Nevada State Health Division
Capitol Complex
505 E. King Street, Room 201
Carson City, NV 89701-4797

Written comments, testimony, or documentary evidence in excess of two typed pages will not be accepted at the time of the hearing. The purpose of this requirement is to allow Board members adequate time to review the documents.

Members of the public who are disabled and require special accommodations or assistance at the meeting are required to notify Yvonne Sylva, Secretary, Board of Health, in writing at the Nevada State Health Division, 505 E. King Street, Room 201, Carson City, NV 89701, or by calling (702) 687-4740.

A copy of this notice and the proposed regulation amendments are on file for inspection at the following locations during normal business hours:

Bureau of Licensure and Certification, 1550 E. College Pkwy, Suite 158, Carson City, Nevada (702) 687-4475).

Bureau of Licensure and Certification, 4220 S. Maryland Parkway, Suite 810, Las Vegas, Nevada (702) 486-6515.

Bureau of Licensure and Certification, 1755 E. Plumb Lane, Suite 241, Reno, Nevada
(702) 688-2888

Emergency Medical Services, 850 Elm Street, Elko, Nevada (702) 753-1154.

Emergency Medical Services, 100 Frankie, Tonopah, Nevada (702) 482-3722.

Copies may be obtained in person, by mail, or by calling (702) 687-4475. Copies are also available for review at all physical locations of program offices (see above) or the following main public libraries in each county:

- Carson City Library, 900 North Roop St.
  Carson City, NV 89701
- Churchill County Library, 533 S. Main St.
  Fallon, NV 89406
- Clark County Library, 4020 Maryland Parkway,
  Las Vegas, NV 89119
- Douglas County Library, 1625 Library Lane, (PO Box 337)
  Minden, NV 89423
- Elko County Library, 720 Court St.
  Elko, NV 89801
- Goldfield Public Library (Esmeralda Co.), Corner of Crook and Ramsey, (PO Box 430)
  Goldfield, NV 89013
- Eureka Branch Library, 10190 Monroe St.,
  Eureka, NV 89316
- Humboldt County Library, 85 East 5th St.,
  Winnemucca, NV 89445
- Battle Mountain Branch Library (Lander Co.), 6255 Broad St.,
  Battle Mountain, NV 89820
- Lincoln County Library, 63 Maine St., (PO Box 330)
  Pioche, NV 89043
- Lyon County Library, 20 Nevin Way,
  Yerington, NV 89447
- Mineral County Library, 125 A St., (PO Box 1390)
  Hawthorne, NV 89415
- Pershing County Library, 125 Central, (PO Box 781)
  Lovelock, NV 89419
- Storey County Library, 95 South R St., (PO Box 14)
  Virginia City, NV 89440

- Tonopah Public Library (Nye Co.), 171 Central, (PO Box 449)
  Tonopah, NV 89049
- Washoe County Library, 301 South Center St., (PO Box 2151)
  Reno, NV 89505
- White Pine County Library, 950 Campton St.,
  Ely, NV 89301

Per NRS 233B.064(2), upon adoption of any regulations, the agency, if requested to do so by an interested person, either prior to adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, and incorporate therein its reason for overruling the consideration urged against its adoption.

LCB File No. R130-99

PROPOSED REGULATION OF THE STATE BOARD OF HEALTH

FACILITIES FOR THE TREATMENT OF IRREVERSIBLE RENAL DISEASE

EXPLANATION - Italicized material is new

GENERAL PROVISIONS.

Chapter 449 of NAC is hereby amended by adding, thereto the provision set forth as Section 1 to 64, inclusive, of this regulation.

Section 1. ***Definitions. As used in Sections 1 to 64, inclusive unless the context otherwise requires, the words and terms defined in Section 1 to 64 inclusive, have the meaning ascribed to them in those sections.***

Definitions. The following words and terms, when used in this chapter, must have the following meanings, unless the context clearly indicates otherwise.

1. Competency - The demonstrated ability to carry out specified tasks or activities with reasonable skill and safety that adheres to the prevailing standard of practice.

2. Core staff members - The facility's medical director, supervising nurse, dietitian, social worker, administrator.

3. Bureau - the Bureau of Licensure and Certification.

4. Dialysis - A process by which dissolved substances are removed from a patient's body by diffusion, osmosis and convection (ultrafiltration) from one fluid compartment to another across a semipermeable membrane.

5. Dialysis technician - An individual who is not a registered nurse or physician and who provides dialysis care under the direct supervision of a registered nurse or physician.

6. Division - Division means the Health Division.

7. End stage renal disease - That stage of renal impairment that appears irreversible and permanent and that requires a regular course of dialysis or kidney transplantation to maintain life.

8. Facility - Facility for the treatment of irreversible renal disease has the meaning ascribed to it in NRS 449.0046.

9. Intermediate level disinfection - A surface treatment using chemical germicides or disinfectants which are capable of inactivating various classes of microorganisms including, but not limited to, viruses (primarily medium to large viruses and lipid-containing viruses), fungi, and actively growing bacteria (including tubercle bacteria) when such chemical germicides or disinfectants are used in accordance with the manufacturer's instructions or per established guidelines. Intermediate level disinfection is generally not effective in inactivation or eliminating bacterial endospores. Examples of intermediate level disinfectants include bleach, 70-90% ethanol or isopropanol, and certain phenolic or iodophor preparations.

10. Licensed practical nurse (LPN) - A person who is currently licensed in accordance with NAC 632.242.

11. Pediatric patient - An individual 14 years of age or younger under the care of a facility.

12. Product water - The effluent water from the last component of the facility's water treatment system.

13. Progress note - A dated and signed written notation by a facility staff member summarizing facts about care and a patient's response during a given period of time.

14. Supervision - Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the

actual act of accomplishing the function or activity. Immediate supervision means the supervisor is actually observing the task or activity as it is performed. Direct supervision means the supervisor is on the premises but not necessarily immediately physically present where the task or activity is being performed. Indirect supervision means the supervisor is not on the premises but is accessible by two-way communication and able to respond to an inquiry when made, and is readily available for consultation.

15. Training - The learning of tasks through on-the-job experience or instruction by an individual who has the capacity through education or experience to perform the task or activity to be delegated.

Section 2. *For a facility providing end stage renal disease services prior to October 1, 1999, a notarized attestation that each dialysis technician on staff as of October 1, 1999, will have completed the training and competency evaluation programs described in Section 52 through Section 62, inclusive, of this title. A facility initiating end stage renal disease services on or after October 1, 1999, must have available an attestation from the medical director that each dialysis technician on staff has completed the training competency evaluation programs;*

Section 3.

1. A facility must notify the bureau in writing thirty days prior to the occurrence of any construction, renovation or modification of the facility's physical plant; or cessation of the operation of the facility. A facility must obtain approval by the bureau in order to increase the number of stations which appear on the facility license.

2. A facility must submit a new license application thirty days prior to the anticipated date of station increase. The application must be accompanied by the following;

(a) evidence that the facility has reviewed staffing availability and added staff positions if indicated to accommodate the increase;

(b) evidence that the water treatment system is of sufficient size to produce safe water for the increase in stations; and

(c) $160 fee for processing.

3. The bureau may conduct an on-site inspection prior to taking action on the requested increase.

4. No later than three weeks after initiating use of the new stations, the facility must submit to the bureau laboratory reports of chemical analysis and bacteriologic cultures of the product water demonstrating compliance with Section 3.2.1 Water Bacteriology and 3.2.2 Maximum Level of Chemical Contaminants of the American National Standard, Hemodialysis Systems, March 1992 Edition, published by the Association for the Advancement of Medical Instrumentation, 3330 Washington Boulevard, Suite 400, Arlington, Virginia 22201, 1-703-525-4890 . Ask for publication RD5. The cost is $50.00 for AAMI members, $100.00 for non-members and shipping and handling is $5.00.

Section 4. *Optional Plan Review and Inspection.*

1. Request for plan review. Plans and specifications covering the construction of new buildings or alterations, additions, conversions, modernization or renovations to existing buildings may be submitted to the bureau for review to determine compliance with this chapter. Submission of plans and specifications is not mandatory. If a plan review is requested by the facility, plans and specifications must be submitted in accordance with this section.

2. A review of minor alterations or remodeling changes which do not include alterations to load-bearing members of partitions, change functional operation, affect fire safety, or add additional stations may be requested. The request for review must be in writing to the bureau with a brief description of the proposed changes.

3. If review of preliminary plans and outline specifications is requested, the submittal must contain sufficient information to establish the scope of the project and compliance with the design and space requirements in this chapter.

4. If review of final drawings and specifications is requested, one complete set of drawings must be submitted. All working drawings must be well-prepared so that clear and distinct prints may be obtained, be accurately dimensioned, and include all necessary explanatory notes, schedules, and legends. Final drawings must be complete and adequate for construction contract purposes. All final plans and specifications must be appropriately sealed and signed by a registered architect and professional engineer licensed by the State of Nevada. Drawings and specifications must comply with the design and space requirements in these regulations.

5. A construction inspection must be scheduled at the convenience of the bureau at 100% completion when the project is ready to be occupied. The purpose of the inspection must be to verify compliance with design and space requirements in this chapter.

Section 5. ***Design and Space Requirements.***

1. Facilities will be considered to be in compliance if the facility is licensed on October 1, 1999, the use of the physical space does not change, and the existing construction does not have any deficiencies which are likely to cause serious injury, serious harm or impairment to public health and welfare. If there are deficiencies that are likely to cause serious injury,

serious harm, or impairment to public health and welfare, the facility must take corrective action before the center can continue to operate.

2. The facility must provide a physical environment that protects the health and safety of patients, personnel and the public. The physical premises of the facility and those areas of the facility's surrounding physical structure that are used by the patients (including all stairwells, corridors and passageways) must meet the local building and fire safety codes as they relate to design and space requirements for safe access and patient privacy.

3. Newly constructed and existing facilities must be designed and maintained to comply with the current National Fire Protection Association, Life Safety Code, Standard 101. A copy of the code may be obtained from the National Fire Protection Association, 11 Tracey Drive, Avon, Massachusetts 02322, for the cost of $44.50, plus $4.84 for shipping and handling.

4. If hepatitis B positive patients are treated, they must be treated with a designated machine, blood pressure cuff, sink, and other equipment.

Section 6. *Fire protection.*

1. If the facility is equipped with an approved sprinkler system, the sprinkler system, and other fire-fighting equipment must be inspected and tested at least once each year to maintain it in serviceable condition. The sprinkler system must be installed and maintained in accordance with the National Fire Protection Association 13, and maintained in accordance with National Fire Protection Association 25, Standard for the Installation of Sprinkler Systems, 1994 Edition, published by the National Fire Protection Association, 11 Tracy Drive, Avon, Massachusetts, 02322, 10800-344-3555. The cost is $33.00 plus $5.95 for shipping and handling.

2. The facility must have an emergency lighting system capable of providing sufficient illumination to allow safe evacuation from the building. Battery pack systems must be maintained and tested weekly. If a facility maintains a back-up generator, the generator must be installed, tested and maintained in accordance with the National Fire Protection Association 110, Standard for Emergency and Standby Power Systems, 1999 Edition (NFPA 110), published by the National Fire Protection Association, 11 Tracy Drive, Avon, Massachusetts, 02322, 10800-344-3555. The cost is $23.25 plus $5.95 for shipping and handling.

3. A facility housed in or adjacent to a building classified as a "high hazard industrial occupancy," as defined in Section 28, Subsection 1.4.11 of the NFPA 101, must have a special feature such as a two-hour fire wall between the facility and the other occupancy and written approval by the fire authority having jurisdiction.

4. The facility must be equipped with smoke detectors which are maintained in proper operating condition at all times and must be tested according to manufacturer's specifications.

Section 7. *Construction. If construction takes place in or near occupied areas, adequate provision must be made for the safety and comfort of patients during the construction. A facility may impose more stringent design and space standards than the minimum standards.*

Section 8. *Equipment.*

1. All equipment used by the facility, including backup equipment, must be maintained free of defects which could be a potential hazard to patients, staff, or visitors. Maintenance and repair of all equipment must be performed by qualified staff or contract personnel.

(a) Staff must be able to identify malfunctioning equipment and report such equipment to the appropriate staff for repair.

(b) Medical equipment that malfunctions must be immediately removed from service until the malfunction is identified and corrected.

(c) Written evidence of all maintenance and repairs must be maintained.

(d) After repairs or alterations are made to any equipment or system, the equipment or system must be thoroughly tested for proper operation before returning to service.

(e) The facility must comply with the federal Food, Drug, and Cosmetic Act, 21 United States Code(USC), Section 360i, Subsection (b), relating to reporting when a medical device as defined in 21 USC Section 321, Subsection (h) has or may have caused or contributed to the injury or death of a patient of the facility.

2. The facility must develop, implement and enforce a written preventive maintenance program to ensure patient care related equipment used in the facility or provided by the facility for use by the patient in the patient's home receives electrical safety inspections, if appropriate, and maintenance at least annually or more frequently as recommended by the manufacturer. The preventive maintenance may be provided by facility staff or by contract personnel.

3. At least one complete dialysis machine must be available on-site as backup for every fourteen (14) dialysis machines in use.

4. If pediatric patients are treated, the facility must use equipment and supplies, to include blood pressure cuffs, dialyzers, and blood tubing, appropriate for this special population.

5. All equipment and appliances must be properly grounded in accordance with the National Fire Protection Association 99, Standard for Health Care Facilities, Section 3-4.1 and Section 7-5.1, 1999 Edition (NFPA 99) published by the National Fire Protection Association. All documents published by the NFPA as referenced in this section may be

obtained by writing or calling the NFPA at the following address and telephone number: Post Office Box 9101, Batterymarch Park, Quincy, Massachusetts 02169, 1-800-344-3555. The cost is $37.25 plus $5.95 for shipping and handling.

6. Extension cords and cables must not be used for permanent wiring.

7. The facility must have emergency equipment and supplies immediately accessible in the treatment area

(a) At a minimum, the emergency equipment and supplies must include the following:

(i) oxygen;

(ii) ventilatory assistance equipment, to include airways, manual breathing bag, and mask;

(iii) suction equipment;

(iv) supplies specified by the medical director; and

(b) If pediatric patients are treated, the facility must have the appropriate type and size emergency equipment and supplies listed in paragraph (4) of this subsection for this special population.

8. The facility must establish, implement, and enforce a policy for the periodic testing and maintenance of emergency equipment. Staff must properly maintain and test emergency equipment and supplies and document the testing and maintenance.

9. If the facility employs a central delivery system for bicarbonate dialysate, the system must be drained at the end of each treatment day and cultured weekly to identify potential bacterial contamination. If cultures demonstrate more than 2,000 colony forming units (CFUs) per milliliter, the bicarbonate delivery system must be disinfected and recultured.

Section 9. ***Water Treatment and Reuse.***

1. The facility must meet the requirements of this section. The facility may follow more stringent requirements for water treatment and reuse of hemodialyzers than the minimum standards required by this section.

2. The design for the water treatment system in the facility must be based on considerations of the source water for the facility and designed by a water quality professional with education, training, or experience in dialysis system design.

(a) When a public water system supply is not used by a facility, the water used must be subjected to bacteriological analysis by the appropriate health authority as defined in the statute or a commercial laboratory, certified by the Health Division every 3 months.

(b) The physical space in which the water treatment system is located must be adequate to allow for maintenance, testing, and repair of equipment. If mixing of dialysate is performed in the same area, the physical space must also be adequate to house and allow for the maintenance, testing, and repair of the mixing equipment and for performing the mixing procedure.

(c) The water treatment system components must be arranged and maintained so that bacterial and chemical contaminant levels in the product water do not exceed the standards for hemodialysis water quality described in [3.2.1] (relating to Hemodialysis Systems) and [3.2.2](relating to Maximum Level of Chemical Contaminants) of the American National Standard, Hemodialysis Systems of the AAMI standards as described in these regulations. March 1992 Edition, published by the AAMI as referenced in this section may be obtained by writing the following address: 3330 Washington Boulevard, Suite 400, Arlington, Virginia 22201. The cost is $125.00 plus $5.95 for shipping and handling.

(d) Written policies and procedures for the operation of the water treatment system must be developed and implemented. Parameters for the operation of each component of the water treatment system must be developed in writing and known to the operator. The facility must establish and maintain in the water area written procedures describing the actions to be taken when parameters are not met.

(e) Each water treatment system must include reverse osmosis membranes or deionization tanks and a minimum of two carbon tanks in series. If the source water is from a private supply which does not use chlorine/chloramine, the water treatment system must include reverse osmosis membranes or deionization tanks and a minimum of one carbon tank.

(i) Reverse osmosis membranes, if used, must meet the standards in [3.2.3.5] (relating to Reverse Osmosis) of the AAMI.

(ii) Deionization systems, if used, must meet the standards in [3.2.3.3] (relating to Regenerated or Reconstituted Devices) and [3.2.3.4](relating to Deionization) of the AAMI.

(iii) The carbon tanks must contain acid washed 30-mesh or smaller carbon placed in series with a minimum empty bed contact time of three minutes for each tank or bank of tanks and a testing port between the tanks or bank of tanks. Water from this port(s) must be tested for chlorine/chloramine levels prior to each patient shift. The first test each treatment day for chlorine/chloramine must be done no sooner than 15 minutes after start-up of the water treatment system.

(iv) Test results of greater than 0.5 parts per million (p p.m.) for chlorine or 0.1 p p.m. for chloramine from the port between the initial tank(s) and final tank(s) must require testing to be performed at the final exit and replacement of the initial tank(s). If test results at the exit of the final tank(s) are greater than the parameters for chlorine or chloramine described in this

subparagraph, dialysis treatment must be immediately terminated to protect patients from exposure to chlorine/ chloramine and the medical director must be notified.

3. Water softeners, if used, must have the capacity to treat a sufficient volume of water to supply the facility for the entire treatment day.

4. Cartridge filters, if used, must be made of material (e.g., pure polypropylene) which will not leach surfactants, formaldehyde, or other material which has been used in their manufacture.

5. Cartridge filter housings, if used during disinfectant procedures, must include a means to clear the lower portion of the housing of the disinfecting agents. Filter housings must be opaque.

6. The water treatment system must be continuously monitored during patient treatment and be guarded by audible and visual alarms which can be seen and heard in the dialysis treatment area should water quality drop below specified parameters

7. When deionization tanks do not follow a reverse osmosis system, parameters for the rejection rate of the membranes must assure that the lowest rate accepted would provide product water in compliance with [3.2.2](relating to Maximum Level of Chemical Contaminants) of the American National Standard, Hemodialysis Systems, March 1992 Edition published by the AAMI.

8. A facility must maintain written logs of the operation of the water treatment system for each treatment day. The log book must include each component's operating parameter and the action taken when a component is not within the facility's set parameters.

9. Microbiological testing of product water must be conducted monthly and following any repair or change to the water treatment system. The results must demonstrate that water

quality meets [3.2.1](relating to Hemodialysis Systems) of the American National Standard, Hemodialysis Systems, of the AAMI as described in these regulations. Sample sites chosen for the testing must include the beginning of the distribution piping, the product water in the reuse room, and the end of the distribution piping. If the results do not meet the AAMI standard described in this paragraph, the water system must be immediately disinfected and recultured. If after disinfection, the cultures do not meet the AAMI standards described in this paragraph, the facility must determine the source of contamination by immediately reculturing the sample sites, all patient stations, any water storage tanks, water used to mix dialysate, and product water from the final component of the water treatment system. A calibrated loop may not be used in microbiological testing of water samples.

10. A sample of product water must be submitted for chemical analysis every six months and must demonstrate that water quality meets [3.2.2](relating to Maximum Level of Chemical Contaminants) of the American National Standard, by the AAMI. Additional chemical analysis must be submitted if substantial changes are made to the water treatment system or if the percent rejection of a reverse osmosis system decreases 5.0% or more from the percent rejection measured at the time the water sample for the preceding chemical analysis was taken. Portable units must submit and demonstrate water quality yearly.

11. Facility records must include all test results and evidence that the medical director had reviewed the results of the water quality testing and directed corrective action when indicated.

12. Only persons qualified by the education or experience described in Section 43 of this chapter may repair or replace components of the water treatment system. Documentation of education or training which qualifies these persons must be maintained on file in the facility.

13. Reuse of hemodialyzers and related devices. Reuse practice in a facility must comply with the American National Standard, Reuse of Hemodialyzers, 1992 Edition published by the AAMI as described in these regulation

(a) A transducer protector must be replaced when wetted during a dialysis treatment and must be used for one treatment only.

(b) The water supply in the reuse room must incorporate a back flow to prevent chemical agents used from inadvertently back flowing into the water distribution system.

(c) Ventilation systems in the reuse room must be connected to an exhaust system to the outside which is separate from the building exhaust system, have an exhaust fan located at the discharge end of the system, and have an exhaust duct system of noncombustible corrosion-resistant material as needed to meet the planned usage of the system. Exhaust outlets must be above the roof level and arranged to minimize recirculation of exhaust air into the building.

(d) The facility must establish, implement, and enforce a policy for dialyzer reuse criteria (including any facility-set number of reuses allowed) which is included in patient education materials.

(e) The facility must consider and address the health and safety of patients sensitive to disinfectant solution residuals.

(f) The facility must provide each patient with information regarding the reuse practices at the facility, and the opportunity to have questions answered.

(g) The facility must restrict the reprocessing room to authorized personnel.

(h) The facility must obtain written informed consent of the patient or legal representative for reuse.

14. Centralized dialyzer reprocessing. If the facility participates in centralized reprocessing in which dialyzers from multiple facilities are reprocessed at one site, the facility must:

(a) require the use of automated reprocessing equipment;

(b) maintain responsibility and accountability for the entire reuse process;

(c) adopt, implement, and enforce policies to ensure that the transfer and transport of used and reprocessed dialyzers to and from the off-site location does not increase contamination of the dialyzers, staff , or the environment; and

(d) provide bureau staff access to the off-site reprocessing site as part of a facility inspection.

Section 10. *Sanitary Conditions and Hygienic Practices.*

1. Standard universal precautions must be followed in the facility for all patient care activities in accordance with 29 Code of Federal Regulations, [1910.1030](d)(1)-(3)(relating to Bloodborne Pathogens) and the Health and Safety Code, Chapter 85, Subchapter I (relating to Prevention of HIV and Hepatitis B Virus by Health Care Workers).

Facility staff must wash their hands before and after each patient contact in which there is a potential exposure to blood or body fluids. Location and arrangement of hand washing facilities must permit ease of access and proper use.

(a) Hand washing sinks must be readily accessible in each patient care area.

(b) All fixtures and lavatories in the treatment area must be trimmed with valves which can be operated without the use of hands. There must be sufficient clearance for the operation of blade- type handles, if they are used.

(c) Provisions for hand drying must be included at all hand washing facilities.

2. Facility staff must explain the potential risks associated with blood and blood products to patients and family members and provide the indicated personal protective equipment to a patient or family member if the patient or family member assists in procedures which could result in contact with blood or body fluids.

Section 11. *Documentation and Coordination of Infection Control Activities.*

1. The facility must designate a person to monitor and coordinate infection control activities.

2. The facility must develop and maintain a system to identify and track infections to allow identification of trends or patterns. This activity must be reviewed as a part of the facility's quality assurance program. The record must include trends, corrective actions, and improvement actions taken.

3. The facility must establish, implement, and enforce a no smoking policy.

Section 12. *Environmental Infection Control.*

1. The facility must provide and actively monitor a sanitary environment which minimizes or prevents transmission of infectious diseases.

2. Wall bases in patient treatment and other areas which are frequently subject to wet cleaning methods must be tightly sealed to the floor and the wall, impervious to water and constructed without voids that can harbor insects.

3. Floor materials must be easily cleanable and have wear resistance appropriate for the location involved. In all areas subject to wet cleaning methods, floor materials must not be physically affected by germicidal and cleaning solutions.

4. Wall finishes must be washable and, in the immediate areas of plumbing fixtures, smooth and moisture resistant.

5. Floor and wall penetrations by pipes, ducts, and conduits must be tightly sealed to minimize entry of rodents and insects. Joints of structural elements must be similarly sealed.

6. All exposed ceilings and ceiling structures in areas normally occupied by patients, staff, and visitors must be finished so as to be cleanable with equipment used in daily housekeeping activities. Ceiling tiles stained with blood must be cleaned or replaced.

7. Ceiling fans must not be utilized in patient treatment areas

8. Blood spills must be cleaned immediately or as soon as is practical with a disposable cloth and an appropriate chemical disinfectant.

(a) The surface should be subjected to intermediate level disinfection in accordance with the manufacturer's instructions, if a commercial liquid chemical disinfectant is used or,

(b) If a solution of chlorine bleach (sodium hypochlorite) is used, the solution must be at least 1:100 sodium hypochlorite and the surface to be treated must be compatible with this type of chemical treatment.

Section 13. *Specific Procedures for Equipment and Dialysis Machines.*

1. Routine disinfection of active and backup dialysis machines must be performed according to facility defined protocol, accomplishing at least intermediate level disinfection.

2. Samples of dialysate from machines chosen at random must be cultured monthly, and culture results must not exceed 2,000 colony forming units per milliliter. Hemodialysis machines of home patients must be cultured monthly until results not exceeding 2,000 colony forming units per milliliter are obtained for three consecutive months, then quarterly samples must be cultured.

3. Between patient shifts, facility staff must clean machine exteriors, treatment chairs, tourniquets, and hemostats. Blood pressure cuffs which become contaminated with blood must be removed from service, disinfected, and allowed to dry prior to being returned to use.

(a) The facility must comply with the requirements set forth by the state and local municipality. Regarding handling of waste from Healthcare related facilities and,

(b) All sewage and liquid wastes must be disposed of in a municipal sewerage system or a septic tank system permitted by State Regulations and /or local municipalities.

Section 14. *Hepatitis B Prevention.*

1. The facility must offer hepatitis B vaccination to previously unvaccinated, susceptible new staff members in accordance with 29 Code of Federal Regulations. [1910.1030](f)(1)-(2) (relating to Bloodborne Pathogens). Staff vaccination records must be maintained in each staff member's health record.

2. New staff members must be screened for hepatitis B surface antigen (HBsAg) and the results reviewed prior to the staff providing patient care, unless the new staff member provides the facility documentation of positive serologic response to hepatitis B vaccine.

3. The facility must establish, implement and enforce a policy for repeated serologic screening of staff. The repeated serologic screening must be based on each staff member's HBsAg/antibody to HBsAg (anti-HBs), and must be congruent with Appendices I and II of the National Surveillance of Dialysis Associated Disease in the United States, 1993, published by the United States Department of Health and Human Services (USDHHS) at the following address and telephone number: Public Health Service, Centers for Disease Control and Prevention, National Center for Infectious Diseases, Hospital Infection Program, Mail Stop C01, Atlanta, Georgia 30333, 404-639-2318 at no cost.

Section 15. ***Prevention requirements concerning patients.***

1. With the advice and consent of a patient's attending nephrologist, facility staff must make the hepatitis B vaccine available to a patient who is susceptible to hepatitis B.

2. The facility must make available to patients literature describing the risks and benefits of the hepatitis B vaccination.

Section 16. ***Serologic screening of patients.***

1. Candidates for dialysis must be screened for Hepatitis B surface Antigens (HbsAg). Screening may be performed within one month before admission to the facility.

(a) Repeated serologic screening must be based on the antigen or antibody status of the patient.

(b) Monthly screening for HBsAg is required for patients whose previous test results are negative for HBsAg.

(c) Screening of HBsAg-positive or anti-HBs-positive patients may be performed on a less frequent basis, provided that the facility's policy on this subject remains congruent with Appendices I and II of the National Surveillance of Dialysis Associated Disease in the United States, as described in Section 14.

Section 17. ***Isolation procedures for the HBsAg-positive patient.***

1. The facility must treat patients positive for HBsAg on a dedicated machine in an area which includes a handwashing sink, a work area, patient care supplies and equipment, and sufficient space to prevent cross-contamination to other patients.

(a) A patient who tests positive for HBsAg must be dialyzed on equipment reserved and maintained for the HBsAg-positive patient's use only.

(b) If an HBsAg-positive patient is discharged, the equipment which had been reserved for that patient must be given intermediate level disinfection prior to use for a patient testing negative for HBsAg.

(c) A patient who is admitted for treatment before results of HBsAg testing are known must undergo treatment as if the HBsAg test results were potentially positive, but should not be treated on a machine used for a current HBsAg positive patient.

2. If a central delivery system is used by the facility, the facility must treat potentially HBsAg-positive patients on a designated machine and may not reuse the dialyzer until the HBsAg test results are known. The dialysis machine used by this patient must be given intermediate level disinfection prior to its use by another patient.

2. The facility must obtain HBsAg status results of the patient no later than three days after admission.

Section 18. *Tuberculosis prevention.*

1. Facility staff must be screened for tuberculosis upon employment or receiving privileges as a member of the medical staff and prior to patient contact in accordance with NAC 441A.375

2. The facility must screen patients for tuberculosis when indicated by the presence of risk factors for, or the signs and symptoms of tuberculosis. Screening must be performed after potential exposure to active laryngeal or pulmonary tuberculosis.

Section 19. *Quality Assurance for Patient Care.*

1. The facility must perform a systematic, ongoing, concurrent and comprehensive review of the care provided. The review must be specific to the facility. A facility must adopt,

implement, and enforce a quality assurance program based on information specific to that facility supplied by the ESRD Network.

2. The facility must demonstrate through quality assurance activities that staff have evaluated the provision of dialysis care and patient services, set treatment goals, identified opportunities for improvement, developed and implemented improvement plans, and evaluate the implementation until resolution is achieved. Evidence must support that aggregate patient data including identification and tracking of patient infections, is continuously reviewed for trends.

3. Core staff members must actively participate in the quality assurance activities.

4. A facility must conduct quality assurance meetings quarterly or more often as necessary to identify or correct problems. The meetings must be documented in written minutes which are maintained in the facility.

5. A record of each accident or incident occurring in a facility, including medication errors and adverse drug reactions, must be prepared immediately. These records must be available for review by the bureau.

6. The facility must report the following to the bureau within three working days of the occurrence:

(a) an accident or incident to the patient occurring during dialysis treatment resulting in an unexpected death or overnight admission to a hospital;

(b) conversion of staff or a patient to HBsAg positive; or

(c) fire.

Section 20. ***Patients rights.***

1. Each facility must adopt, implement, and enforce policies and procedures appropriate to the patient population served which ensure that each patient is:

(a) treated with respect, dignity, and full recognition of the patient's individuality and personal needs;

(b) provided sufficient privacy during procedures to prevent undue exposure and ensure confidentiality, of the patient's clinical record;

(c) provided a safe and comfortable treatment environment;

(d) provided treatment information in a manner to facilitate understanding by the patient and the patient's legal representative, family or significant other. Written patient information materials must be available, with materials in languages other than English if the census of the facility includes more than eight patients who read that primary language only. In lieu of written materials in the patient's primary language, an interpreter may be provided if documentation and patient interview support that information sufficient to allow the patient to participate in the treatment has been communicated;

(e) informed by a physician of the patient's medical status;

(f) informed of all treatment modalities and settings for the treatment of end stage renal disease;

(g) informed about and participates in, if desired, all aspects of care, including the right to refuse treatment, and be informed of the medical consequences of such refusal;

(h) aware of all services available in the facility and the charges for services provided;

(i) informed about the facility's reuse of dialysis supplies, including hemodialyzers. If printed materials such as brochures are used to describe a facility and its services, the brochures must contain a statement with respect to reuse;

2. The facility must ensure that each patient is:

(a) assured of a reasonable response by the facility to the patient's requests and needs for treatment or service, within the facility's capacity, the facility's stated mission, and applicable law and regulation;

(b) transferred only for medical reasons, for the patient's welfare or that of other patients or staff members, or for nonpayment of fees. A patient must be given thirty days advance notice to ensure orderly transfer or discharge;

(c) provided information regarding advance directives and allowed to formulate such directives to the extent permitted by law.

(d) aware of the mechanisms and agencies to express a complaint against the facility without fear of reprisal or denial of services. A facility must provide to each individual who is admitted to the facility a written statement that informs the individual that a complaint against the facility may be directed to the bureau. The statement must be provided at the time of admission and must advise the patient that registration of complaints may be filed with the Department of Human Resources Health Divisions local office, 1-702-486-6515 in Las Vegas and 1-775-687-4475 in Northern Nevada; and

(e) fully informed of the rights listed in this subsection, the responsibilities established by the facility, and all rules and regulations governing patient conduct and responsibilities. A written copy of the patient's rights and responsibilities must be provided to each patient or the

patient's legal representative upon admission and copy must be posted with the facility license in a public area, such as the waiting room.

Section 21. ***Patient care plan.***

1. The facility must establish, implement, and enforce a policy whereby patient services are coordinated using an interdisciplinary team approach. The interdisciplinary team must consist of the patient's primary dialysis physician, registered nurse, social worker, and dietitian.

2. The interdisciplinary team must develop a written, individualized, comprehensive patient care plan that specifies the services necessary to address the patient's medical, psychological, social, and functional needs, and includes treatment goals.

3. The patient care plan must include evidence of coordination with other service providers (e.g. hospitals, long term care facilities, home and community support services agencies, or transportation providers) as needed to assure the provision of safe care.

4. The patient care plan must include evidence of the patient's (or patient's legal representative's) input and participation, unless they refuse to participate. At a minimum, the patient care plan must demonstrate that the content was shared with the patient or the patient's legal representative.

5. The patient care plan must be developed within 30 days from the patient's admission to the facility and updated as indicated by any change in the patient's medical, nutritional, or psychosocial condition, or at least every six months. Evidence of the review of the patient care plan with the patient and the interdisciplinary team members to evaluate the patient's progress or lack of progress toward the goals of the care plan, and interventions taken when the goals are not achieved, must be documented and included in the patient's clinical record.

Section 22. ***Emergency preparedness.***

1. The facility must implement written procedures which describe staff and patient actions to manage potential medical and non-medical emergencies, including but not limited to fire, equipment failure, power outages, medical emergencies, and natural disasters which are likely to threaten the health or safety of facility patients, the staff, or the public.

2. The facility must have a functional plan to access the community emergency medical services

3. The facility must have personnel qualified to operate emergency equipment and to provide emergency care to patients on-site and available during all treatment times. A charge nurse qualified to provide basic cardiopulmonary life support (BCLS) must be on site and available to the treatment area whenever patients are present. All clinical staff members must maintain current certification and competency in BCLS.

4. The facility must have a transfer agreement with one or more hospitals which provide acute dialysis service for the provision of inpatient care and other hospital services to the facility's patients. The facility must have documentation from the hospital to the effect that patients from the facility will be accepted and treated in emergencies. There must be reasonable assurances that:

(a) the transfer or referral of patients will be effected between the hospital and the facility whenever such transfer or referral is determined as medically appropriate by the attending physician, with timely acceptance and admission;

(b) the interchange of medical and other information necessary or useful in the care and treatment of the patient transferred will occur within one working day; and

(c) security and accountability will be assured for the transferred patient's personal effects.

5. The facility must establish, implement and enforce a written plan for the protection of patients in the event of a fire.

(a) An evacuation plan must be developed and diagrams posted in conspicuous places.

(b) The facility must conduct fire drills at least quarterly for each patient shift to include the use of alarms and equipment, and discussion with patients, visitors, employees and staff about the evacuation plan. Written reports must be maintained to include evidence of staff and patient participation.

(c) All staff must be familiar with the locations of fire-fighting equipment. Fire-fighting equipment must be located so that a person does not have to travel more than 75 feet from any point to reach the equipment.

6. A written disaster preparedness plan specific to each facility must be developed and in place. The plan must be based on an assessment of the probability and type of disaster in each region and the local resources available to the facility. The plan must include procedures designed to minimize harm to patients and staff along with ensuring safe facility operations. The plan and in-service programs for patients and staff must include provisions or procedures for responsibility of direction and control, communications, alerting and warning systems, evacuation, and closure.

Section 23. *Medication storage and administration. Pharmaceutical services must be provided in accordance with accepted professional principles and federal and state laws and regulations.*

1. Medications must be administered only if such medication is ordered by the patient's physician, the advanced nurse practitioner or physician's assistant.

2. All verbal or telephone orders must be received by a licensed nurse and countersigned by the physician.

3. Medications maintained in the facility must be properly stored and safeguarded in enclosures of sufficient size which are not accessible to unauthorized persons. Refrigerators used for storage of medications must maintain appropriate temperatures for such storage.

4. The facility must maintain an emergency stock of medications, as specified by the medical director, to treat the emergency needs of patients.

5. Medications must be prepared for administration in an area which includes a work counter and a sink. This area must be located in such a manner as to prevent contamination of medicines being prepared for administration.

6. Medications not given immediately must be labeled with the patient's name, the name of the medication, the dosage prepared, and the initials of the person preparing the medication and date. All medications must be administered by the individual who prepares them.

7. All medications must be administered by licensed nurses, physician assistants, or physicians except that intravenous normal saline, intravenous heparin, and subcutaneous lidocaine may be administered as part of a routine hemodialysis treatment by dialysis technicians qualified according to Sections 53 to 63.

Section 24. *Nursing services. Nursing services to prevent or reduce complications and to maximize the patient's functional status must be provided to a patient and the patient's family or significant other.*

1. The facility must employ a full-time supervising registered nurse to manage the provision of patient care.

2. A registered nurse must be responsible for:

(a) conducting admission nursing assessments;

(b) conducting assessments of a patient when indicated by a question relating to a change in the patient's status or at the patient's request;

(c) participating in team review of a patient's progress;

(d) recommending changes in treatment based on the patient's current needs;

(e) facilitating communication between the patient, patient's family or significant other, and other team members to ensure needed care is delivered;

(f) providing oversight and direction to dialysis technicians and licensed practical nurses; and

(g) participating in continuous quality assurance activities

3. A registered nurse must be on site and available to the treatment area to provide patient care during all treatments.

4. At least one registered nurse must be available on-site to provide patient care for every fourteen (14) patients or portion thereof. This may include the charge nurse required by paragraph (4) of this subsection.

5. If pediatric dialysis is provided, a registered nurse with experience or training in pediatric dialysis must be available to provide care for pediatric dialysis patients younger than 14 years of age or smaller than 35 kilograms in weight.

6. The facility must have sufficient direct care staff on-site to meet the needs of the patients.

7. A licensed nurse or dialysis technician must evaluate each patient before and after treatment according to facility policy and the staff member's level of training. A registered

nurse must conduct a patient assessment when indicated by a question relating to a change in the patient's status or at the patient's request.

8. The initial nursing assessment must be initiated by a registered nurse at the time of the first treatment in the facility and completed by a registered nurse within two weeks following the start of treatment.

Section 25. *This chapter does not preclude a licensed practical nurse (LPN) from practicing in accordance with the rules adopted by the Nevada State Board of Nursing. The LPN should be I.V. certified to work as an LPN in the dialysis setting. If the LPN is acting in the capacity of a dialysis technician, the facility must determine that the LPN has passed a training and competency evaluation curriculum which meets the requirements in Sections 52 to 62 of this chapter (relating to Training Curricula and Competency Evaluation).*

Section 26. *Dialysis technicians. A dialysis technician providing direct patient care must demonstrate knowledge and competency for the responsibilities specified in Section 52 through 62 inclusive.*

Section 27. *Nutrition services. Nutrition services must be provided to a patient and the patient's caregiver(s) in order to maximize the patient's nutritional status.*

1. The dietitian must be responsible for:

(a) conducting a nutrition assessment of a patient;

(b) participating in a team review of a patient's progress;

(c) recommending therapeutic diets in consideration of cultural preferences and changes in treatment based on the patient's nutritional needs in consultation with the patient's physician.

(d) counseling a patient, a patient's family, and a patient's significant other on prescribed diets and monitoring adherence and response to diet therapy. Correctional institutions must not be required to provide counseling to family members or significant others;

(e) referring a patient for assistance with nutrition resources such as financial assistance, community resources or in-home assistance;

(f) participating in continuous quality improvement activities; and

(g) providing ongoing monitoring to determine the need for timely intervention and follow-up. Measurement criteria include but are not limited to weight changes, blood chemistries, adequacy of dialysis, and medication changes which affect nutrition status and potentially cause adverse nutrient interactions.

2. The collection of data to assess nutrition status must occur within two weeks or seven treatments from admission to the facility, whichever occurs later. A comprehensive nutrition assessment with an educational component must be completed within 30 days or 13 treatments from admission to the facility, whichever occurs later.

3. A nutrition reassessment must be conducted annually or more often if indicated.

4. Each facility must employ or contract with a dietitian(s) to provide clinical nutrition services for each patient. One full-time equivalent of dietitian time must be available for facilities seeing 100 patients or more.

5. Nutrition services must be available at the facility during scheduled treatment times. Access to services may require an appointment.

Section 28. *Social services. Social services must be provided to patients and their families and must be directed at supporting and maximizing the adjustment, social functioning, and rehabilitation of the patient.*

1. The social worker must be responsible for:

(a) conducting psychosocial evaluations;

(b) participating in team review of patient progress;

(c) recommending changes in treatment based on the patient's current psychosocial needs;

(d) providing case work and group work services to patients and their families in dealing with the special problems associated with end stage renal disease;

(e) identifying community social agencies and other resources and assisting patients and families to utilize them. Correctional institutions must not be required to provide the services of (d) and (e);

(f) participating in continuous quality assurance activities; and

2. Initial contact between the social worker and the patient must occur and be documented within two weeks or seven treatments from the patient's admission, whichever occurs later. A comprehensive psychosocial assessment must be completed within thirty days or thirteen treatments from the patient's admission, whichever occurs later.

3. A psychosocial reassessment must be conducted annually or more often if indicated

4. Each facility must employ or contract with a social worker(s) to meet the psychosocial needs of the patients. One full-time equivalent social worker must be available for facilities seeing one hundred patients or more.

5. Social services must be available at the facility during the times of patient treatment. Access to social services may require an appointment.

Section 29. *The facility is under the control of an identifiable governing body, or designated person(s) so functioning, with full legal authority and responsibility for the governance and operation of the facility.*

1. The governing body adopts and enforces rules and regulations relative to:

(a) its own governance;

(b) health care and safety of patients;

(c) the general operation of the facility ;

(d) the protection of the patients' personal and property rights.

1. The governing body is responsible for appointing the medical director.

2. The governing body is responsible for:

(a) receiving and acting upon recommendations;

(b) appointing a medical director;

(c) maintaining compliance with state and local laws and regulations.

Section 30. *Medical director. The facility must have a medical director who is appointed by the governing body.*

1. The medical director must be

(a) board eligible or board certified in nephrology or pediatric nephrology by a professional board; or

(b) during the five years prior to October 1, 1999 has served for at least twelve months as a director of a dialysis program;

2. The medical director is responsible for:

(a) developing facility treatment goals which are based on review of aggregate data assessed through quality assurance activities;

(b) assuring adequate training of licensed nurses and dialysis technicians;

(c) adequate monitoring of patients and the dialysis process; and

(d) developing and implementing all policies required by this chapter.

Section 31. ***Medical staff. Each patient must be under the care of a physician on the medical staff.***

1. The care of a pediatric dialysis patient must be supervised by a pediatric nephrologist. If a pediatric nephrologist is not available as the primary physician, an adult nephrologist may serve as the primary physician with direct patient evaluation by a pediatric nephrologist at the initiation of care and annually until the age of six.

2. At a minimum, each patient receiving dialysis in the facility must be seen by a physician on the medical staff once monthly; home patients must be seen at least every three months. There must be evidence of monthly assessment for new and recurrent problems and review of dialysis adequacy.

3. One physician on the medical staff must be on call and available 24 hours a day (in person or by telecommunication) to patients and staff.

4. Orders for treatment must be in writing and signed by the prescribing physician. Routine orders for treatment must be updated at least annually. Orders for treatment must include treatment time, dialyzer, blood flow rate, target weight, medications including heparin, and specific infection control measures as needed.

Section 32. ***If advanced practice nurses or physician assistants are utilized there must be evidence of communication with the treating physician whenever the advanced practice nurse or physician assistant changes treatment orders per the requirements of NRS 630 and NRS 632.***

1. The advanced practice nurse or physician assistant may not replace the physician in participating in patient care planning or in quality assurance activities; and

2. The treating physician must be notified and direct the care of patient medical emergencies.

Section 33. *Home dialysis (self dialysis). If a facility provides self dialysis training, a licensed nurse with at least 12 months experience in the applicable dialysis modality (hemodialysis or peritoneal dialysis) must be responsible for training the patient or family . The licensed nurse must supervise all other personnel who assist in training.*

1. For a patient who performs self dialysis at home, the following services must be provided:

(a) a yearly physical examination;

(b) monthly contact from facility staff by telephone calls or facility visits;

(c) a facility visit at least every three months;

(d) communication with the appropriate interdisciplinary team member(s);

(e) routine laboratory work according to facility policy; and

(f) a mechanism to contact staff including the physician at any time in the event of an emergent need.

2. The facility must provide directly or under arrangement the following services for hemodialysis.

(a) surveillance of the patient's home adaptation, including provisions for visits to the home;

(b) consultation for the patient with a registered nurse, social worker and a dietitian;

(c) a record keeping system which assures continuity of care;

(d) installation and maintenance of equipment;

(e) testing and appropriate treating of the water used for dialysis; and

(f) ordering of supplies on an ongoing basis.

Section 34. *If providing for continuous ambulatory peritoneal dialysis, the required services are:*

1. consultation for the patient with a registered nurse, a social worker and a dietitian;

2. a record keeping system which assures continuity of care; and

3. ordering of supplies on an ongoing basis.

Section 35. *If providing for continuous cycling peritoneal dialysis, the required services are:*

1. surveillance of the patient's home adaptation, including provisions for visits to the home;

2. consultation for the patient with a registered nurse, a social worker and a dietitian;

3. a record keeping system which assures continuity of care;

4. installation and maintenance of equipment; and

5. ordering of supplies on an ongoing basis.

Section 36. *If services are provided under contract the facility remains responsible for supervision and adequacy of care.*

Section 37. *Laboratory services. If a facility has its own laboratory it must be licensed under the provisions of Chapter 652 of NRS.*

Section 38. *Qualifications of Staff. The facility must develop and implement a written-orientation program to familiarize all new employees (including office staff) with the facility, its policies, and job responsibilities.*

1. New staff members who are to provide direct patient care must be provided sufficient time to become familiar with the facility. The orientation program provided by the facility must be a minimum time of two weeks for individuals with previous dialysis experience. For new

direct patient care staff member with no previous dialysis experience, the orientation program must include two weeks of direct care orientation.

2. The facility must provide licensed nurses with no previous dialysis experience an orientation program of a minimum of six weeks. For these licensed nurses, the six-week orientation program must contain at least the following subject content specific to the management of the end stage renal disease patient and appropriate to the population served by the facility:

(a) fluid, electrolyte and acid-base balance

(b) kidney disease and treatment;

(c) dietary management of kidney disease;

(d) principles of dialysis;

(e) dialysis technology;

(f) venipuncture technique;

(g) care of the dialysis patient;

(h) psychological, social, financial, and physical complications of long-term dialysis;

(i) prevention of hepatitis and other infectious diseases; and

(j) risks and benefits of reuse (if reuse is practiced).

4. The facility must maintain documentation to demonstrate that each staff member providing patient care completes at least five hours of continuing education related to end stage renal disease annually. Continuing education may be provided by facility staff.

Section 39. *Medical staff. Each physician on the medical staff must have a current license to practice medicine in the State of Nevada.*

1. The governing body of a facility must designate a medical director.

2. The members of the medical staff may include nephrologists and other physicians with training or demonstrated experience in the care of end stage renal disease patients.

3. If an advanced practice nurse or physician assistant is utilized, such individuals must meet the requirements established by the Nurse Practice Act NRS (for an advanced practice nurse) or the Board of Medical Examiners (for a physician assistant).

Section 40. *Each licensed nurse must have a current Nevada license to practice nursing.*

1. Each nurse assigned charge responsibilities must be a registered nurse and have six months experience in hemodialysis as a nurse obtained within the last twenty-four months. An RN who holds a current certification from nationally recognized board in nephrology nursing or hemodialysis may substitute the certification for the six months experience in dialysis obtained within the last twenty-four months.

2. The responsibilities of the charge nurse must include making daily assignments based on patient needs;

(a) providing immediate supervision of direct patient care;

(b) making patient assessments when indicated; and

(c) communication with the physician(s), social worker(s), and dietitian(s).

3. If patient self-care training is provided, a registered nurse who has at least twelve months experience in dialysis and experience in the applicable dialysis modality must be responsible for training the patient or family. The registered nurse must supervise other personnel who assist in training.

Section 41. *Nutritional staff. Each dietitian must be eligible for registration by the Commission of Dietetic Registration of the American Dietetic Association, and have one year of experience in clinical dietetics after becoming eligible for registration.*

Section 42. ***Social services staff. Each social worker must:***

1. be licensed as a social worker by the State of Nevada, and hold a masters degree in social work from a graduate school of social work accredited by the Council on Social Work Education; or

2. have worked for at least two years as a social worker, one year of which was in a dialysis facility or transplantation program prior to September 1, 1976, and have established a consultative relationship with a social worker who has a masters degree in social work from a graduate school of social work accredited by the Council on Social Work Education.

Section 43. ***Staff responsible for the water treatment system.***

1. Facility staff responsible for the water treatment system must demonstrate understanding of the risks to patients of exposure to water which has not been treated so as to remove contaminants and impurities. Documentation of training to assure safe operation of the water treatment system must be maintained for each individual responsible for the operation of the system.

2. Only individuals qualified by training, education, or experience may repair or replace components of the water treatment system. Documentation of such training to qualify these persons must be maintained on file in the facility.

Section 44. ***Staff providing equipment maintenance and repair must have successfully completed a training course and demonstrated competency in providing maintenance and repair for the equipment being serviced. The training course must include at least the following components:***

1. prevention of transmission of hepatitis through dialysis equipment;

2. safety requirements of dialysate delivery systems;

3. bacteriologic control;

4. water quality standards; and

5. repair and maintenance of dialysis and other equipment in use.

Section 45. *Clinical Record*

1. The facility must establish and maintain a clinical record system to assure that the care provided to each patient is completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. Archived medical records must be available within forty-eight hours.

2. All information must be centralized in the patient's clinical record and be protected against loss or damage.

3. The facility must provide an area for clinical records storage which is separate from all patient treatment areas. The clinical records area must have adequate space for reviewing, dictating, sorting, or recording records. If electronic imaging devices are employed (i.e., microfilm or optical disc), the clinical records area must have adequate space for transcribing records in the electronics format. The facility must store the active clinical record of each patient currently treated by the facility on site.

4. The facility must ensure that each patient's personal and medical records are treated with confidentiality.

Signature stamps may not be used to authenticate medical record entries. Computerized records must meet all requirements of paper records including protection form casual access and retention for the specified period. Systems must assure that entries regarding the delivery of care may not be altered without evidence and explanation of such alteration.

5. Inactive clinical records may be preserved on microfilm, optical disc or other electronic means and may be stored off-site as long as security is maintained and the record is readily retrievable for review by the division or the division's designee.

6. Each clinical record must include:

(a) identifying information;

(b) consents and notifications;

(c) physician orders;

(d) progress notes;

(e) problem list;

(f) medical history and physical;

(g) professional assessments by the registered nurse, social worker, and dietitian;

(h) medication record to include medications given during treatment (which may be listed on the treatment record) and a listing of medications the patient takes at home;

(i) transfusion record;

(j) laboratory reports;

(k) diagnostic studies;

(l) hospitalization records;

(m) consultation;

(n) record of creation and revision of access for dialysis if possible;

(o) patient care plans, including evidence of team review and adjustment;

(p) evidence of patient education;

(q) daily treatment records; and

(r) discharge summary, if applicable.

Section 46. ***A patient's medical history and physical must be completed thirty days before or within two weeks after admission to the facility. Prior to the first treatment in the facility, the physician must inform the charge nurse of the patient's diagnoses, medications, hepatitis status, allergies, and dialysis prescription. The clinical record must include this data.***

Section 47. ***The medical record must provide an accurate picture of the progress of the patient, reflecting changes in patient status, plans for and results of changes in treatment, diagnostic testing, consultations, and unusual events. Each of the interdisciplinary team members must record the progress of the patient as indicated by any change in the patient's medical, nutritional, or psychosocial condition or at least every six months.***

Section 48. ***The patient's condition and response to treatment must be noted on the daily treatment record.***

Section 49. ***Clinical records of transient patients must include, at a minimum, orders for treatment in this facility, laboratory reports performed within a month of treatment at this facility including hepatitis B antigen status, the most current patient care plan and treatment records from the home facility, and records of care and treatment at this facility.***

Section 50. ***Clinical records must be completed within thirty days after discharge. The discharge summary must clearly identify the disposition of the patient and include the diagnosis or cause of death, date of discharge or death, location of death, transplant or relocation information when appropriate, and reason for discharge if not for transplantation or death.***

1. Clinical records are the property of the facility and must not be removed from the premises or approved storage site except by subpoena or court order, or for protection in disaster situations.

2. Copies of pertinent portions of a patient's record must be provided when the patient is transferred. The records provided must include, at a minimum, the most current orders for dialysis treatment, the last three treatment records, the current hepatitis status, and the most current patient care plan. If the patient is transferred to another outpatient facility, copies of the most recent history and physical and assessment of each member of the interdisciplinary team must also be provided.

Section 51. *If a facility ceases operation, there must be an arrangement for the preservation of records to insure compliance with this section. The facility must send the bureau written notification of the location of the clinical records and the name and address of the clinical records custodian.*

Section 52. *An individual may not act as a dialysis technician unless that individual is trained and competent as required by Sections 53 through 63.*

1. Trainees must be identified via name tags as such during any time spent in the patient treatment area.

2. Until the successful completion of the competency evaluation, the trainee may provide patient care only as part of the training program and under the immediate supervision of registered nurse or an assigned preceptor. A preceptor must be a licensed nurse or dialysis technician who has one year of experience in hemodialysis obtained within the last twenty-four months, a recommendation by the supervising nurse to be a preceptor and a current skills checklist on file in the facility.

Section 53. *Specific objectives for training curricula. Each training program for dialysis technicians must develop a written curriculum with objectives specified for each section.*

1. Components of training curricula. The training curricula for dialysis technicians must include the following minimum components:

(a) Introduction to dialytic therapies to include history and major issues as follows:

(i) history of dialysis;

(ii) definitions and terminology;

(iii) communication skills;

(iv) ethics and confidentiality;

(v) multidisciplinary process;

(vi) roles of other team members; and

(vii) information about renal organizations and resources;

(b) Principles of hemodialysis to include:

(i) principles of dialysis;

(ii) access to the circulatory system; and

(iii) anticoagulation, local anesthetics, and normal saline;

(c) Understanding the individual with kidney failure to include:

(i) basic renal anatomy, physiology, and pathophysiology;

(ii) the effect of renal failure on the other body systems;

(iii) symptoms and findings related to the uremic state;

(iv) modes of renal replacement therapy, including transplantation;

(v) basic renal nutrition;

(vi) basic psychosocial aspects of end stage renal disease (ESRD);

(vii) medications commonly administered to patients with ESRD including the administration and effects;

(viii) confidentiality of patient personal and clinical records;

(ix) professional conduct;

(x) patient rights and responsibilities; and

(xi) rehabilitation;

(d) Dialysis procedures to include:

(i) using aseptic technique;

(ii) technical aspects of dialysis, operation and monitoring of equipment, initiation and termination of dialysis;

(iii) delivering an adequate dialysis treatment and factors which may result in inadequate treatment;

(iv) observing and reporting patient reactions to treatment;

(v) glucose monitoring and hemoglobin/hematocrit monitoring;

(vi) emergency procedures and responses such as cardiopulmonary resuscitation, air embolism management, and response to line separation and hemolysis;

(vii) external and internal disasters, fire, natural disasters, and emergency preparedness; and

(viii) safety, qualify control, and continuous quality improvement;

(e) Information regarding hemodialysis devices to include:

(i) theory and practice of conventional, high efficiency, and high flux dialysis;

(ii) dialysate composition, options, indications, complications, and safety;

(iii) monitoring and safety; and

(iv) disinfection of equipment;

(f) Water treatment to include:

(i) standards for water treatment used for dialysis as described in the American National Standard, Hemodialysis Systems, March 1992 Edition, published by the American Association for the Advancement of Medical Instrumentation (AAMI), 3330 Washington Boulevard, Suite 400, Arlington, Virginia 22201;

(ii) systems and devices;

(iii) monitoring; and

(iv) risks to patients of unsafe water;

(g) If the facility practices reuse, information about reprocessing to include:

(i) principles of reuse;

(ii) safety, quality control, standard precautions, and water treatment; and

(iii) standards for reuse as described in the American National Standard, Reuse of Hemodialyzers, 1993 Edition, published by the AAMI;

(h) Patient teaching to include:

(i) the role of the technician in supporting patient education goals; and

(ii) adult education principles;

(i) Infection control and safety to include:

(i) risks to patients of nosocomial infections, accidents, and errors in treatment;

(ii) standard precautions, aseptic technique, sterile technique, and specimen handling;

(iii) basic bacteriology and epidemiology;

(iv) risks to employees of blood and chemical exposure; and

(v) electrical, fire, disaster, environmental safety, and hazardous substances; an

(j) Quality assurance and continuous quality improvement (QA/CQI) to include:

(i) role of the technician in quality assurance activities;

(ii) principles of QA/CQI; and

(iii) the importance of ongoing quality control activities in assuring safe dialysis treatments are provided to patients.

2. If a dialysis technician is to assist with training or treatment of peritoneal dialysis patients, the following content must also be included:

(a) principles of peritoneal dialysis;

(b) sterile technique;

(c) peritoneal dialysis delivery systems;

(d) symptoms of peritonitis; and

(e) other complications of peritoneal dialysis.

3. If a dialysis technician, is to cannulate access or administer normal saline, heparin, or lidocaine, the following content must be included:

(a) Access to the circulation to include:

(i) fistula: creation, development, needle placement, and prevention of complications;

(ii) grafts: materials used, creation, needle placement, and prevention of complications; and

(iii) symptoms to report;

(b) Safe administration of medications to include:

(i) identifying the right patient;

(ii) assuring the right medication;

(iii) measuring the right dose;

(iv) ascertaining the right route; and

(v) checking the right time for administration;

(c) Administration of normal saline to include:

(i) reasons for administration;

(ii) potential complications;

(iii) administration limits; and

(iv) information to report and record;

(d) Administration of heparin to include:

(i) reasons for administration;

(ii) methods of administration;

(iii) preparation of ordered dose;

(iv) potential complications; and

(v) information to report and record; and

(e) Administration of lidocaine to include:

(i) reasons for administration;

(ii) method of administration;

(iii) preparation of ordered dose;

(iv) potential complications and risks; and

(v) information to report and record.

4. A roster of attendance for each training class must be maintained by the instructor.

5. Each trainee must be evaluated on a weekly basis during the training program to ascertain the trainee's progress.

6. The dialysis technician trainee must complete a written examination. The examination must encompass the content required in subsections 1 and 2 of this section. If the dialysis technician trainee will cannulate access and administer medications, the examination must

encompass the content described in subsection 3 of this section. A score of 80% is required on the written examination(s) covering the required content. Current certification as a dialysis technician by a nationally recognized testing organization may be substituted for the written examination.

Section 54. *An instructor for the course to train an individual as a dialysis technician must be:*

1. a physician who qualifies as a medical director;

2. a registered nurse with at least twelve months of experience in hemodialysis obtained within the last 24 months and a current competency skills checklist on file in the facility or a registered nurse instructor of a dialysis technician training course of an accredited college or university; or

3. a qualified dietitian or social worker providing training only within the person's area of expertise.

Section 55. *Licensed nurses and dialysis technicians who have a least one year of experience in hemodialysis and a current competency skills checklist on file in the facility may assist in didactic sessions and serve as preceptors.*

Section 56. *For persons with no previous experience on direct patient care, a minimum of 80 clock hours of classroom education and 200 clock hours of directly supervised clinical training is required. Training programs for dialysis technician trainees who have previous direct patient care experience may be shortened if competency with the required knowledge and skills is demonstrated, but may not be less than a total of 80 clock hours of combined classroom education and clinical training.*

Section 57. ***Each facility must appoint a training review committee to consist of at least the medical director, supervising nurse, chief technician, and administrator. This committee must review the training records of each trainee, including tests and skills checklists, hear comments from the training instructor(s) and preceptor(s), and validate that the trainee has successfully completed the training program.***

Section 58. ***An individual who completed the facility's orientation program and was determined by the facility to be qualified to deliver dialysis patient care before October 1, 1999 may qualify as a dialysis technician:***

1. By passing the written examination described in Section 53, subsection 6 of this title (relating to Training Curricula) and demonstrating competency by completion of the skills checklist described in Section 59 of this section. Current certification as a dialysis technician by a nationally recognized testing organization may be substituted for the written examination or,

1. By demonstrating competency to the facility instructor or supervising nurse and completing a skills checklist as described in Section 59.

Section 59. ***The supervising nurse or a registered nurse who qualifies as an instructor must complete a competency skills checklist to document each dialysis technician trainee's knowledge and skills for the following allowed acts:***

1. assembling necessary supplies;

2. preparing dialysate according to procedure and dialysis prescription;

3. assembling and preparing the dialysis extracorporeal circuit correctly;

4. securing the correct dialyzer for the specific patient;

5. installing and rinsing dialyzer and all necessary tubing;

6. testing monitors and alarms, conductivity, and (if applicable) presence and absence of residual sterilants;

7. setting monitors and alarms according to facility and manufacturer protocols;

8. obtaining predialysis vital signs, weight, and temperature according to facility protocol and informing the registered nurse of unusual findings;

9. inspecting access for patency and, after cannulation is performed and heparin administered, initiating dialysis according to the patient's prescription, observing universal precautions, and reporting unusual findings to the registered nurse;

10. adjusting blood flow rates according to established protocols and the patient's prescription;

11. calculating and setting the dialysis machine to allow fluid removal rates according to established protocols and the patient's prescription;

12. monitoring the patient and equipment during treatment, responding appropriately to patient needs and machine alarms and reporting unusual occurrences to the registered nurse;

13. changing fluid removal rate, placing patient in Trendelenburg position, and administering replacement normal saline as directed by the registered nurse, physician order, or facility written protocol;

14. documenting findings and actions per facility written protocol;

15. describing appropriate response to dialysis-related emergencies such as cardiac or respiratory arrest, needle displacement or infiltration, clotting, blood leaks, or air emboli and to nonmedical emergencies such as power outages or equipment failure;

16. discontinuing dialysis and establishing hemostasis:

(a) inspecting, cleaning, and dressing access according to facility protocol; and

(b) reporting unusual findings and occurrences to the registered nurse;

17. obtaining and recording post dialysis vital signs, temperature, and weight and reporting unusual findings to the registered nurse.

18. discarding supplies and sanitizing equipment and treatment chair according to facility protocol.

19. communicating the patient's emotional, medical, psychological, and nutritional concerns to the registered nurse;

20. obtaining current certification in cardiopulmonary resuscitation, and

21. maintaining professional conduct, good communication skills, and confidentiality in the care of patients.

Section 60. *For dialysis technician trainees who will be assisting with training or treatment of peritoneal dialysis patients, the following checklist must be completed satisfactorily:*

1. assisting patients in ordering supplies:

2. making a dialysate exchange (draining and refilling the peritoneal space with dialysate) to include continuous ambulatory peritoneal dialysis exchange procedures and initiation or discontinuation of continuous cycling peritoneal dialysis;

3. observing peritoneal effluent;

4. knowing what observations to report;

5. collecting dialysate specimen;

6. performing a transfer tubing change; and

7. setting up and operating continuous cycling peritoneal dialysis equipment.

Section 61.

1. For dialysis technician trainees who will be cannulating dialysis access and administering heparin and normal saline, the following checklist must also be completed satisfactorily:

(a) Cannulation to include:

(i) inspecting the access for patency;

(ii) preparing the skin;

(iii) using aseptic technique;

(iv) placing needles correctly;

(v) establishing blood access;

(vi) replacing needles;

(vii) knowing when to call for assistance; and

(viii) securing needles;

2. For administration of heparin to include:

(i) checking the patient's individual prescription;

(ii) preparing the dose;

(iii) labeling the prepared syringe;

(iv) administering the dose; and

(v) observing for complications;

3. For administration of normal saline to include:

(i) understanding unit protocol;

(ii) checking the patient's prescription;

(iii) recognizing signs of hypotension;

(iv) notifying the registered nurse;

(v) administering normal saline; and

(vi) rechecking vital signs; and

4. Administration of lidocaine to include:

(i) checking the patient's prescription;

(ii) identifying the correct vial of medication;

(iii) preparing the dose;

(iv) administering the dose; and

(vi) observing for complications.

Section 62. *If a dialysis technician is to cannulate a dialysis access or administer normal saline, heparin or lidocaine, the medical director must verify and document competency of the dialysis technician to perform these tasks.*

Section 63. *A training program is required to provide a document to the trainee on the successful completion of the training program and competency evaluation.*

1. This document must indicate that the program completed met the requirements of this subchapter.

2. This document may be accepted by another facility that may later employ the dialysis technician. The competency evaluation documentation may only be accepted for a period of six months after the date of completion. After that date, a competency skill checklist must be completed in accordance with Section 58.

Section 64. *Performance of the following acts by any dialysis technician is prohibited:*

1. initiation of patient education; or

2. alteration of ordered treatment, including shortening of the treatment time.

3. Performance of the following acts by a dialysis technician:

(a) administration of medications other than normal saline, heparin or lidocaine, which may only be administered in the course of a routine dialysis treatment;

(b) administration of blood or blood products;

(c) performance of non-access site venipuncture

(d) performance of arterial puncture;

(e) acceptance of physician orders; or

(f) provision of hemodialysis treatment to pediatric patients under 14 years of age or under 35 kilograms.