p. Every patient may designate persons who are permitted to visit the patient during the patient's hospital stay.

Note 1: In reference to subpars. c. and d, ss. 146.81 to 146.83, Stats., permit the patient and certain other persons to have access to the patient's health care records. Access to the records of a patient receiving treatment for mental illness, a developmental disability, alcohol abuse or drug abuse is governed by s. 51.30 (4), Stats.

Note 2: In reference to subpar. o, complaints may be sent to the Bureau of Quality Compliance, P.O. Box 309, Madison, WI 53701.

2. A patient who receives treatment for mental illness, a developmental disability, alcohol abuse or drug abuse shall be recognized as having, in addition, the rights listed under s. 51.61, Stats., and ch. HSS 94.

3. Hospital staff assigned to direct patient care shall be informed of and demonstrate their understanding of the policies on patient rights and responsibilities through orientation and appropriate inservice training activities.

(b) *Movement of visitors.* Every hospital shall have written policies established by the governing board to control the movement of visitors. The hospital shall control traffic and access to each patient care unit to ensure patient privacy and infection control.

(c) *Use of volunteers.* Every hospital shall have written policies established by the governing board on the use of volunteers, which:

1. Delineate the scope of volunteer activities;

2. Provide that volunteers may assist with patient care only under the direct supervision of appropriate hospital personnel and after appropriate inservice training which is documented. Volunteers may not assist with patient care if this involves functions that require performance by licensed practical or registered nurses; and

3. Provide that no volunteer under 16 years of age may give direct patient care.

(d) *Identification of employes and patients.* Every hospital shall have written policies established by the governing board on identification of employes and patients.

(e) *Maintenance of personnel records and patient files.* Every hospital shall have written policies established by the governing board on maintenance of personnel records and patient files.

(f) *Post-mortem examinations.* 1. Every hospital shall have written policies established by the governing board to protect hospital and mortuary personnel in the performance of necropsy or other postmortem procedures on individuals who have been treated with radioactive materials or are known to have had an infection or communicable disease at the time of death, or in those cases in which an unrecognized postmortem infection is found at the time of the postmortem examination.

2. Delay in releasing a dead human body to a funeral director or other person authorized to make the removal, pending an autopsy, shall be as provided in s. HSS 135.03 (3).

(g) *Tagging of bodies.* If a dead human body to be removed from a hospital was treated for or is suspected of having a communicable or infectious disease or contains radioactive materials, the body shall be

tagged by staff of the hospital to indicate the possibility of the presence of the communicable or infectious disease or radioactive materials. If the body is in a container, a tag shall also be applied to the outside of the container.

(h) *Cancer reporting.* Every hospital shall report to the department all malignant neoplasms that are diagnosed by the hospital and all malignant neoplasms diagnosed elsewhere if the individual is subsequently admitted to the hospital. The report of each malignant neoplasm shall be made on a form prescribed or approved by the department and shall be submitted to the department within 6 months after the diagnosis is made or within 6 months after the individual's first admission to the hospital if the neoplasm is diagnosed elsewhere, as appropriate. In this paragraph, "malignant neoplasm" means an in situ or invasive tumor of the human body, but does not include a squamous cell carcinoma or basal cell carcinoma arising in the skin.

Note: Copies of the Department's reporting form, Neoplasm Record/Report (DOH 5500), may be obtained without charge from the Center for Health Statistics, P.O. Box 309, Madison WI 53701 (608-266-8926).

History: Cr. Register, January, 1988, No. 385, eff. 2-1-88.

HSS 124.06 Chief executive officer. (1) APPOINTMENT. The hospital shall be directed by a chief executive officer. The chief executive officer shall be appointed by the governing body, shall act as the executive officer of the governing body, shall be responsible for the management of the hospital and shall provide liaison among the governing body, medical staff, the nursing service and other services of the hospital.

(2) QUALIFICATIONS. The chief executive officer shall meet at least one of the following requirements:

(a) Have a high school diploma and 4 years of experience in an administrative capacity in a health care facility;

(b) Be a college or university graduate in an administrative field with 2 years of experience in a health care facility;

(c) Possess a college or university graduate degree in hospital or health care administration; or

(d) Have been hired before February 1, 1988.

(3) RESPONSIBILITIES. The chief executive officer shall:

(a) Keep the governing body fully informed about the quality of patient care, the management and financial status of the hospital, survey results and the adequacy of physical plant, equipment and personnel;

(b) Organize the day-to-day functions of the hospital through appropriate departmentalization and delegation of duties;

(c) Establish formal means of staff evaluation and accountability on the part of subordinates to whom duties have been assigned;

(d) Provide for the maintenance of an accurate, current and complete personnel record for each hospital employe;

(e) Ensure that there is sufficient communication among the governing body, medical staff, nursing services and other services, hold interdepartmental and departmental meetings, when appropriate, attend or be rep-

(d) *Personnel.* 1. Adequate numbers of personnel who are qualified to supervise and operate the service shall be provided.

2. a. A registered medical records administrator or an accredited records technician shall head the service, except that if such a professionally qualified person is not in charge of medical records, a consultant who is a registered records administrator or an accredited records technician shall organize the service, train the medical records personnel and make periodic visits to the hospital to evaluate the records and the operation of the service.

b. In this subdivision, "registered medical records administrator" means a person who has graduated from a 4-year college or university or from a one-year post-graduate certificate program in medical records administration and who meets the standards for registration as a medical records administrator of the American medical record association, and "accredited records technician" means a person who is a graduate of an independent study program or an associate degree program in medical records technology and meets the standards for accreditation as a medical records technician of the American medical record association.

(e) *Availability.* 1. The system for identifying and filing records shall permit prompt location of each patient's medical records.

2. A master patient index shall include at least the patient's full name, sex, birthdate and medical record number.

3. Filing equipment and space shall be adequate to maintain the records and facilitate retrieval.

4. The inpatient, ambulatory care and emergency records of a patient shall be kept in such a way that all information can be assembled routinely when the patient is admitted to the hospital, when the patient appears for a pre-scheduled ambulatory care visit, or as needed for emergency services.

5. Pertinent medical record information obtained from other providers shall be available to facilitate continuity of the patient's care.

6. The original or a legally reproduced copy of all documents containing clinical information pertaining to a patient's stay shall be filed in the medical record.

(f) *Coding and indexing.* 1. Records shall be coded and indexed according to disease, operation and physician. Indexing shall be kept up-to-date.

2. Any recognized system may be used for coding diseases and operations.

3. The indices shall list the specific diseases for which the patient was treated during the hospitalization and the operations and procedures which were performed during the hospitalization.

(3) RESPONSIBILITIES. (a) *Medical record contents.* The medical record staff shall ensure that each patient's medical record contains:

1. Accurate patient identification data;

2. A concise statement of complaints, including the chief complaint which led the patient to seek medical care and the date of onset and duration of each;

3. A health history, containing a description of present illness, past history of illness and pertinent family and social history;

4. A statement about the results of the physical examination, including all positive and negative findings resulting from an inventory of systems;

5. The provisional diagnosis;

6. All diagnostic and therapeutic orders;

7. All clinical laboratory, x-ray reports and other diagnostic reports;

8. Consultation reports containing a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record;

9. Except in an emergency, an appropriate history and physical work-up recorded in the medical record of every patient before surgery;

10. An operative report describing techniques and findings written or dictated immediately following surgery and signed by the surgeon;

11. Tissue reports, including a report of microscopic findings if hospital regulations require that microscopic examination be done. If only macroscopic examination is warranted, a statement that the tissue has been received and a macroscopic description of the findings provided by the laboratory shall be filed in the medical record;

12. Physician notes and non-physician notes providing a chronological picture of the patient's progress which are sufficient to delineate the course and the results of treatment;

13. A definitive final diagnosis expressed in the terminology of a recognized system of disease nomenclature;

14. A discharge summary including the final diagnosis, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient or family or both the patient and the family; and

15. Autopsy findings when an autopsy is performed.

(b) *Authentication.* Only members of the medical staff or other professional personnel authorized by the medical staff shall record and authenticate entries in the medical record. In hospitals with house staff, documentation of medical staff participation in the care of the patient shall be evidenced by at least:

1. The attending physician's countersignature on the patient's health history and results of his or her physical examination;

2. Periodic progress notes or countersignatures as defined by the medical staff rules;

3. The surgeon's signature on the operative report; and

4. The attending physician's signature on the face sheet and discharge summary.

(c) *Completion.* 1. Current records and those on discharged patients shall be completed promptly.

2. If a patient is readmitted within 30 days for the same or a related condition, there shall be a reference to the previous history with an interval note, and any pertinent changes in physical findings shall be recorded.

3. All records of discharged patients shall be completed within a reasonable period of time specified in the medical staff by-laws, but not to exceed 30 days.

(4) MATERNITY PATIENT AND NEWBORN RECORDS. (a) *Prenatal findings.* Except in an emergency, before a maternity patient may be admitted to a hospital, the patient's attending physician shall submit a legible copy of the prenatal history to the hospital's obstetrical staff. The prenatal history shall note complications, Rh determination and other matters essential to adequate care.

(b) *Maternal medical record.* Each obstetric patient shall have a complete hospital record which shall include:

1. Prenatal history and findings;

2. The labor and delivery record, including anesthesia;

3. The physician's progress record;

4. The physician's order sheet;

5. A medicine and treatment sheet, including nurses' notes;

6. Any laboratory and x-ray reports;

7. Any medical consultant's notes; and

8. An estimate of blood loss.

(c) *Newborn medical record.* Each newborn infant shall have a complete hospital record which shall include:

1. A record of pertinent maternal data, type of labor and delivery, and the condition of the infant at birth;

2. A record of physical examinations;

3. A progress sheet recording medicines and treatments, weights, feedings and temperatures; and

4. The notes of any medical consultant.

(d) *Fetal death.* In the case of a fetal death, the weight and length of the fetus shall be recorded on the delivery record.

(5) AUTHENTICATION OF ALL ENTRIES. (a) *Documentation.* 1. All entries in medical records by medical staff or other hospital staff shall be legible, permanently recorded, dated and authenticated with the name and title of the person making the entry.

2. A rubber stamp reproduction of a person's signature may be used instead of a handwritten signature, if:

a. The stamp is used only by the person whose signature the stamp replicates; and

b. The facility possesses a statement, signed by the person, certifying that only that person is authorized to possess and use the stamp.

(b) *Symbols and abbreviations.* Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and controls their use.

History: Cr. Register, January, 1988, No. 385, eff. 2-1-88.

HSS 124.15 Pharmaceutical services. (1) DEFINITIONS. In this section:

(a) "Drug room" means the room in a hospital that does not have a pharmacy, in which prescription drugs are stored and from which they are distributed.

(b) "Pharmacist" means a person licensed in Wisconsin under ch. 450, Stats., as a pharmacist.

(c) "Pharmacy" means any place in which prescription drugs, as defined in s. 450.07 (1) (g), Stats., are compounded or dispensed, and which is licensed under s. 450.02 (9) (a), Stats.

(2) SERVICE. The hospital shall have a pharmacy directed by a pharmacist or a drug room under competent supervision. The pharmacy or drug room shall be administered in accordance with accepted professional practices.

(3) ADMINISTRATION. (a) *Pharmacist accountability.* The pharmacist shall be responsible to the chief executive officer for developing, supervising and coordinating all the activities of the pharmacy.

(b) *Licensed pharmacy.* In a hospital with a pharmacy, except for emergency orders, a pharmacist shall review the practitioner's order, a direct copy of the order or another type of verifiable order before the initial dose of a medication is dispensed. When a pharmacist is not on the premises, the medication order shall be reviewed by the pharmacist by the end of the next day.

(c) *Drug room.* If the hospital has only a drug room, prescription medications shall be dispensed by a qualified pharmacist elsewhere and only storing and distributing shall be done in the hospital. In this case:

1. An on-site review of the medication administration system shall be conducted at least monthly by a consultant pharmacist;

2. A consulting pharmacist shall assist in the development of the correct procedures and rules for storage and distribution of drugs, and shall visit the hospital on a regularly scheduled basis; and

3. A consulting pharmacist shall participate in reviewing at least a sample of current medication orders on a periodic basis.

(d) *Availability.* All hospitals shall have a pharmacist on call and available for consultation at all times.