

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended LR 33:284 (February 2007).

§9507. Obstetrical Units

A. These requirements are applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care Units. There are four established obstetrical levels of care units:

1. Obstetrical Level I Unit;
2. Obstetrical Level II Unit;
3. Obstetrical Level III Unit; and
4. Obstetrical Level III Regional Unit.

C. Obstetrical services shall be provided in accordance with current acceptable standards of practice as delineated in the current AAP/ACOG *Guidelines for Perinatal Care*. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a Level III regional unit must meet the requirements of a Level I, II, and III unit.

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§9509. Obstetrical Unit Functions

A. Obstetrical Level I Unit

1. General Provisions

a. Care and supervision for low risk pregnancies greater or equal to 35 weeks gestation shall be provided.

b. There shall be a triage system for identification, stabilization and referral of high risk maternal and fetal conditions beyond the scope of care of a Level I Unit.

c. There shall be a written transfer agreement with a hospital which has an approved appropriate higher level of care.

d. The unit shall provide detection and care for unanticipated maternal-fetal problems encountered in labor.

e. Blood and fresh frozen plasma for transfusion shall be immediately available.

f. Postpartum care facilities shall be available.

g. There shall be capability to provide for resuscitation and stabilization of inborn neonates.

h. The facility shall have a policy for infant security and an organized program to prevent infant abductions.

i. The facility shall support breast feeding.

j. The facility shall have data collection and retrieval capabilities including current birth certificate in

Subchapter S. Obstetrical and Newborn Services (Optional)

§9505. General Provisions

A. This Subchapter S requires that the level of care on the Obstetrical Unit and the Neonatal Intensive Care Unit shall be at the identical level except for free standing children's hospitals. All hospitals with existing obstetrical and neonatal services must be in compliance with this Subchapter S within one year of the promulgation date of this Rule. All new providers of obstetrical and neonatal services will be required to be in compliance with this Subchapter S immediately upon promulgation.

use, and shall cooperate and report the requested data to the appropriate supervisory agencies for review.

k. The facility shall have a program in place to address the needs of the family, including parent-sibling-neonate visitation.

l. The facility shall have written transport agreements. The transport service must be designed to be adequately equipped and have transport personnel with appropriate expertise for obstetrical and neonatal care during transport. Transport services shall meet appropriate local, state, and federal guidelines.

2. Personnel Requirements

a. Obstetrical services shall be under the medical direction of a qualified physician who is a member of the medical staff with obstetric privileges. The physician shall be Board Certified or Board Eligible in obstetrics/gynecology or Family Practice Medicine. The physician has the responsibility of coordinating perinatal services with the pediatric chief of service.

b. The nursing staff must be adequately trained and staffed to provide patient care at the appropriate level of service. The facility shall utilize the guidelines for staffing as provided by the AAP and the ACOG in the current *Guidelines for Perinatal Care* (See Table 2-1 in §9515, Additional Support Requirements).

c. The unit shall provide credentialed medical staff to ensure the capability to perform emergency Cesarean delivery within 30 minutes of the decision to operate (30 minutes from decision to incision).

d. Anesthesia, radiology, ultrasound, electronic fetal monitoring (along with personnel skilled in its use) and laboratory services shall be available on a 24-hour basis. Anesthesia services shall be available to ensure performance of a Cesarean delivery within 30 minutes as specified in Subparagraph c above.

e. At least one qualified physician or certified registered nurse midwife shall attend all deliveries, and at least one qualified individual capable of neonatal resuscitation shall attend all deliveries.

f. The nurse manager shall be a registered nurse (RN) with specific training and experience in obstetric care. The RN manager shall participate in the development of written policies, procedures for the obstetrical care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

3. Physical Plant

a. Obstetrical patients shall not be placed in rooms with non-obstetrical patients.

b. Each room shall have at least one toilet and lavatory basin for the use of obstetrical patients.

c. The arrangement of the rooms and areas used for obstetrical patients shall be such as to minimize traffic of

patients, visitors, and personnel from other departments and prevent traffic through the delivery room(s).

d. There shall be an isolation room provided with hand washing facilities for immediate segregation and isolation of a mother and/or baby with a known or suspected communicable disease.

e. Any new construction or major alteration of obstetrical units shall have a facility to enable Cesarean section deliveries in the obstetrical unit.

B. Obstetrical Level II Unit

1. General Provisions

a. The role of an obstetrical Level II unit is to provide care for most obstetric conditions in its population, but not to accept transports of obstetrical patients with gestation age of less than 32 weeks or 1,500 grams if delivery of a viable infant is likely to occur.

b. Conditions which would result in the delivery of an infant weighing less than 1,500 grams or less than 32 weeks gestation shall be referred to an approved Level III or Level III regional obstetrical unit unless the patient is too unstable to transport safely. Written agreements with approved obstetrical Level III and/or obstetrical Level III regional units for transfer of these patients shall exist for all obstetrical Level II units.

c. The unit shall be able to manage maternal complications of a mild to moderate nature that do not surpass the capabilities of a board certified obstetrician/gynecologist.

d. The needed subspecialty expertise is predominantly neonatal although perinatal cases might be appropriate to co-manage with a perinatologist.

e. Ultrasound equipment shall be on site, in the hospital, and available to labor and delivery 24 hours a day.

2. Personnel Requirements

a. The chief of obstetric services shall be a board-certified obstetrician or an active candidate for certification in obstetrics. This obstetrician has the responsibility of coordinating perinatal services with the neonatologist or pediatrician in charge of the neonatal intensive care unit (NICU).

b. A board-certified radiologist and a board-certified clinical pathologist shall be available 24 hours a day. Specialized medical and surgical consultation shall be readily available.

C. Obstetrical Level III Unit

1. General Provisions

a. There shall be provision of comprehensive perinatal care for high risk mothers.

b. The unit shall provide care for the most challenging of perinatal conditions. Only those conditions requiring a medical team approach not available to the

perinatologist in an obstetrical Level III unit shall be transported to an obstetrical Level III regional unit.

c. Cooperative transfer agreements with approved obstetrical Level III regional units shall exist for the transport of mothers and fetuses requiring care unavailable in an obstetrical Level III unit or that are better coordinated at an obstetrical Level III regional unit.

d. Obstetric imaging capabilities to perform targeted ultrasound examination in cases of suspected abnormalities shall be available.

e. Genetic counseling and diagnostics shall be provided.

f. Ongoing educational opportunities shall be provided through organized educational programs.

g. This unit shall provide for and coordinate maternal transport with obstetrical Level I and II units.

2. Personnel Requirements

a. The chief of the obstetrical unit providing maternal-fetal medicine at a Level III unit shall assure that appropriate care is provided by the primary attending physician for high risk maternal patients and shall be:

- i. board-certified in maternal-fetal medicine; or
- ii. an active candidate for subspecialty certification in maternal-fetal medicine; or
- iii. a board-certified obstetrician with experience in maternal-fetal medicine and credentialing to care for high risk mothers.

b. If there is no hospital-based perinatologist, a written consultative agreement shall exist with an approved obstetrical Level III or Level III regional obstetrical unit with a hospital-based perinatologist. The agreement shall also provide for a review of outcomes and case management for all high risk obstetrical patients for educational purposes.

c. A board-certified anesthesiologist with special training or experience in maternal-fetal anesthesia services at a Level III unit shall direct obstetrical anesthesia services. Personnel, including certified registered nurse anesthetists (CRNAs), with credentials to administer obstetric anesthesia shall be in-house 24 hours a day.

D. Obstetrical Level III Regional Unit

1. General Provisions

a. The unit shall have the ability to care for both mother and fetus in a comprehensive manner in an area dedicated to the care of the critically ill parturient.

b. These units shall provide for and coordinate maternal and neonatal transport with Level I, II and III NICU units throughout the state.

2. Personnel Requirements

a. The chief of service at the Level III regional obstetrical unit must be a board-certified perinatologist.

b. The obstetrical Level III Regional unit shall have the following obstetrical specialties or subspecialties on staff and clinical services available to provide consultation and care to the parturient in a timely manner:

- i. maternal-fetal medicine;
- ii. cardiology;
- iii. neurology; and
- iv. hematology.

c. Subspecialists to provide consultation in the care of the critically ill parturient shall be on staff in the following areas:

- i. adult critical care;
- ii. cardiothoracic surgery;
- iii. nephrology;
- iv. pulmonary medicine;
- v. neurosurgery;
- vi. endocrinology;
- vii. urology;
- viii. infectious disease; and
- ix. gastroenterology.

d. Personnel qualified to manage obstetrical emergencies shall be in-house 24 hours per day, including CRNAs, with credentials to administer obstetrical anesthesia.

e. A lactation consultant shall be on staff to assist breast feeding mothers.

f. Registered nurses with experience in the care of high risk maternity patients shall be in house on a 24-hour basis.

g. A nutritionist and a social worker shall also be available for the care of these patients.

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§9511. Medical Staff

A. This §9511 is applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care. There are four established neonatal levels of care units:

1. Neonatal Level I Unit;
2. Neonatal Level II Unit;
3. Level III NICU Unit; and
4. Level III regional NICU.

C. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a Level III regional unit must meet the requirements of the Level I, II, and III units.

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§9513. Neonatal Unit Functions

A. Level I Neonatal Unit

1. General Provisions

a. The unit shall have the capability for resuscitation and stabilization of all inborn neonates in accordance with Neonatal Resuscitation Program (NRP) guidelines. The unit shall stabilize unexpected small or sick neonates before transfer to the appropriate advanced level of care.

b. The unit shall maintain consultation and transfer agreements with an approved Level II or III as appropriate, and an approved Level III regional NICU, emphasizing maternal transport when possible.

c. There shall be a defined nursery area with limited access and security or rooming-in facilities with security.

d. Parent and/or sibling visitation/interaction with the neonate shall be provided.

e. The unit shall have the capability for data collection and retrieval.

2. Personnel Requirements

a. The unit's chief of service shall be a physician who is board-certified or board-eligible in pediatric or family practice medicine.

b. The nurse manager shall be a registered nurse with specific training and experience in neonatal care. The RN manager shall participate in the development of written policies and procedures for the neonatal care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

c. Registered nurse to patient ratios may vary in accordance with patient needs. However, the ratio for a Level I neonatal unit shall be 1:6-8. This ratio reflects traditional newborn nursery care. If couplet care or rooming-in is used, a registered nurse who is responsible for the mother should coordinate and administer neonatal care. If direct assignment of the nurse is also made to the nursery to cover the newborn's care, there shall be double assignment (one nurse for the mother-neonate couplet and one for just the neonate if returned to the nursery). A registered nurse shall be available at all times, but only one may be necessary as most neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the registered nurse's direct supervision. Adequate staff is needed to respond to acute and emergency situations.

B. Neonatal Level II Unit

1. General Provisions

a. There shall be management of small, sick neonates with a moderate degree of illness that are admitted or transferred.

b. There shall be neonatal ventilatory support, vital signs monitoring, and fluid infusion in the defined area of the nursery. Neonates requiring greater than 24-hour continuous ventilatory support shall be transferred to an approved Level III or Level III regional unit.

c. Neonates born at a Level II facility with a birth weight of less than 1,500 grams shall be transferred to an approved Level III or Level III regional NICU unit unless a neonatologist is providing on-site care in the hospital.

d. Neonates requiring transfer to a Level III or Level III regional NICU may be returned to an approved Level II unit for convalescence.

2. Personnel Requirements

a. A board-certified pediatrician with special interest and experience in neonatal care or a neonatologist shall be the chief of service.

b. Registered nurse to patient ratios may vary in accordance with patient needs. However, the ratio for a Level II neonatal unit shall be 1:3-4 (See Table 2-1 of §9515, Additional Support Requirements).

C. Level III NICU

1. General Provisions

a. There shall be a written neonatal transport agreement with an approved Level III regional unit. There shall be an organized outreach educational program.

b. If the neonatologist is not in-house, there shall be a pediatrician who has successfully completed the Neonatal Resuscitation Program (NRP) or one neonatal nurse practitioner in-house for Level III NICU patients.

c. Direct consultation with a neonatologist shall be available 24 hours per day.

2. Personnel Requirements

a. The chief of service of a Level III NICU shall be a board-certified neonatologist. The following exceptions are recognized.

i. A board-certified pediatrician who is an active candidate for a subspecialty certification in neonatal medicine.

ii. In 1995, those physicians in existing units who were designated as the chief of service of the unit and who were not neonatal or perinatal board-certified, were granted a waiver by written application to the Office of the Secretary, Department of Health and Hospitals. This waiver shall be maintained as it applies only to the hospital where that chief of service's position is held. The physician cannot relocate to another hospital nor can the hospital replace the chief of

service for whom the exception was granted and retain the exception.

b. Medical and surgical consultation shall be readily available and pediatric subspecialists may be used in consultation with a transfer agreement with a Level III regional NICU.

c. Registered nurse to patient ratios may vary in accordance with patient needs. However, the ratio for a Level III NICU unit shall be 1:2-3 (See Table 2-1 of §9515, Additional Support Requirements).

D. Level III Regional NICU

1. General Provisions

a. Twenty-four hours per day in-house coverage shall be provided by a neonatologist, a second year or higher pediatric house officer, or a neonatal nurse practitioner. If the neonatologist is not in-house, there shall be immediate consultative ability with the neonatologist and he/she shall be available to be on-site in the hospital within 30 minutes.

b. The unit shall have a transport team and provide for and coordinate neonatal transport with Level I, Level II units and Level III NICUs throughout the state. Transport shall be in accordance with national standards as published by the American Academy of Pediatrics' Section on neonatal and pediatric transport.

c. The unit shall be recognized as a center of research, educational and consultative support to the medical community.

2. Personnel Requirements

a. The chief of service shall be a board-certified neonatologist.

b. Nurse to patient ratios may vary in accordance with patient needs. However, the ratio for a Level III regional NICU shall be 1:1-2 (See Table 2-1 in §9515, Additional Support Requirements).

c. The unit shall have the following pediatric specialties/subspecialties on staff and clinical services available to provide consultation and care to neonates in a timely manner:

- i. anesthesia;
- ii. pediatric surgery;
- iii. pediatric cardiology; and
- iv. pediatric ophthalmology.

d. Subspecialists to provide consultation in the care of the critically ill neonate shall be on staff in the following areas:

- i. pediatric neurology;
- ii. pediatric hematology;
- iii. genetics;
- iv. pediatric nephrology;
- v. pediatric endocrinology;

- vi. pediatric gastroenterology;
- vii. pediatric infectious disease;
- viii. pediatric pulmonary medicine;
- ix. orthopedic surgery;
- x. pediatric urologic surgery;
- xi. ENT surgery; and
- xii. cardiothoracic surgery.

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§9515. Additional Support Requirements

A. A Bioethics Committee shall be available for consultation with care providers at all times.

B. The following support personnel shall be available to provide consultation and care and services to Level II, Level III and Level III regional obstetrical, neonatal, and NICU units in a timely manner:

1. at least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy);

2. at least one occupational or physical therapist with neonatal expertise; and

3. at least one registered dietitian/nutritionist who has special training or experience in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.

C. The following support personnel shall be immediately available to be on-site in the hospital for Level II, Level III and Level III regional obstetrical, neonatal, and NICU units:

1. qualified personnel for support services such as laboratory studies, radiological studies, and ultrasound examinations (these personnel shall be readily available 24 hours a day); and

2. registered respiratory therapists or registered nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

D. The staffing guidelines shall be those recommended by the current AAP/ACOG *Guidelines for Perinatal Care*. (See Table 2-1 below).

Table 2-1. Recommended Registered Nurse/Patient Ratios for Perinatal Care Services	
Nurse/Patient Ratio	Care Provided

Table 2-1. Recommended Registered Nurse/Patient Ratios for Perinatal Care Services	
Nurse/Patient Ratio	Care Provided
Intrapartum	Patients in labor
1:2	Patients in second stage of labor
1:1	Patients with medical or obstetric complications
1:1	Oxytocin induction or augmentation of labor
1:2	Coverage for initiating epidural anesthesia
1:1	Circulation for Cesarean delivery
1:1	
Antepartum/ Postpartum	Antepartum/postpartum patients without complications
1:6	Patients in postoperative recovery
1:2	Antepartum/postpartum patients with complications but in stable condition
1:3	Recently born infants and those requiring close observation
1:4	
Newborns	Newborns requiring only routine care
1:6-8	Normal mother-newborn couplet care
1:3-4	Newborns requiring continuing care
1:3-4	Newborns requiring intermediate care
1:2-3	Newborns requiring intensive care
1:1-2	Newborns requiring multi-system support
1:1	Unstable newborns requiring complex critical care
1:1 or Greater	care

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