**Section 250.1830 General Requirements for All Obstetric Departments**

a) The temperature and humidity in the nurseries and in the delivery suite shall be maintained at a level best suited for the protection of mothers and infants as recommended by the Guidelines for Perinatal Care. Chilling of the neonate shall be avoided; a non-stable neonate shall, immediately after birth, be placed in a radiant heat source that is ready to receive the infant and that allows access for resuscitation efforts. The radiant heat source shall comply with the recommendations of the Guidelines for Perinatal Care. When the neonate has been stabilized, if the mother wishes to hold the newborn, a radiant heater or pre-warmed blankets shall be available to keep the neonate warm. Stable infants shall be placed, and remain, in direct skin-to-skin contact with their mother immediately after delivery to optimally support infant breastfeeding and to promote mother/infant bonding. Personnel shall be available who are trained to use the equipment to maintain a neutral thermal environment for the neonate. For general temperature and humidity requirements, see Section 250.2480(d)(1). In general, a temperature between 72 degrees and 76 degrees and relative humidity between 35% and 60% are acceptable.

b) Linens and Laundry: Linens shall be cleaned and disinfected in compliance with the Guidelines for Perinatal Care.

1) Nursery linens shall be washed separately from other hospital linens.

2) No new unlaundered garments shall be used in the nursery.

c) Sterilizing equipment, as required in Section 250.1090, shall be available. Sterilizing equipment may be provided in the obstetric department or in a central sterilizing unit, provided that flash sterilizing equipment or adequate sterile supplies and instruments are provided in the obstetric department.

d) Accommodations and Facilities for Obstetric Patients

1) The hospital shall identify specific rooms and beds, adjacent when possible to other obstetric facilities, as obstetric rooms and beds. These rooms and beds shall be used exclusively for obstetric patients or for combined obstetric and clean gynecological service beds in accordance with Section 250.1820(g).

2) Patient rooms and beds that are adjacent to another nursing unit may be used for clean cases as part of the adjacent nursing unit. A corridor partition with doors is recommended to provide a separation between the obstetric beds and facilities and the non-obstetric rooms. The doors shall be kept closed except when in active use as a passageway.

3) Facilities shall be available for the immediate isolation of all patients in whom an infectious condition inimical to the safety of other obstetric and neonatal patients exist.

4) Labor rooms shall be convenient to the delivery rooms and shall have facilities for examination and preparation of patients. Each room used for labor, delivery and postpartum (see Section 250.1870) shall include a bathroom equipped with a toilet and a shower. The bathroom also shall include a sink, unless a sink is located in the patient room. The bathroom shall be directly accessible from the patient room without going through the corridor.

5) Delivery rooms shall be equipped and staffed to provide emergency resuscitation for infants pursuant to the recommendation of the American Academy of Pediatrics and ACOG and shall comply with the American Academy of Pediatrics/American Health Association's American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines.

6) If only one delivery room is available and in use, one labor room shall be arranged as an emergency delivery room and shall have a minimum clear floor area of 180 square feet.

7) The patient shall be kept under close observation until the patient's condition is stabilized following delivery. Observations at established time intervals shall be recorded in the patient's medical record. A recovery area shall be provided. Emergency equipment and supplies shall be available for use in the recovery area.

e) Accommodations and Facilities for Infants

1) Level I nurseries:

A) A clean nursery or nurseries shall be provided, near the mothers' rooms, with adequate lighting and ventilation. A minimum of 30 square feet of floor area for each bassinet and 3 feet between bassinets shall be provided. Equipment shall be provided to prevent direct draft on the infants. Individual nursery rooms shall have a capacity of six to eight neonates or 12 to 16 neonates. The normal newborn infant care area in a smaller hospital shall limit room size to eight neonates, with a minimum of two rooms available to permit cohorting in the presence of infection.

B) Bassinets equipped to provide for the medical examination of the newborn infant and for the storage of necessary supplies and equipment shall be provided in a number to exceed obstetric beds by at least 20% to accommodate multiple births, extended stay, and fluctuating patient loads. Bassinets shall be separated by a minimum of 3 feet, measuring from the edge of one bassinet to the edge of the adjacent one.

C) A glass observation window shall be provided through which infants may be viewed.

D) Resuscitation equipment as described in subsection (e)(1)(E)(iii), and personnel trained to use it, shall be available in the nursery at all times.

E) Each nursery shall have necessary equipment immediately available to stabilize the sick infant prior to transfer. Equipment shall consist of:

i) A heat source capable of maintaining the core temperature of even the smallest infant at 98 degrees (an incubator, or preferably a radiant heat source);

ii) Equipment with the ability to monitor bedside blood sugar;

iii) A resuscitation tray containing equipment pursuant to the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines; and

iv) Equipment for delivery of 100% oxygen concentration, and the ability to measure delivered oxygen in fractional inspired concentrations (FI O2) pursuant to American Academy of Pediatrics (AAP) recommendations. The oxygen analyzer shall be calibrated and serviced according to the manufacturer's instructions at least monthly by the hospital's respiratory therapy department or other responsible personnel trained to perform the task.

F) Consultation and referral protocols shall comply with the Regionalized Perinatal Health Care Code.

2) Level II and Level III nurseries shall comply with the Regionalized Perinatal Health Care Code. Cribs shall be separated by 4 to 6 feet to allow for ease of movement of additional personnel, and to allow space for additional equipment used in care of infants in these areas. New buildings or additions or material alterations to existing buildings that affect the Level II with Extended Neonatal Capabilities nursery shall provide at least 70 square feet of space for each infant.

3) A Level III nursery shall provide 80 to 100 square feet of space for each infant.

4) Facilities shall be available for the immediate isolation of all newborn infants who have or are suspected of having an infectious disease.

5) When an infectious condition exists or is suspected of existing, the infant shall be isolated in accordance with policies and procedures established and approved by the hospital and consistent with recommended procedures of the Guidelines for Perinatal Care and the Control of Communicable Diseases Code.

f) The personnel requirements and recommendations set forth in Subpart D apply to the operation of the obstetric department, in addition to the following:

1) Each hospital shall have a staffing plan for nursing personnel providing care for obstetric and neonatal patients. The registered nursing components of the plan shall comply with Section 250.1130, with requirements for the level of perinatal care, as designated in accordance with the Regionalized Perinatal Health Care Code, the Guidelines for Perinatal Care, the National Association of Neonatal Nurses' (NANN) Position Statement #3074 RN Staffing in the NICU, and the following parameters:

A) Nursing supervision by a registered nurse shall be provided for the entire 24-hour period for each occupied unit of the obstetric and neonatal services. This nurse shall have education and experience in obstetric and neonatal nursing.

B) At least one registered nurse trained in obstetric and nursery care shall be assigned to the care of mothers and infants at all times. To prepare for an unexpected delivery, at least one registered nurse or LPN trained to give care to newborn infants shall be assigned at all times to the nursery with duties restricted to the care of the infants. Infants shall never be left unattended.

C) A registered nurse shall be in attendance at all deliveries and shall be available to monitor the mother's general condition and that of the fetus during labor, for at least two hours after delivery, and longer if complications occur.

D) Nursing personnel providing care for obstetric and other patients shall be instructed on a continuing basis in the proper technique to prevent cross-infection. When it is necessary for the same nurse to care for both obstetric and non-obstetric patients in the gynecologic unit, proper technique shall be followed.

E) Obstetric and neonatal department nurses providing input to the hospital's nursing care committee pursuant to Section 250.1130 shall, prior to proposing their recommendations for the hospital's written staffing plan, consider the staffing standards listed in subsection (f)(1).

F) Temporary relief from outside the obstetric and neonatal division by qualified personnel shall be permitted as necessary according to appropriate infection control policy.

G) For each shift in the obstetric department, at least one of the registered nurses or LPNs shall also have certification or experience in lactation training, pursuant to the requirements of subsection (k).

2) Nursing staff – Level I requirements for occupied units. These units shall meet the following requirements in addition to General Care Requirements in subsection(f)(1).

A) At least two nursing personnel shall be assigned per shift. One shall be a registered nurse and one shall be a registered nurse or an LPN.

B) The capability to provide neonatal resuscitation in the delivery room shall be demonstrated by the current completion of a nationally recognized neonatal resuscitation program by medical, nursing and respiratory care staff or a hospital rapid response team, in accordance with the requirements of the Regionalized Perinatal Health Care Code.

C) Hospitals shall have the capability for continuous electronic maternal-fetal monitoring for patients, with staff available 24 hours a day, including physician and nursing, who are knowledgeable of electronic maternal-fetal monitoring use and interpretation. Physicians and nurses shall complete a competence assessment in electronic maternal-fetal monitoring every two years, in accordance with the Regionalized Perinatal Health Care Code.

3) Nursing staff – Level II requirements for occupied units. These units shall meet the requirements for Level I in subsection (f)(2). Nursery personnel may be shared with the Level I nursery as needed.

4) Nursing staff – Level II with Extended Neonatal Capabilities requirements for occupied units. In addition to the requirements in subsection (f)(3), the obstetric-newborn nursing services shall be directed by a full-time registered nurse experienced in perinatal nursing. Preference shall be given to registered nurses with a master's degree.

5) Nursing staff – Level III requirements for occupied units. These units shall meet the following requirements in addition to requirements in subsection (f)(3). Half of all neonatal intensive care direct nursing care hours shall be provided by registered nurses who have two years or more of nursing experience in a Level III NICU. All neonatal intensive care direct nursing care hours shall be provided or supervised by registered nurses who have advanced neonatal intensive care training and documented competence in neonatal pathophysiology and care technologies used in the NICU.

6) Medical personnel

A) Each hospital providing obstetric services shall have an organized obstetric staff with a chief of obstetric service. The chief's level of qualification and expertise shall be appropriate to the hospital's designated level of care. The responsibilities of the chief of obstetric services shall include the following requirements, as they relate to the care of obstetric patients:

i) General supervision of the care of the perinatal patients assigned to the unit;

ii) Establishment of criteria for admissions;

iii) Adherence to licensing requirements;

iv) Adoption, by the medical staff, of standards of practice and privileges;

v) Identification of clinical conditions and procedures requiring consultation;

vi) Arrangement of conferences, held at least quarterly, to review operations, complications and mortality;

vii) Assurance that the clinical records, consultations and reports are properly completed and analyzed; and

viii) Provision for exchange of information between medical, administrative and nursing staffs.

B) Each hospital providing pediatric services shall have an organized pediatric staff with a chief of pediatric service. The chief's level of qualification and expertise shall be appropriate to the hospital's designated level of care. The responsibilities of the chief of pediatric services shall include those listed in subsection (f)(6)(A), as they relate to the care of newborn infants.

C) Level I shall comply with the Regionalized Perinatal Health Care Code:

i) One physician shall be Chief of Obstetrical Care. The Chief of Obstetrical Care shall be a board certified or board qualified obstetrician. If this is not possible, a physician with experience and regular practice may be the Chief and be responsible for obstetrical care and available on a 24-hour basis, and a source of obstetric or maternal fetal medicine consultation shall be documented when indicated.

ii) One physician shall be Chief of Pediatric Service. The Chief of Pediatric Service shall be a board certified or board qualified pediatrician. If this is not possible, a physician with experience and regular practice may be the Chief and be responsible for pediatric care and available on a 24-hour basis, and a source of neonatology consultation shall be documented when indicated.

D) Level II shall comply with the Regionalized Perinatal Health Care Code:

A board certified obstetrician shall be Chief of Obstetrical Care. A board certified pediatrician shall be Chief of Neonatal Care. Obstetrical anesthesia shall be directed by a board certified anesthesiologist with experience and competence in obstetrical anesthesia. Hospital staff shall also include a pathologist and an on call radiologist 24 hours a day. Specialized medical and surgical consultation shall be readily available.

E) Level II With Extended Neonatal Capabilities: Staffing shall comply with the Regionalized Perinatal Health Care Code.

F) Level III: Staffing shall comply with the Regionalized Perinatal Health Care Code.

g) Practices and procedures for care of mothers and infants:

1) The hospital shall follow procedures approved by the infection control committee for the isolation of known or suspected cases of infectious disease in the obstetric department.

2) Patients with clean obstetric complications (regardless of month of gestation), such as pregnancy-induced hypertension for observation and treatment, placenta previa for observation or delivery, ectopic pregnancy, and hypertensive heart disease in a pregnant patient, may be admitted to the obstetric department and be subject to the same requirements as any other obstetric case. (See Section 250.1820(g)(6).)

3) The physician shall determine whether a prenatal serological test for syphilis and a test for HIV have been done on each mother and the results recorded. If no tests have been done before the admission of the patients, the tests shall be performed as soon as possible pursuant to the Perinatal HIV Prevention Act. Specimens for a syphilis test may be submitted in appropriate containers to an Illinois Department of Public Health laboratory for testing without charge. Mothers shall be tested for Group B streptococcus prior to delivery and for Hepatitis B prior to discharge of either mother or infant, pursuant to AAP recommendations.

4) No obstetric patient under the effect of an analgesic or an anesthetic, in the second stage of labor or delivery, shall be left unattended at any time.

5) Fetal lung maturity shall be established and documented prior to elective inductions and caesarean sections if the infant is at less than 39 weeks of gestation, or 38 weeks of gestation for twins. The hospital shall establish a written policy and procedure concerning the administration of oxytocic drugs.

A) Oxytocin shall be used for the contraction stress test only when qualified personnel, determined by the hospital staff and administration, can attend the patient closely. Written policies and procedures shall be available to the team members assuming this responsibility.

B) The oxytocin solution shall be administered intravenously via a controlled infusion device, using both a primary intravenous solution and a secondary oxytocin solution.

C) Oxytocin shall be used for medical induction or stimulation of labor only when qualified personnel, determined by the hospital staff and administration, can attend the patient closely. Written policies and procedures shall be available to the team members assuming this responsibility. The following shall be included in these policies:

i) An attending physician shall evaluate the patient for induction or stimulation, especially with regard to indications.

ii) The physician or other individuals starting the oxytocin shall be familiar with its effect and complications and be qualified to identify both maternal and fetal complications.

iii) A qualified physician shall be immediately available as is necessary to manage any complication effectively.

iv) During oxytocin administration, the fetal heart rate; the resting uterine tone; and the frequency, duration and intensity of contractions shall be monitored electronically and recorded. Maternal blood pressure and pulse shall be monitored and recorded at intervals comparable to the dosage regimen; that is, at 30 to 60 minute intervals, when the dosage is evaluated for maintenance, increase or decrease. Evidence of maternal and fetal surveillance shall be documented.

6) Identification of infants:

A) While the neonate is still in the delivery room, the nurse in the delivery room shall prepare identical identification bands for both the mother and the neonate, as outlined in the hospital's policy. Wrist bands alone may be used; however, it is recommended that both wrist and ankle bands be used on the neonate. The hospital shall not use foot-printing and fingerprinting alone as methods of patient identification. The bands shall indicate the mother's admission number, the neonate's sex, the date and time of birth, and any other information required by hospital policy. Delivery room personnel shall review the bands prior to securing them on the mother and the neonate to ensure that the information on the bands is identical. The nurse in the delivery room shall securely fasten the bands on the neonate and the mother without delay as soon as the nurse has verified the information on the identification bands. The birth records and identification bands shall be checked again before the neonate leaves the delivery room.

B) If the condition of the neonate does not allow the placement of identification bands, the identification bands shall accompany the neonate and shall be attached as soon as possible, as outlined in the hospital's policy. Identification bands shall not be left unattached and unattended in the nursery.

C) When the neonate is taken to the nursery, both the delivery room nurse and the admitting nursery nurse shall check the neonate's identification bands and birth records, verify the sex of the neonate, and sign the neonate's medical record. The admitting nurse shall complete the bassinet card and attach it to the bassinet.

D) When the neonate is taken to the mother, the nurse shall check the mother's and the neonate's identification bands, verify the sex of the neonate and verify that the information on the bands is identical.

E) The umbilical cord (cords, with multiple births) shall be identified according to hospital policy (e.g., by the use of a different number of clamps) so that umbilical cord blood specimens are correctly labeled. All umbilical cord blood samples shall be labeled correctly with an indication that these are a sample of the neonate's umbilical cord blood and not the blood of the mother.

F) The hospital shall develop a newborn infant security system. This system shall include instructions to the mother regarding safety precautions designed to avoid abduction. Electronic sensor devices may be included as well.

7) Within one hour after delivery, ophthalmic ointment or drops containing tetracycline or erythromycin shall be instilled into the eyes of the newborn infant as a preventive against ophthalmia neonatorum. The eyes shall not be irrigated.

8) A single parenteral dose of vitamin K-1, water soluble to 0.5-1.0 milligrams, shall be given to the infant, shortly after birth, but usually within the first hour after delivery, as a prophylaxis against hemorrhagic disorder in the first days of life.

9) Mandatory Hearing Screening

A) *Each* hospital *shall conduct bilateral hearing screening of each newborn infant prior to discharge unless medically contraindicated or the infant is transferred to another hospital before the hearing screening can be completed.* (Section 5(a) of the Early Hearing Detection and Intervention Act)

B) *The* hospital *performing the hearing screening shall report the results of the hearing screening to the Department within 7 days after screening.*

i) *If there is no hearing screening result or an infant does not pass the hearing screening in both ears at the same time, the* hospital *shall refer the infant's parents or guardians to a health care practitioner for follow-up, and document and report the referral, including the name of the health care practitioner, to the Department in a format determined by the Department.*

ii) *For infants born outside a* hospital*, the newborn's primary care provider shall refer the patient to a* hospital *for the hearing screening to be done in compliance with the Act* and this Section *within 30 days after birth, unless a different time period is medically indicated.* (Section 5(b) of the Early Hearing Detection and Intervention Act)

10) Each infant shall be given complete individual crib-side care. The use of a common bath table is prohibited. Scales shall be adequately protected to prevent cross-infection.

11) Artificial feedings and formula changes shall not be instituted except by written order of the attending physician, pursuant to the requirements of the Hospital Infant Feeding Act.

12) Facilities for drug services. See Section 250.2130(a).

13) Newborn infants shall be transported from the delivery room to the nursery in a safe manner. Adequate support systems (heating, oxygen, suction) shall be incorporated into the transport units for infants (e.g., to x-ray). Chilling of the newborn and cross-infection shall be avoided. If travel is excessive and through other areas, special transport incubators may be required. The method of transporting infants from the nursery to the mothers shall be individual, safe and free from cross-infection hazards.

14) The stay of the mother and the infant in the hospital after delivery shall be planned to allow the identification of problems and to reinforce instructions in preparation for the infant's care at home. The mother and infant shall be carefully observed for a sufficient period of time and assessed prior to discharge to ensure that their conditions are stable. Healthy infants shall be discharged from the hospital simultaneously with the mother, or to other persons authorized by the mother, if the mother remains in the hospital for an extended stay. Follow-up shall be provided for mothers and infants discharged within 48 hours after delivery, including a face-to-face encounter with a health care provider who will assess the condition of mother and infant and arrange for intervention if problems are identified.

15) When a patient's condition permits, an infant may be transferred from an intensive care nursery to the referring nursery or to another nursery that is nearest the home and at which an appropriate level of care may be provided. Transfers shall be conducted pursuant to the Regionalized Perinatal Health Care Code.

16) The hospital shall have a policy regarding circumcisions performed by a Mohel.

17) Circumcisions shall not be performed in the delivery room or within the first six hours after birth. A physician may order and perform a circumcision when the infant is over the age of six hours and, in the physician's professional judgment, is healthy and stable.

18) The hospital shall comply with the Guidelines for Perinatal Care and Guidelines for Women's Health Care (see Section 250.105).

h) Medical Records

1) Obstetric records:

A) Adequate, accurate, and complete medical records shall be maintained for each patient. The medical records shall include findings during the prenatal period, which shall be available in the obstetric department prior to the patient's admission and shall include medical and obstetric history, observations and proceedings during labor, delivery and the postpartum period, and laboratory and x-ray findings.

B) Records shall be maintained in accordance with hospital medical records policies and procedures, including the applicable requirements of the Health Insurance Portability and Accountability Act and the minimum observations and laboratory tests outlined in Guidelines for Perinatal Care and Guidelines for Women's Health Care. The physician director of the obstetric department shall require all physicians delivering obstetric care to send copies of the prenatal records, including laboratory reports, to the obstetric unit at or before 37 weeks of gestation, including updates from that time until admission.

2) Infant records. Accurate and complete medical records shall be maintained for each infant. The medical records shall include:

A) History of maternal health and prenatal course, including mother's HIV status, if known.

B) Description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid.

C) Time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room.

D) Report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining hospital stay.

E) Physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily.

F) Documentation of infant feeding: intake, content, and amount if by formula.

G) Clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3) The hospital shall keep a record of births that contains data sufficient to duplicate the birth certificate. The requirement may be met by:

A) Retaining the yellow "hospital copy" of the birth certificate properly bound in chronological order, or

B) Retaining this copy with the individual medical record.

i) Reports

1) Each hospital that provides obstetric and neonatal services shall submit a monthly perinatal activities report to its affiliated Administrative Perinatal Center.

2) Maternal death report

A) The hospital shall submit an immediate report of the occurrence of a maternal death to the Department, in accordance with the Department's Maternal Death Review rules (77 Ill. Adm. Code 657). Maternal death is the death of any woman dying of any cause whatsoever while pregnant or within one year after termination of the pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it was terminated. A death shall be reported regardless of whether the death occurred in the obstetric department or any other section of the hospital, or whether the patient was delivered in the hospital where death occurred, or elsewhere.

B) The filing of this report shall in no way preclude the necessity of filing a death certificate or of including the death on the Perinatal Activities Report.

3) The hospital shall comply with the laws of the State and the rules of the Department in the preparation and filing of birth, death and fetal death certificates.

4) Epidemic and communicable disease reporting

A) The hospital shall develop a protocol for the management and reporting of infections consistent with the Control of Communicable Diseases Code, the Perinatal HIV Prevention Act, Guidelines for Perinatal Care and Guidelines for Women's Health Care, and as approved by the infection control committee. These policies shall be known to obstetric and nursery personnel.

B) The hospital shall particularly address those infections specifically related to mothers and infants, including but not limited to, methicillin-resistant Staphylococcus Aureus occurring in infants under 61 days of age, ophthalmia neonatorum, and perinatal hepatitis B infection.

j) Infant Feeding Policy

1) For the purposes of this subsection (j):

A) "*Baby-Friendly Hospital Initiative" means the voluntary program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) that recognizes hospitals that meet certain evaluation criteria regarding the promotion of breastfeeding.*

B) "*Infant Nutrition Resource" means breastfeeding education and infant formula safety and preparation.*

2) *Infant Feeding Policy Required*

A) *Every hospital that provides birthing services must adopt an infant feeding policy that promotes breastfeeding. In developing the policy, a hospital shall consider guidance provided by the Baby-Friendly Hospital Initiative*.

B) *An infant feeding policy adopted under* this Section *shall include guidance on the use of formula for medically necessary supplementation, if preferred by the mother, or when exclusive breastfeeding is contraindicated for the mother or for the infant*.

3) *Communication of Policy. A hospital shall routinely communicate the infant feeding policy to staff in the hospital's obstetric and neonatal areas, beginning with hospital staff orientation. The hospital shall also ensure that the policy and infant nutrition resources are posted in a conspicuous place in the hospital's obstetric or neonatal area or on the hospital's Internet or Intranet web site or on the Internet or Intranet web site of the health system of which the hospital is a part. The hospital shall make copies of the policy available to the Department upon request.*

4) *Application of Policy. A hospital's infant feeding policy adopted under* the Hospital Infant Feeding *Act must apply to all mother-infant couplets in the hospital's obstetric and neonatal areas*. (Sections 5 through 20 of the Hospital Infant Feeding Act)

k) Breast Milk and Formula

1) Pursuant to the requirements of subsection (j), the hospital shall provide the mother with information regarding lactation, the nutritional benefits of breast milk, and lactation support organizations within the area. The hospital staff shall include, at a minimum, lactation support staff with certification or experience in lactation training. The lactation support staff shall attend continuing education in relation to lactation counseling and training, consistent with hospital policy. At least one lactation support staff shall be on duty at all times in the obstetric department.

2) Pursuant to the requirements of subsection (j), the hospital shall have a policy for the preparation of formula by hospital staff when hospital-prepared formula is needed in place of commercially prepared formula. Adequate space, equipment and procedures for processing, handling and storing commercially-prepared formula shall be provided.

A) All hospitals providing obstetric or pediatric services that prepare their own formula shall provide a well-ventilated and well-lighted formula room, which shall be adequately supervised and used exclusively for the preparation of formulas.

B) Equipment shall include hand-washing facilities with hot and cold running water with knee, foot or elbow controlled valves; a double-section sink for washing and rinsing bottles; facilities for storing cleaning equipment, refrigeration facilities; utensils in good condition for preparation of formulas; cupboard and work space and a work table; an autoclave and a supply of individual formula bottles, nipples and protecting caps, adequate to prepare a 24-hour supply of formula and water for each infant. Procedures shall be established by the hospital and enforced.

3) *A hospital shall provide information and instructional materials to parents of each newborn, upon discharge from the hospital, regarding the option to voluntarily donate milk to non-profit milk banks that are accredited by the Human Milk Banking Association of North America or its successor organization.*

A) *The materials shall be provided free of charge and shall include general information regarding non-profit milk banking practices and contact information for area nonprofit milk banks that are accredited by the Human Milk Banking Association of North America.*

B) *The information and instructional materials described in* subsection (k)(3) *may be provided electronically.*

C) Hospitals may obtain *free and suitable information on voluntary milk donation from the Human Milk Banking Association of North America, or its successor organization, or its accredited members.* (Section 11.9 of the Act)

l) Visiting Policy

1) The visiting requirements set forth in Subpart B shall apply to obstetric departments, except as modified in this subsection (l).

2) Each obstetric department shall have a visiting policy that complies with the Guidelines for Perinatal Care and is approved by the hospital's infection control committee.

3) The visiting policy shall cover all programs in the obstetric department.

4) The visiting policy shall comply with the hospital's infection control policy and shall include signage instructing visitors to wash their hands.

m) Infant Abduction Policies

*Every hospital shall demonstrate to the Department that the following* have been adopted:

1) *Procedures designed to reduce the likelihood that an infant patient will be abducted from the hospital. The procedures may include, but need not be limited to, architectural plans to control access to infant care areas, video camera observation of infant care areas, and procedures for identifying hospital staff and visitors.*

2) *Procedures designed to aid in identifying allegedly abducted infants who are recovered. The procedures may include, but need not be limited to, foot-printing infants by staff who have been trained in that procedure, photographing infants, and obtaining and retaining blood samples for genetic testing.* (Section 6.15 of the Act)

n) Staff Continuing Education Policies and Requirements.

1) Hospitals shall have a *written policy and conduct continuing education yearly* (calendar) *for providers and staff of obstetric medicine and of the emergency department and other staff that may care for pregnant or postpartum women. The written policy and continuing education shall include management of severe maternal hypertension and obstetric hemorrhage, addressing airway emergencies experienced during childbirth, and management of other leading causes of maternal mortality for units that care for pregnant or postpartum women*.

2) Hospitals shall *demonstrate compliance* by annually submittinga copy of the facility's *written policy and education requirements* to the hospital's Administrative Perinatal Center*.* (Section 2310-222(b) of the Department of Public Health Powers and Duties Law)

o) Hospitals *shall incorporate best practices for timely identification and assessment of all pregnant and postpartum women for common pregnancy or postpartum complications in the emergency department and for care provided by the* hospital *throughout the pregnancy and postpartum period,* to be *provided* to the hospital *by the Department, in consultation with the Illinois Perinatal Quality Collaborative*, *into the written policy* required in subsection (n). (Section 2310-222(d) of the Department of Public Health Powers and Duties Law)

(Source: Amended at 48 Ill. Reg. 7321, effective May 3, 2024)