290-5-8-.10 Medical, Dental and Nursing Care.

(1) Each patient shall have a physician's written statement of his or her condition at time of admission or within forty-eight (48) hours thereafter and it shall be kept on file with the patient's medical record.
(2) Each patient shall have a physician's orders for treatment and/or care upon admission to the facility.
(3) Each home shall have an adequate arrangement for medical and dental emergencies.
(4) Reports of all evaluations and examinations shall be kept with the patient's medical records.
(5) The home shall have a microbial and infection control program. Policies and procedures for infection control shall be written, assembled and available to all staff members. Procedures shall be specific for practice in the home and shall be included in the training of every staff member. As a minimum, procedures shall include the following control measures:
(a) Prevention of spread of infection from personnel to patient: Any person whose duties include direct patient care, handling food, or handling clean linen, and who has an acute illness such as "strep" throat, or an open sore or boil, shall not be allowed to work until he is fully recovered;
(b) Prevention of spread of infection from visitors to patients;
(c) Prevention of spread of infection from patient to personnel or other patients: Isolation techniques to be observed according to the source of infection and the method of spread;
(d) Reporting of communicable diseases as required by the rules and regulations for notification of diseases which have been promulgated by the Department.
(6) All medications, administered to patients must be ordered in writing by the patient's physician or oral orders may be given to a licensed nurse, immediately reduced to writing, signed by the nurse and countersigned by the physician as soon as practical. Medications not specifically limited as to time or number of doses, when ordered, must be automatically stopped in accordance with written policy approved by the organized professional staff.
(a) The patient's attending physician shall be notified of stop order policies and contacted promptly for renewal of such orders so that continuity of the patient's therapeutic regimen is not interrupted.
(7) All medications must be administered by medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of the State of Georgia. Each dose administered shall be properly recorded in the clinical records:
(a) The nurses' station shall have readily available items necessary for the proper administration of medication;
(b) In administering medications, medication cards or other State approved systems must be used and checked against the physician's orders;
(c) Legend drugs prescribed for one patient shall not be administered to any other patient unless ordered by a physician;
(d) Self-administration of medications by patients should be discouraged except for emergency drugs on special order of the patient's physician or in a predischarge program under the supervision of a licensed nurse;
(e) Medication errors and drug reactions shall be immediately reported to the patient's

physician and an entry thereof made in the patient's clinical records as well as on an incident report;
(f) Up-to-date medication reference texts and sources of information shall be available.
(8) Nursing care shall be provided each patient according to his needs and in accordance with his patient care plan.
(9) Restraint and/or forcible seclusion of a patient will be used only on a signed order of a physician, except in emergency and then only until the advice of a physician can be obtained.
(10) Provisions shall be made for proper sterilization of supplies, utensils, instruments, and other materials as needed for the patients.
Authority Ga. L. 1964, pp. 507, 612, as amended by Ga. L. 1969, p. 715 et seq; and Ga. L. 1972, p. 1015 et seq. **Administrative History.** Original Rule was filed on October 26, 1976; effective November 15, 1976.