HEALTH & SAFETY CODE
SUBTITLE B. LICENSING OF HEALTH FACILITIES
CHAPTER 241. HOSPITALS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 241.001. SHORT TITLE. This chapter may be cited as the Texas Hospital Licensing Law.
Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.002. PURPOSE. The purpose of this chapter is to protect and promote the public health and welfare by providing for the development, establishment, and enforcement of certain standards in the construction, maintenance, and operation of hospitals.
Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.003. DEFINITIONS. In this chapter:

(1) "Advanced practice nurse" means a registered nurse recognized as an advanced practice nurse by the Board of Nurse Examiners.

(2) "Board" means the Texas Board of Health.

(3) "Comprehensive medical rehabilitation hospital" means a general hospital that specializes in providing comprehensive medical rehabilitation services, including surgery and related ancillary services.

(4) "Department" means the Texas Department of Health.

(5) "General hospital" means an establishment that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(B) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

(6) "Governmental unit" means a political subdivision of the state, including a hospital district, county, or municipality, and any department, division, board, or other agency of a political subdivision.

(7) "Hospital" includes a general hospital and a special hospital.

(8) "Medical staff" means a physician or group of physicians and a podiatrist or a group of podiatrists who by action of the governing body of a hospital are privileged to work in and use the facilities of a hospital for or in connection with the observation, care, diagnosis, or treatment of an individual who is, or may be, suffering from a mental or physical disease or disorder or a physical deformity or injury.

(9) "Pediatric and adolescent hospital" means a general hospital that specializes in providing services to children and adolescents, including surgery and related ancillary services.

(10) "Person" means an individual, firm, partnership, corporation, association, or joint stock company, and includes a receiver, trustee, assignee, or other similar representative of those entities.

(11) "Physician" means a physician licensed by the Texas State Board of Medical Examiners.

(12) "Physician assistant" means a physician assistant licensed by the Texas State Board of Physician Assistant Examiners.

(13) "Podiatrist" means a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners.

(14) Repealed by Acts 2005, 79th Leg., ch. 1286, Sec. 2.

(15) "Special hospital" means an establishment that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care;

(B) has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment;

(C) has a medical staff in regular attendance; and

(D) maintains records of the clinical work performed for each patient.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended

by Acts 1995, 74th Leg., ch. 965, Sec. 79, eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 43, Sec. 1, eff. May 7, 1997; Acts 1997, 75th Leg., ch. 623, Sec. 2, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 428, Sec. 1, eff. Sept. 1, 1999; Acts 2005, 79th Leg., ch. 1286, Sec. 2, eff. Sept. 1, 2005.

Sec. 241.004. EXEMPTIONS. This chapter does not apply to a facility:

(1) licensed under Chapter 242 or 577;

(2) maintained or operated by the federal government or an agency of the federal government; or

(3) maintained or operated by this state or an agency of this state.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 76, Sec. 16, eff. Sept. 1, 1991.

Sec. 241.005. EMPLOYMENT OF PERSONNEL. The department may employ stenographers, inspectors, and other necessary assistants in carrying out the provisions of this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.006. COORDINATION OF SIGNAGE REQUIREMENTS IMPOSED BY STATE AGENCIES. (a) The department is authorized to review current and proposed state rules issued by the department or by other state agencies that mandate that a hospital place or post a notice, poster, or sign in a conspicuous place or in an area of high public traffic, concerning the rights of patients or others or the responsibilities of the hospital, which is directed at patients, patients' families, or others. The purpose of this review shall be to coordinate the placement, format, and language contained in the required notices in order to:

(1) eliminate the duplication of information;

(2) reduce the potential for confusion to patients, patients' families, and others; and

(3) reduce the administrative burden of compliance on hospitals.

(b) Notwithstanding any other law, this section applies to all notices, posters, or signs described in Subsection (a).

Added by Acts 1995, 74th Leg., ch. 965, Sec. 3, eff. June 16, 1995.

SUBCHAPTER B. HOSPITAL LICENSES

Sec. 241.021. LICENSE REQUIRED. A person or governmental unit, acting severally or jointly with any other person or governmental unit, may not establish, conduct, or maintain a hospital in this state without a license issued under this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.022. LICENSE APPLICATION. (a) An application for a license must be made to the department on a form provided by the department.

(b) The application must contain:

(1) the name and social security number of the sole proprietor, if the applicant is a sole proprietor;

(2) the name and social security number of each general partner who is an individual, if the applicant is a partnership;

(3) the name and social security number of any individual who has an ownership interest of more than 25 percent in the corporation, if the applicant is a corporation; and

(4) any other information that the department may reasonably require.

(c) The department shall require that each hospital show evidence that:

(1) at least one physician is on the medical staff of the hospital, including evidence that the physician is currently licensed;

(2) the governing body of the hospital has adopted and implemented a patient transfer policy in accordance with Section 241.027; and

(3) if the governing body has chosen to implement patient transfer agreements, it has implemented the agreements in accordance with Section 241.028.

(d) The application must be accompanied by:

(1) a copy of the hospital's current patient transfer policy;

(2) a nonrefundable license fee;

(3) copies of the hospital's patient transfer agreements, unless the filing of copies has been waived by the hospital licensing director in accordance with the rules adopted under this chapter; and

(4) a copy of the most recent annual fire safety inspection report from the fire marshal in whose jurisdiction the hospital is located.

(e) The department may require that the application be approved by the local health authority or other local official for compliance with municipal ordinances on building construction, fire prevention, and sanitation. A hospital located outside the limits of a municipality shall comply with corresponding state laws.

(f) The department shall post on the department's Internet website a list of all of the individuals named in applications as required by Subsections (b)(1)--(3). The department may not post on its Internet website a social security number of an individual required to be named in an application under Subsections (b)(1)--(3).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 82, eff. Sept. 1, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 1, eff. Sept. 1, 1993; Acts 2005, 79th Leg., ch. 1161, Sec. 1, eff. Sept. 1, 2005.

Sec. 241.023. ISSUANCE OF LICENSE. (a) On receiving a license application and the license fee, the department shall issue a license if it finds that the applicant and the hospital comply with this chapter and the rules or standards adopted under this chapter.

(b) A license may be renewed annually after payment of the required fee and submission of an application for license renewal that contains the information required by Section 241.022(b).

(c) Except as provided by Subsection (c-1), the department may issue a license only for the premises of a hospital and person or governmental unit named in the application.

(c-1) The department may issue one license for multiple hospitals if:

(1) all buildings in which inpatients receive hospital services and inpatient services of each of the hospitals to be included in the license are subject to the control and direction of the same governing body;

(2) all buildings in which inpatients receive hospital services are within a 30-mile radius of the main address of the applicant;

(3) there is integration of the organized medical staff of each of the hospitals to be included in the license;

(4) there is a single chief executive officer for all of the hospitals who reports directly to the governing body and through whom all administrative authority flows and who exercises control and surveillance over all administrative activities of the hospital;

(5) there is a single chief medical officer for all of the hospitals who reports directly to the governing body and who is responsible for all medical staff activities of the hospital;

(6) each building of a hospital to be included in the license that is geographically separate from other buildings of the same hospital contains at least one nursing unit for inpatients, unless providing only diagnostic or laboratory services, or a combination of diagnostic or laboratory services, in the building for hospital inpatients; and

(7) each hospital that is to be included in the license complies with the emergency services standards:

(A) for a general hospital, if the hospital provides surgery or obstetrical care or both; or

(B) for a special hospital, if the hospital does not provide surgery or obstetrical care.

(c-2) The hospital licensing director may recommend a waiver of the requirement of Subsection (c-1)(7) for a hospital if another hospital that is to be included in the license:

(1) complies with the emergency services standards for a general hospital; and

(2) is in close geographic proximity to the hospital.

(c-3) The executive commissioner of the Health and Human Services Commission shall adopt rules to implement the waiver provision of Subsection (c-2). The rules must provide for a determination by the department that the waiver will facilitate the creation or operation of the hospital seeking the waiver and that the waiver is in the best interest of the individuals served or to be served by the hospital.

(d) Subject to Subsection (e), a license issued under this

section for a hospital includes each outpatient facility that is not separately licensed, that is located apart from the hospital, and for which the hospital has submitted to the department:

(1) a copy of a fire safety survey that is dated not earlier than one year before the submission date indicating approval by:

(A) the local fire authority in whose jurisdiction the outpatient facility is located; or

(B) the nearest fire authority, if the outpatient facility is located outside of the jurisdiction of a local fire authority; and

(2) if the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, a copy of documentation from the accrediting body showing that the outpatient facility is included within the hospital's accreditation.

(e) Subsection (d) applies only if the federal Department of Health and Human Services, Health Care Financing Administration, or Office of Inspector General adopts final or interim final rules requiring state licensure of outpatient facilities as a condition of the determination of provider-based status for Medicare reimbursement purposes.

(f) A license may not be transferred or assigned without the written approval of the department.

(g) A license shall be posted in a conspicuous place on the licensed premises.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1411, Sec. 2.01, eff. Sept. 1, 1999; Acts 2005, 79th Leg., ch. 1161, Sec. 2, eff. Sept. 1, 2005; Acts 2005, 79th Leg., ch. 1286, Sec. 1, eff. Sept. 1, 2005.

Sec. 241.024. HOSPITAL LICENSING DIRECTOR. (a) The commissioner of health shall appoint, with the advice and consent of the board, a person to serve as hospital licensing director.

(b) A person appointed as the hospital licensing director must:

(1) have at least five years experience or training, or both, in the field of hospital administration;

(2) be of good moral character; and

(3) have been a resident of this state for at least three years.

(c) The hospital licensing director shall administer this chapter and is directly responsible to the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.025. LICENSE FEES. (a) The department shall charge each hospital an annual license fee for an initial license or a license renewal.

(b) The board by rule shall adopt the fees authorized by Subsection (a) according to a schedule under which the number of beds in the hospital determines the amount of the fee. The fee may not exceed $15 a bed. A minimum license fee may be established. The minimum fee may not exceed $1,000.

(c) A fee adopted under this chapter must be based on the estimated cost to and level of effort expended by the department to conduct the activity for which the fee is imposed.

(d) All license fees collected shall be deposited in the state treasury to the credit of the department to administer and enforce this chapter. These fees are hereby appropriated to the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1993, 73rd Leg., ch. 584, Sec. 3, eff. Sept. 1, 1993; Acts 1999, 76th Leg., ch. 1411, Sec. 2.02, eff. Sept. 1, 1999.

Sec. 241.026. RULES AND MINIMUM STANDARDS. (a) The board shall adopt and enforce rules to further the purposes of this chapter. The rules at a minimum shall address:

(1) minimum requirements for staffing by physicians and nurses;

(2) hospital services relating to patient care;

(3) fire prevention, safety, and sanitation requirements in hospitals;

(4) patient care and a patient bill of rights;

(5) compliance with other state and federal laws affecting the health, safety, and rights of hospital patients; and

(6) compliance with nursing peer review under Subchapter I, Chapter 301, and Chapter 303, Occupations Code, and the rules of the Board of Nurse Examiners relating to peer review.

(b) In adopting rules, the board shall consider the conditions of participation for certification under Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.) and the standards of the Joint Commission on Accreditation of Healthcare Organizations and will attempt to achieve consistency with those conditions and standards.

(c) Upon the recommendation of the hospital licensing director and the council, the board by order may waive or modify the requirement of a particular provision of this Act or minimum standard adopted by board rule under this section to a particular general or special hospital if the board determines that the waiver or modification will facilitate the creation or operation of the hospital and that the waiver or modification is in the best interests of the individuals served or to be served by the hospital.

(d) The board shall adopt rules establishing procedures and criteria for the issuance of the waiver or modification order. The criteria must include at a minimum a statement of the appropriateness of the waiver or modification against the best interests of the individuals served by the hospital.

(e) If the board orders a waiver or modification of a provision or standard, the licensing record of the hospital granted the waiver or modification shall contain documentation to support the board's action. The board's rules shall specify the type and specificity of the supporting documentation that must be included.

(f) A comprehensive medical rehabilitation hospital or a pediatric and adolescent hospital shall have an emergency treatment room but is not required to have an emergency department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 350, Sec. 1, eff. Aug. 26, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 4, eff. Sept. 1, 1993; Acts 1997, 75th Leg., ch. 43, Sec. 2, eff. May 7, 1997; Acts 1997, 75th Leg., ch. 617, Sec. 2, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 623, Sec. 3, eff. Sept. 1, 1997; Acts 2001, 77th Leg., ch. 1420, Sec. 14.786, eff. Sept. 1, 2001.

Sec. 241.0262. CIRCULATING DUTIES FOR SURGICAL SERVICES. Circulating duties in the operating room must be performed by qualified registered nurses. In accordance with approved medical staff policies and procedures, licensed vocational nurses and surgical technologists may assist in circulatory duties under the direct supervision of a qualified registered nurse circulator.

Added by Acts 2005, 79th Leg., ch. 966, Sec. 2, eff. Sept. 1, 2005.

Sec. 241.0263. RECOMMENDATIONS RELATING TO MISSING INFANTS. (a) The department shall recommend hospital security procedures to:

(1) reduce the likelihood of infant patient abduction; and

(2) aid in the identification of missing infants.

(b) In making recommendations, the department shall consider hospital size and location and the number of births at a hospital.

(c) The procedures recommended by the department under Subsection (a)(1) may include:

(1) controlling access to newborn nurseries;

(2) expanding observation of newborn nurseries through the use of video cameras; and

(3) requiring identification for hospital staff and visitors as a condition of entrance to newborn nurseries.

(d) The procedures recommended by the department under Subsection (a)(2) may include:

(1) footprinting, photographing, or writing descriptions of infant patients at birth; and

(2) obtaining umbilical cord blood samples for infant patients born at the hospital and storing the samples for genetic testing purposes.

(e) Each hospital licensed under this chapter shall consider implementing the procedures recommended under this section.

Added by Acts 1997, 75th Leg., ch. 314, Sec. 1, eff. Sept. 1, 1997.

Sec. 241.0265. STANDARDS FOR CARE FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY. (a) The care and treatment of a patient receiving mental health services in a facility licensed by the department under this chapter or Chapter 577 are governed by the standards adopted by the Texas Department of Mental Health and Mental Retardation to the same extent as if the standards adopted by

that department were rules adopted by the board under this chapter or Chapter 577.

(b) The care and treatment of a patient receiving chemical dependency treatment in a facility licensed by the department under this chapter are governed by the same standards that govern the care and treatment of a patient receiving treatment in a treatment facility licensed under Chapter 464 and that are adopted by the Texas Commission on Alcohol and Drug Abuse, to the same extent as if the standards adopted by the commission were rules adopted by the board under this chapter.

(c) The department shall enforce the standards provided by Subsections (a) and (b). A violation of a standard is subject to the same consequence as a violation of a rule adopted by the board under this chapter or Chapter 577. The department is not required to enforce a standard if the enforcement violates a federal law, rule, or regulation.

Added by Acts 1993, 73rd Leg., ch. 573, Sec. 3.02, eff. Sept. 1, 1993.

Sec. 241.027. PATIENT TRANSFERS. (a) The board shall adopt rules to govern the transfer of patients between hospitals that do not have a transfer agreement and governing services not included in transfer agreements.

(b) The rules must provide that patient transfers between hospitals be accomplished through hospital policies that result in medically appropriate transfers from physician to physician and from hospital to hospital by providing:

(1) for notification to the receiving hospital before the patient is transferred and confirmation by the receiving hospital that the patient meets the receiving hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to treat the patient;

(2) for the use of medically appropriate life support measures that a reasonable and prudent physician exercising ordinary care in the same or a similar locality would use to stabilize the patient before the transfer and to sustain the patient during the transfer;

(3) for the provision of appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care in the same or a similar locality would use for the transfer;

(4) for the transfer of all necessary records for continuing the care for the patient; and

(5) that the transfer of a patient not be predicated on arbitrary, capricious, or unreasonable discrimination because of race, religion, national origin, age, sex, physical condition, or economic status.

(c) The rules must require that if a patient at a hospital has an emergency medical condition which has not been stabilized, the hospital may not transfer the patient unless:

(1) the patient or a legally responsible person acting on the patient's behalf, after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility;

(2) a licensed physician has signed a certification, which includes a summary of the risks and benefits, that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or

(3) if a licensed physician is not physically present in the emergency department at the time a patient is transferred, a qualified medical person has signed a certification described in Subdivision (2) after a licensed physician, in consultation with the person, has made the determination described in such clause and subsequently countersigns the certificate.

(d) The rules also shall provide that a public hospital or hospital district shall accept the transfer of its eligible residents if the public hospital or hospital district has appropriate facilities, services, and staff available for providing care to the patient.

(e) The rules must require that a hospital take all reasonable steps to secure the informed refusal of a patient or of a person acting on the patient's behalf to a transfer or to related examination and treatment.

(f) The rules must recognize any contractual, statutory, or regulatory obligations that may exist between a patient and a designated or mandated provider as those obligations apply to the transfer of emergency or nonemergency patients.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 83, eff. Sept. 1, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 5, eff. Sept. 1, 1993.

Sec. 241.028. TRANSFER AGREEMENTS. (a) If hospitals execute a transfer agreement that is consistent with the requirements of this section, all patient transfers between the hospitals are governed by the agreement.

(b) The hospitals shall submit the agreement to the department for review for compliance with the requirements of this section. The department shall complete the review of the agreement within 30 days after the date the agreement is submitted by the hospitals.

(c) At a minimum, a transfer agreement must provide that:

(1) transfers be accomplished in a medically appropriate manner and comply with Sections 241.027(b)(2) through (5) and Section 241.027(c);

(2) the transfer or receipt of patients in need of emergency care not be based on the individual's inability to pay for the services rendered by the transferring or receiving hospital;

(3) multiple transfer agreements be entered into by a hospital based on the type or level of medical services available at other hospitals;

(4) the hospitals recognize the right of an individual to request transfer to the care of a physician and hospital of the individual's choice;

(5) the hospitals recognize and comply with the requirements of Chapter 61 (Indigent Health Care and Treatment Act) relating to the transfer of patients to mandated providers; and

(6) consideration be given to availability of appropriate facilities, services, and staff for providing care to the patient.

(d) If a hospital transfers a patient in violation of Subsection (c)(1), (2), (4), (5), or (6), relating to required provisions for a transfer agreement, the violation is a violation of this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 84, eff. Sept. 1, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 6, eff. Sept. 1, 1993.

Sec. 241.029. POLICIES AND PROCEDURES RELATING TO WORKPLACE SAFETY. (a) The governing body of a hospital shall adopt policies and procedures related to the work environment for nurses to:

(1) improve workplace safety and reduce the risk of injury, occupational illness, and violence; and

(2) increase the use of ergonomic principles and ergonomically designed devices to reduce injury and fatigue.

(b) The policies and procedures adopted under Subsection (a), at a minimum, must include:

(1) evaluating new products and technology that incorporate ergonomic principles;

(2) educating nurses in the application of ergonomic practices;

(3) conducting workplace audits to identify areas of risk of injury, occupational illness, or violence and recommending ways to reduce those risks;

(4) controlling access to those areas identified as having a high risk of violence; and

(5) promptly reporting crimes committed against nurses to appropriate law enforcement agencies.

Added by Acts 2003, 78th Leg., ch. 876, Sec. 13, eff. June 20, 2003.

SUBCHAPTER C. ENFORCEMENT

Sec. 241.051. INSPECTIONS. (a) The department may make any inspection, survey, or investigation that it considers necessary. A representative of the department may enter the premises of a hospital at any reasonable time to make an inspection, a survey, or an investigation to assure compliance with or prevent a violation of this chapter, the rules adopted under this chapter, an order or special order of the commissioner of health, a special license provision, a court order granting injunctive relief, or other enforcement procedures. The department shall maintain the confidentiality of hospital records as applicable under state or federal law.

(b) The department or a representative of the department is entitled to access to all books, records, or other documents maintained by or on behalf of the hospital to the extent necessary to enforce this chapter, the rules adopted under this chapter, an order or special order of the commissioner of health, a special license provision, a court order granting injunctive relief, or other enforcement procedures.

(c) By applying for or holding a hospital license, the hospital consents to entry and inspection of the hospital by the department or a representative of the department in accordance with this chapter and the rules adopted under this chapter.

(d) All information and materials obtained or compiled by the department in connection with a complaint and investigation concerning a hospital are confidential and not subject to disclosure under Section 552.001 et seq., Government Code, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the department or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with the department in the enforcement action against the hospital;

(2) the hospital that is the subject of the enforcement action, or the hospital's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate hospital services;

(4) law enforcement agencies; and

(5) persons engaged in bona fide research, if all individual-identifying and hospital-identifying information has been deleted.

(e) The following information is subject to disclosure in accordance with Section 552.001 et seq., Government Code:

(1) a notice of alleged violation against the hospital, which notice shall include the provisions of law which the hospital is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the pleadings in the administrative proceeding; and

(3) a final decision or order by the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1993, 73rd Leg., ch. 584, Sec. 8, eff. Sept. 1, 1993; Acts 1999, 76th Leg., ch. 1444, Sec. 15, eff. Aug. 30, 1999.

Sec. 241.052. COMPLIANCE WITH RULES AND STANDARDS. (a) A hospital that is in operation when an applicable rule or minimum standard is adopted under this chapter must be given a reasonable period within which to comply with the rule or standard.

(b) The period for compliance may not exceed six months, except that the department may extend the period beyond six months if the hospital sufficiently shows the department that it requires additional time to complete compliance with the rule or standard.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.053. DENIAL OF APPLICATION, SUSPENSION, REVOCATION, PROBATION, OR REISSUANCE OF LICENSE. (a) The department, after providing notice and an opportunity for a hearing to the applicant or license holder, may deny, suspend, or revoke a hospital's license if the department finds that the hospital:

(1) failed to comply with:

(A) a provision of this chapter;

(B) a rule adopted under this chapter;

(C) a special license condition;

(D) an order or emergency order by the commissioner of health; or

(E) another enforcement procedure permitted under this chapter;

(2) has a history of noncompliance with the rules adopted under this chapter relating to patient health, safety, and rights which reflects more than nominal noncompliance; or

(3) has aided, abetted, or permitted the commission of an illegal act.

(b) A hospital whose license is suspended or revoked may apply to the department for the reissuance of a license. The department may reissue the license if the department determines that the hospital has corrected the conditions that led to the suspension or revocation of the hospital's license, the initiation of enforcement action against the hospital, the assessment of administrative penalties, or the issuance of a court order

enjoining the hospital from violations or assessing civil penalties against the hospital. A hospital whose license is suspended or revoked may not admit new patients until the license is reissued.

(c) A hospital must apply for reissuance in the form and manner required in the rules adopted under this chapter.

(d) Administrative hearings required under this section shall be conducted under the board's formal hearing rules and the contested case provisions of Chapter 2001, Government Code.

(e) Judicial review of a final decision by the department is by trial de novo in the same manner as a case appealed from the justice court to the county court. The substantial evidence rule does not apply.

(f) If the department finds that a hospital is in repeated noncompliance under Subsection (a) but that the noncompliance does not endanger public health and safety, the department may schedule the hospital for probation rather than suspending or revoking the hospital's license. The department shall provide notice to the hospital of the probation and of the items of noncompliance not later than the 10th day before the date the probation period begins. The department shall designate a period of not less than 30 days during which the hospital will remain under probation. During the probation period, the hospital must correct the items that were in noncompliance and report the corrections to the department for approval.

(g) The department may suspend or revoke the license of a hospital that does not correct items that were in noncompliance or that does not comply with the applicable requirements within the applicable probation period.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1993, 73rd Leg., ch. 584, Sec. 9, eff. Sept. 1, 1993; Acts 1993, 73rd Leg., ch. 705, Sec. 3.01, eff. Sept. 1, 1993; Acts 1995, 74th Leg., ch. 76, Sec. 5.95(51), eff. Sept. 1, 1995; Acts 2003, 78th Leg., ch. 802, Sec. 1, 2, eff. June 20, 2003.

Sec. 241.0531. COMMISSIONER'S EMERGENCY ORDERS. (a) Following notice to the hospital and opportunity for hearing, the commissioner of health or a person designated by the commissioner may issue an emergency order, either mandatory or prohibitory in nature, in relation to the operation of a hospital licensed under this chapter if the commissioner or the commissioner's designee determines that the hospital is violating or threatening to violate this chapter, a rule adopted pursuant to this chapter, a special license provision, injunctive relief issued pursuant to Section 241.054, an order of the commissioner or the commissioner's designee, or another enforcement procedure permitted under this chapter and the provision, rule, license provision, injunctive relief, order, or enforcement procedure relates to the health or safety of the hospital's patients.

(b) The department shall send written notice of the hearing and shall include within the notice the time and place of the hearing. The hearing must be held within 10 days after the date of the hospital's receipt of the notice.

(c) The hearing shall not be governed by the contested case provisions of Chapter 2001, Government Code but shall instead be held in accordance with the board's informal hearing rules.

(d) The order shall be effective on delivery to the hospital or at a later date specified in the order.

Added by Acts 1993, 73rd Leg., ch. 584, Sec. 10, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(51), eff. Sept. 1, 1995.

Sec. 241.054. VIOLATIONS; INJUNCTIONS. (a) The department shall:

(1) notify a hospital of a finding by the department that the hospital is violating or has violated this chapter or a rule or standard adopted under this chapter; and

(2) provide the hospital an opportunity to correct the violation.

(b) After the notice and opportunity to comply, the commissioner of health may request the attorney general or the appropriate district or county attorney to institute and conduct a suit for a violation of this chapter or a rule adopted under this chapter .

(c) The department may petition a district court for a temporary restraining order to restrain a continuing violation if the department finds that the violation creates an immediate threat to the health and safety of the patients of a hospital.

(d) On his own initiative, the attorney general, a district attorney, or a county attorney may maintain an action in the name of the state for a violation of this chapter or a rule adopted under this chapter.

(e) The district court shall assess the civil penalty authorized by Section 241.055, grant injunctive relief, or both, as warranted by the facts. The injunctive relief may include any prohibitory or mandatory injunction warranted by the facts, including a temporary restraining order, temporary injunction, or permanent injunction.

(f) The department and the party bringing the suit may recover reasonable expenses incurred in obtaining injunctive relief, civil penalties, or both, including investigation costs, court costs, reasonable attorney fees, witness fees, and deposition expenses.

(g) Venue may be maintained in Travis County or in the county in which the violation occurred.

(h) Not later than the seventh day before the date on which the attorney general intends to bring suit on his own initiative, the attorney general shall provide to the department notice of the suit. The attorney general is not required to provide notice of a suit if the attorney general determines that waiting to bring suit until the notice is provided will create an immediate threat to the health and safety of a patient. This section does not create a requirement that the attorney general obtain the permission of a referral from the department before filing suit.

(i) The injunctive relief and civil penalty authorized by this section and Section 241.055 are in addition to any other civil, administrative, or criminal penalty provided by law.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1993, 73rd Leg., ch. 705, Sec. 3.02, eff. Sept. 1, 1993.

Sec. 241.055. CIVIL PENALTY. (a) A hospital shall timely adopt, implement, and enforce a patient transfer policy in accordance with Section 241.027. A hospital may implement patient transfer agreements in accordance with Section 241.028.

(b) A hospital that violates Subsection (a), another provision of this chapter, or a rule adopted or enforced under this chapter is liable for a civil penalty of not more than $1,000 for each day of violation and for each act of violation. A hospital that violates this chapter or a rule or order adopted under this chapter relating to the provision of mental health, chemical dependency, or rehabilitation services is liable for a civil penalty of not more than $25,000 for each day of violation and for each act of violation.

(c) In determining the amount of the penalty, the district court shall consider:

(1) the hospital's previous violations;

(2) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation;

(3) whether the health and safety of the public was threatened by the violation;

(4) the demonstrated good faith of the hospital; and

(5) the amount necessary to deter future violations.

(d) A penalty collected under this section by the attorney general shall be deposited to the credit of the general revenue fund. A penalty collected under this section by a district or county attorney shall be deposited to the credit of the general fund of the county in which the suit was heard.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 86, eff. Sept. 1, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 11, eff. Sept. 1, 1993; Acts 1993, 73rd Leg., ch. 705, Sec. 3.03, eff. Sept. 1, 1993.

Sec. 241.056. SUIT BY PERSON HARMED. (a) A person who is harmed by a violation under Section 241.028 or 241.055 may petition a district court for appropriate injunctive relief.

(b) Venue for a suit brought under this section is in the county in which the person resides or, if the person is not a resident of this state, in Travis County.

(c) The person may also pursue remedies for civil damages under common law.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 87, eff. Sept. 1, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 12, eff. Sept. 1, 1993.

Sec. 241.057. CRIMINAL PENALTY. (a) A person commits an offense if the person establishes, conducts, manages, or operates a

hospital without a license.

(b) An offense under this section is a misdemeanor punishable by a fine of not more than $100 for the first offense and not more than $200 for each subsequent offense.

(c) Each day of a continuing violation constitutes a separate offense.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.058. MINOR VIOLATIONS. (a) This chapter does not require the commissioner of health or a designee of the commissioner to report a minor violation for prosecution or the institution of any other enforcement proceeding authorized under this chapter, if the commissioner or a designee of the commissioner determines that prosecution or enforcement is not in the best interests of the persons served or to be served by the hospital.

(b) For the purpose of this section, a "minor violation" means a violation of this chapter, the rules adopted under this chapter, a special license provision, an order or emergency order issued by the commissioner of health or the commissioner's designee, or another enforcement procedure permitted under this chapter by a hospital that does not constitute a threat to the health, safety, and rights of the hospital's patients or other persons.

Added by Acts 1993, 73rd Leg., ch. 584, Sec. 13, eff. Sept. 1,1993.

Sec. 241.0585. RECOVERY OF COSTS. If the attorney general brings an action to enforce an administrative penalty assessed under Section 241.058 and the court orders the payment of the penalty, the attorney general may recover reasonable expenses incurred in the investigation, initiation, or prosecution of the enforcement suit, including investigative costs, court costs, reasonable attorney fees, witness fees, and deposition expenses.

Added by Acts 1993, 73rd Leg., ch. 705, Sec. 3.041, eff. Sept. 1, 1993.

Sec. 241.059. ADMINISTRATIVE PENALTY. (a) The commissioner of health may assess an administrative penalty against a hospital that violates this chapter, a rule adopted pursuant to this chapter, a special license provision, an order or emergency order issued by the commissioner or the commissioner's designee, or another enforcement procedure permitted under this chapter. The commissioner shall assess an administrative penalty against a hospital that violates Section 166.004.

(b) In determining the amount of the penalty, the commissioner of health shall consider:

(1) the hospital's previous violations;

(2) the seriousness of the violation;

(3) any threat to the health, safety, or rights of the hospital's patients;

(4) the demonstrated good faith of the hospital; and

(5) such other matters as justice may require.

(c) The penalty may not exceed $1,000 for each violation, except that the penalty for a violation of Section 166.004 shall be $500. Each day of a continuing violation, other than a violation of Section 166.004, may be considered a separate violation.

(d) When it is determined that a violation has occurred the commissioner of health shall issue a report that states the facts on which the determination is based and the commissioner's recommendation on the imposition of a penalty, including a recommendation on the amount of the penalty.

(e) Within 14 days after the date the report is issued, the commissioner of health shall give written notice of the report to the person, delivered by certified mail. The notice must include a brief summary of the alleged violation and a statement of the amount of the recommended penalty and must inform the person that the person has a right to a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(f) Within 20 days after the date the person receives the notice, the person in writing may accept the determination and recommended penalty of the commissioner of health or may make a written request for a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(g) If the person accepts the determination and recommended penalty of the commissioner of health, the commissioner by order shall impose the recommended penalty.

(h) If the person requests a hearing or fails to respond

timely to the notice, the commissioner of health shall set a hearing and give notice of the hearing to the person. The hearing shall be held by the department. The person conducting the hearing shall make findings of fact and conclusions of law and promptly issue to the commissioner a proposal for a decision about the occurrence of the violation and the amount of the penalty. Based on the findings of fact, conclusions of law, and proposal for a decision, the commissioner by order may find that a violation has occurred and impose a penalty or may find that no violation occurred.

(i) The notice of the commissioner of health's order given to the person under Chapter 2001, Government Code must include a statement of the right of the person to judicial review of the order.

(j) Within 30 days after the date the commissioner of health's order is final as provided by Subchapter F, Chapter 2001, Government Code, the person shall:

(1) pay the amount of the penalty;

(2) pay the amount of the penalty and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty; or

(3) without paying the amount of the penalty, file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(k) Within the 30-day period, a person who acts under Subsection (j)(3) may:

(1) stay enforcement of the penalty by:

(A) paying the amount of the penalty to the court for placement in an escrow account; or

(B) giving to the court a supersedeas bond that is approved by the court for the amount of the penalty and that is effective until all judicial review of the board's order is final; or

(2) request the court to stay enforcement of the penalty by:

(A) filing with the court a sworn affidavit of the person stating that the person is financially unable to pay the amount of the penalty and is financially unable to give the supersedeas bond; and

(B) giving a copy of the affidavit to the commissioner of health by certified mail.

(l) When the commissioner of health receives a copy of an affidavit under Subsection (k)(2), he may file with the court, within five days after the date the copy is received, a contest to the affidavit. The court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person who files an affidavit has the burden of proving that the person is financially unable to pay the amount of the penalty and to give a supersedeas bond.

(m) If the person does not pay the amount of the penalty and the enforcement of the penalty is not stayed, the commissioner of health may refer the matter to the attorney general for collection of the amount of the penalty.

(n) Judicial review of the order of the commissioner of health:

(1) is instituted by filing a petition as provided by Subchapter G, Chapter 2001, Government Code; and

(2) is under the substantial evidence rule.

(o) If the court sustains the occurrence of the violation, the court may uphold or reduce the amount of the penalty and order the person to pay the full or reduced amount of the penalty. If the court does not sustain the occurrence of the violation, the court shall order that no penalty is owed.

(p) When the judgment of the court becomes final, the court shall proceed under this subsection. If the person paid the amount of the penalty and if that amount is reduced or is not upheld by the court, the court shall order that the appropriate amount plus accrued interest be remitted to the person within 30 days after the judgment of the court becomes final. The rate of the interest is the rate charged on loans to depository institutions by the New York Federal Reserve Bank, and the interest shall be paid for the period beginning on the date the penalty was paid and ending on the date the penalty is remitted. If the person gave a supersedeas bond and

if the amount of the penalty is not upheld by the court, the court shall order the release of the bond. If the person gave a supersedeas bond and if the amount of the penalty is reduced, the court shall order the release of the bond after the person pays the amount.

(q) A penalty collected under this section shall be remitted to the comptroller for deposit in the general revenue fund.

(r) All proceedings under this section are subject to Chapter 2001, Government Code.

Added by Acts 1993, 73rd Leg., ch. 584, Sec. 14, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(51), (53), (55), (60), eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 450, Sec. 2.03, eff. Sept. 1, 1999.

Sec. 241.060. ADMINISTRATIVE PENALTY FOR MENTAL HEALTH, CHEMICAL DEPENDENCY, OR REHABILITATION SERVICES. (a) The board may impose an administrative penalty against a person licensed or regulated under this chapter who violates this chapter or a rule or order adopted under this chapter relating to the provision of mental health, chemical dependency, or rehabilitation services.

(b) The penalty for a violation may be in an amount not to exceed $25,000. Each day a violation continues or occurs is a separate violation for purposes of imposing a penalty.

(c) The amount of the penalty shall be based on:

(1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of any prohibited acts, and the hazard or potential hazard created to the health, safety, or economic welfare of the public;

(2) enforcement costs relating to the violation;

(3) the history of previous violations;

(4) the amount necessary to deter future violations;

(5) efforts to correct the violation; and

(6) any other matter that justice may require.

(d) If the commissioner determines that a violation has occurred, the commissioner may issue to the board a report that states the facts on which the determination is based and the commissioner's recommendation on the imposition of a penalty, including a recommendation on the amount of the penalty.

(e) Within 14 days after the date the report is issued, the commissioner shall give written notice of the report to the person. The notice may be given by certified mail. The notice must include a brief summary of the alleged violation and a statement of the amount of the recommended penalty and must inform the person that the person has a right to a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(f) Within 20 days after the date the person receives the notice, the person in writing may accept the determination and recommended penalty of the commissioner or may make a written request for a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(g) If the person accepts the determination and recommended penalty of the commissioner, the board by order shall approve the determination and impose the recommended penalty.

(h) If the person requests a hearing or fails to respond timely to the notice, the commissioner shall set a hearing and give notice of the hearing to the person. The administrative law judge shall make findings of fact and conclusions of law and promptly issue to the board a proposal for a decision about the occurrence of the violation and the amount of a proposed penalty. Based on the findings of fact, conclusions of law, and proposal for a decision, the board by order may find that a violation has occurred and impose a penalty or may find that no violation occurred.

(i) The notice of the board's order given to the person under Chapter 2001, Government Code must include a statement of the right of the person to judicial review of the order.

(j) Within 30 days after the date the board's order is final as provided by Subchapter F, Chapter 2001, Government Code, the person shall:

(1) pay the amount of the penalty;

(2) pay the amount of the penalty and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty; or

(3) without paying the amount of the penalty, file a

petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(k) Within the 30-day period, a person who acts under Subsection (j)(3) may:

(1) stay enforcement of the penalty by:

(A) paying the amount of the penalty to the court for placement in an escrow account; or

(B) giving to the court a supersedeas bond that is approved by the court for the amount of the penalty and that is effective until all judicial review of the board's order is final; or

(2) request the court to stay enforcement of the penalty by:

(A) filing with the court a sworn affidavit of the person stating that the person is financially unable to pay the amount of the penalty and is financially unable to give the supersedeas bond; and

(B) giving a copy of the affidavit to the commissioner by certified mail.

(l) The commissioner on receipt of a copy of an affidavit under Subsection (k)(2) may file with the court within five days after the date the copy is received a contest to the affidavit. The court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person who files an affidavit has the burden of proving that the person is financially unable to pay the amount of the penalty and to give a supersedeas bond.

(m) If the person does not pay the amount of the penalty and the enforcement of the penalty is not stayed, the commissioner may refer the matter to the attorney general for collection of the amount of the penalty.

(n) Judicial review of the order of the board:

(1) is instituted by filing a petition as provided by Subchapter G, Chapter 2001, Government Code; and

(2) is under the substantial evidence rule.

(o) If the court sustains the occurrence of the violation, the court may uphold or reduce the amount of the penalty and order the person to pay the full or reduced amount of the penalty. If the court does not sustain the occurrence of the violation, the court shall order that no penalty is owed.

(p) When the judgment of the court becomes final, the court shall proceed under this subsection. If the person paid the amount of the penalty and if that amount is reduced or is not upheld by the court, the court shall order that the appropriate amount plus accrued interest be remitted to the person. The rate of the interest is the rate charged on loans to depository institutions by the New York Federal Reserve Bank, and the interest shall be paid for the period beginning on the date the penalty was paid and ending on the date the penalty is remitted. If the person gave a supersedeas bond and if the amount of the penalty is not upheld by the court, the court shall order the release of the bond. If the person gave a supersedeas bond and if the amount of the penalty is reduced, the court shall order the release of the bond after the person pays the amount.

(q) A penalty collected under this section shall be remitted to the comptroller for deposit in the general revenue fund.

(r) All proceedings under this section are subject to Chapter 2001, Government Code.

Added by Acts 1993, 73rd Leg., ch. 705, Sec. 3.04, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49), (53), (59), eff. Sept. 1, 1995. Renumbered from V.T.C.A., Health & Safety Code Sec. 241.058 by Acts 1995, 74th Leg., ch. 76, Sec. 17.01(22), eff. Sept. 1, 1995.

SUBCHAPTER E. STAFF, RECORDS, AND PLAN REVIEWS

Sec. 241.101. HOSPITAL AUTHORITY CONCERNING MEDICAL STAFF. (a) Except as otherwise provided by this section and Section 241.102, this chapter does not change the authority of the governing body of a hospital, as it considers necessary or advisable, to:

(1) make rules, standards, or qualifications for medical staff membership; or

(2) grant or refuse to grant membership on the medical staff.

(b) This chapter does not prevent the governing body of a hospital from adopting reasonable rules and requirements in compliance with this chapter relating to:

(1) qualifications for any category of medical staff appointments;

(2) termination of appointments; or

(3) the delineation or curtailment of clinical privileges of those who are appointed to the medical staff.

(c) The process for considering applications for medical staff membership and privileges or the renewal, modification, or revocation of medical staff membership and privileges must afford each physician, podiatrist, and dentist procedural due process that meets the requirements of 42 U.S.C. Section 11101 et seq., as amended.

(d) If a hospital's credentials committee has failed to take action on a completed application as required by Subsection (k), or a physician, podiatrist, or dentist is subject to a professional review action that may adversely affect his medical staff membership or privileges, and the physician, podiatrist, or dentist believes that mediation of the dispute is desirable, the physician, podiatrist, or dentist may require the hospital to participate in mediation as provided in Chapter 154, Civil Practice and Remedies Code. The mediation shall be conducted by a person meeting the qualifications required by Section 154.052, Civil Practice and Remedies Code, and within a reasonable period of time.

(e) Subsection (d) does not authorize a cause of action by a physician, podiatrist, or dentist against the hospital other than an action to require a hospital to participate in mediation.

(f) An applicant for medical staff membership or privileges may not be denied membership or privileges on any ground that is otherwise prohibited by law.

(g) A hospital's bylaw requirements for staff privileges may require a physician, podiatrist, or dentist to document the person's current clinical competency and professional training and experience in the medical procedures for which privileges are requested.

(h) In granting or refusing medical staff membership or privileges, a hospital may not differentiate on the basis of the academic medical degree held by a physician.

(i) Graduate medical education may be used as a standard or qualification for medical staff membership or privileges for a physician, provided that equal recognition is given to training programs accredited by the Accreditation Council on Graduate Medical Education and by the American Osteopathic Association.

(j) Board certification may be used as a standard or qualification for medical staff membership or privileges for a physician, provided that equal recognition is given to certification programs approved by the American Board of Medical Specialties and the Bureau of Osteopathic Specialists.

(k) A hospital's credentials committee shall act expeditiously and without unnecessary delay when a licensed physician, podiatrist, or dentist submits a completed application for medical staff membership or privileges. The hospital's credentials committee shall take action on the completed application not later than the 90th day after the date on which the application is received. The governing body of the hospital shall take final action on the application for medical staff membership or privileges not later than the 60th day after the date on which the recommendation of the credentials committee is received. The hospital must notify the applicant in writing of the hospital's final action, including a reason for denial or restriction of privileges, not later than the 20th day after the date on which final action is taken.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 77, Sec. 1, eff. May 11, 1995; Acts 1999, 76th Leg., ch. 159, Sec. 1, eff. May 21, 1999; Acts 2001, 77th Leg., ch. 1175, Sec. 1, eff. June 15, 2001.

Sec. 241.1015. PHYSICIAN COMMUNICATION AND CONTRACTS. (a) A hospital, whether by contract, by granting or withholding staff privileges, or otherwise, may not restrict a physician's ability to communicate with a patient with respect to:

(1) the patient's coverage under a health care plan;

(2) any subject related to the medical care or health care services to be provided to the patient, including treatment options that are not provided under a health care plan;

(3) the availability or desirability of a health care plan or insurance or similar coverage, other than the patient's health care plan; or

(4) the fact that the physician's staff privileges or contract with a hospital or health care plan have terminated or that the physician will otherwise no longer be providing medical care or health care services at the hospital or under the health care plan.

(b) A hospital, by contract or otherwise, may not refuse or fail to grant or renew staff privileges, or condition staff privileges, based in whole or in part on the fact that the physician or a partner, associate, or employee of the physician is providing medical or health care services at a different hospital or hospital system.

(c) A hospital may not contract to limit a physician's participation or staff privileges or the participation or staff privileges of a partner, associate, or employee of the physician at a different hospital or hospital system.

(d) This section does not prevent a hospital from entering into contracts with physicians to ensure physician availability and coverage at the hospital or to comply with regulatory requirements or quality of care standards established by the governing body of the hospital.

(e) This section does not prevent the governing body of a hospital from:

(1) limiting the number of physicians granted medical staff membership or privileges at the hospital based on a medical staff development plan that is unrelated to a physician's professional or business relationships or associations including those with another physician or group of physicians or to a physician or a partner, associate, or employee of a physician having medical staff membership or privileges at another hospital or hospital system; or

(2) limiting the ability of hospital medical directors to contract with or hold medical staff memberships or clinical privileges at different hospitals or hospital systems provided that such limitations do not extend to the medical directors' professional or business relationships or associations including those with another physician, group of physicians, or other health care providers, other than hospitals or hospital systems.

(f) A contract provision that violates this section is void.

(g) In this section, "health care plan" has the meaning assigned by Section 843.002, Insurance Code, and "hospital medical directors" means physicians who have been employed by or are under contract with a hospital to manage a clinical department or departments of the hospital.

Added by Acts 1997, 75th Leg., ch. 735, Sec. 2, eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.526, eff. Sept. 1, 2003.

Sec. 241.102. AUTHORIZATIONS AND RESTRICTIONS IN RELATION TO PHYSICIANS AND PODIATRISTS. (a) This chapter does not authorize a physician or podiatrist to perform medical or podiatric acts that are beyond the scope of the respective license held.

(b) This chapter does not prevent the governing body of a hospital from providing that:

(1) a podiatric patient be coadmitted to the hospital by a podiatrist and a physician;

(2) a physician be responsible for the care of any medical problem or condition of a podiatric patient that may exist at the time of admission or that may arise during hospitalization and that is beyond the scope of the podiatrist's license; or

(3) a physician determine the risk and effect of a proposed podiatric surgical procedure on the total health status of the patient.

(c) An applicant for medical staff membership may not be denied membership solely on the ground that the applicant is a podiatrist rather than a physician.

(d) This chapter does not automatically entitle a physician or a podiatrist to membership or privileges on a medical staff.

(e) The governing body of a hospital may not require a member of the medical staff to involuntarily:

(1) coadmit patients with a podiatrist;

(2) be responsible for the care of any medical problem or condition of a podiatric patient; or

(3) determine the risk and effect of any proposed podiatric procedure on the total health status of the patient.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.103. PRESERVATION OF RECORDS. (a) A hospital may authorize the disposal of any medical record on or after the 10th anniversary of the date on which the patient who is the subject of the record was last treated in the hospital.

(b) If a patient was younger than 18 years of age when the patient was last treated, the hospital may authorize the disposal of medical records relating to the patient on or after the date of the patient's 20th birthday or on or after the 10th anniversary of the date on which the patient was last treated, whichever date is later.

(c) The hospital may not destroy medical records that relate to any matter that is involved in litigation if the hospital knows the litigation has not been finally resolved.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 241.104. HOSPITAL PLAN REVIEWS. (a) The board by rule shall adopt fees for hospital plan reviews according to a schedule based on the estimated construction costs.

(b) The fee schedule may not exceed the following:

	Cost of Construction	Fee
(1)	$ 100,000 or less	$ 500
(2)	$ 100,001 - $ 600,000	$1,500
(3)	$ 600,001 - $ 2,000,000	$3,000
(4)	$ 2,000,001 - $ 5,000,000	$4,500
(5)	$ 5,000,001 - $10,000,000	$6,000
(6)	$ 10,000,001 and over	$7,500

(c) The department shall charge a fee for field surveys of construction plans reviewed under this section. The board by rule shall adopt a fee schedule for the surveys that provides a minimum fee of $500 and a maximum fee of $1,000 for each survey conducted.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1993, 73rd Leg., ch. 584, Sec. 15, eff. Sept. 1, 1993; Acts 1999, 76th Leg., ch. 1411, Sec. 2.03, eff. Sept. 1, 1999.

Sec. 241.105. HOSPITAL PRIVILEGES FOR ADVANCED PRACTICE NURSES AND PHYSICIAN ASSISTANTS. (a) The governing body of a hospital is authorized to establish policies concerning the granting of clinical privileges to advanced practice nurses and physician assistants, including policies relating to the application process, reasonable qualifications for privileges, and the process for renewal, modification, or revocation of privileges.

(b) If the governing body of a hospital has adopted a policy of granting clinical privileges to advanced practice nurses or physician assistants, an individual advanced practice nurse or physician assistant who qualifies for privileges under that policy shall be entitled to certain procedural rights to provide fairness of process, as determined by the governing body of the hospital, when an application for privileges is submitted to the hospital. At a minimum, any policy adopted shall specify a reasonable period for the processing and consideration of the application and shall provide for written notification to the applicant of any final action on the application by the hospital, including any reason for denial or restriction of the privileges requested.

(c) If an advanced practice nurse or physician assistant has been granted clinical privileges by a hospital, the hospital may not modify or revoke those privileges without providing certain procedural rights to provide fairness of process, as determined by the governing body of the hospital, to the advanced practice nurse or physician assistant. At a minimum, the hospital shall provide the advanced practice nurse or physician assistant written reasons for the modification or revocation of privileges and a mechanism for appeal to the appropriate committee or body within the hospital, as determined by the governing body of the hospital.

(d) If a hospital extends clinical privileges to an advanced practice nurse or physician assistant conditioned on the advanced practice nurse or physician assistant having a sponsoring or collaborating relationship with a physician and that relationship ceases to exist, the advanced practice nurse or physician assistant and the physician shall provide written notification to the hospital that the relationship no longer exists. Once the hospital receives such notice from an advanced practice nurse or physician assistant and the physician, the hospital shall be deemed to have met its obligations under this section by notifying the advanced practice nurse or physician assistant in writing that the advanced practice nurse's or physician assistant's clinical privileges no longer exist at that hospital.

(e) Nothing in this section shall be construed as modifying Subtitle B, Title 3, Occupations Code, Chapter 204 or 301, Occupations Code, or any other law relating to the scope of practice of physicians, advanced practice nurses, or physician assistants.

(f) This section does not apply to an employer-employee relationship between an advanced practice nurse or physician assistant and a hospital.

Added by Acts 1999, 76th Leg., ch. 428, Sec. 2, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 1420, Sec. 14.787, eff. Sept. 1, 2001.

SUBCHAPTER F. MEDICAL REHABILITATION SERVICES

Sec. 241.121. DEFINITION. In this subchapter, "comprehensive medical rehabilitation" means the provision of rehabilitation services that are designed to improve or minimize a person's physical or cognitive disabilities, maximize a person's functional ability, or restore a person's lost functional capacity through close coordination of services, communication, interaction, and integration among several professions that share the responsibility to achieve team treatment goals for the person.

Added by Acts 1993, 73rd Leg., ch. 707, Sec. 1, eff. Sept. 1, 1993.

Sec. 241.122. LICENSE REQUIRED. Unless a person has a license issued under this chapter, a person other than an individual may not provide inpatient comprehensive medical rehabilitation to a patient who requires medical services that are provided under the supervision of a physician and that are more intensive than nursing facility care and minor treatment.

Added by Acts 1993, 73rd Leg., ch. 707, Sec. 1, eff. Sept. 1, 1993.

Sec. 241.123. REHABILITATION SERVICES STANDARDS. (a) The board by rule shall adopt standards for the provision of rehabilitation services by a hospital to ensure the health and safety of a patient receiving the services.

(b) The standards adopted by the board at a minimum shall require a hospital that provides comprehensive medical rehabilitation:

(1) to have a director of comprehensive medical rehabilitation who is:

(A) a licensed physician;

(B) either board certified or eligible for board certification in a medical specialty related to rehabilitation; and

(C) qualified by training and experience to serve as medical director;

(2) to have medical supervision by a licensed physician for 24 hours each day; and

(3) to provide appropriate therapy to each patient by an interdisciplinary team consisting of licensed physicians, rehabilitation nurses, and therapists as are appropriate for the patient's needs.

(c) An interdisciplinary team for comprehensive medical rehabilitation shall be directed by a licensed physician. An interdisciplinary team for comprehensive medical rehabilitation shall have available to it, at the hospital at which the services are provided or by contract, members of the following professions as necessary to meet the treatment needs of the patient:

(1) physical therapy;
(2) occupational therapy;
(3) speech-language pathology;
(4) therapeutic recreation;
(5) social services and case management;
(6) dietetics;
(7) psychology;
(8) respiratory therapy;
(9) rehabilitative nursing;
(10) certified orthotics; and
(11) certified prosthetics.

(d) A hospital shall prepare for each patient receiving inpatient rehabilitation services a written treatment plan designed for that patient's needs for treatment and care. The board by rule shall specify a time after admission of a patient for inpatient rehabilitation services by which a hospital must evaluate the patient for the patient's initial treatment plan and by which a hospital must provide copies of the plan after evaluation.

(e) A hospital shall prepare for each patient receiving inpatient rehabilitation services a written continuing care plan that addresses the patient's needs for care after discharge,

including recommendations for treatment and care and information about the availability of resources for treatment or care. The board by rule shall specify the time before discharge by which the hospital must provide a copy of the continuing care plan. The board's rules may allow a facility to provide the continuing care plan by a specified time after discharge if providing the plan before discharge is impracticable.

(f) A hospital shall provide a copy of a treatment or continuing care plan prepared under this section to the following persons in the person's primary language, if practicable:

(1) the patient;

(2) a person designated by the patient; and

(3) as specified by board rule, family members or other persons with responsibility for or demonstrated participation in the patient's care or treatment.

(g) Rules adopted by the board under this subchapter may not conflict with a federal rule, regulation, or standard.

Added by Acts 1993, 73rd Leg., ch. 707, Sec. 1, eff. Sept. 1, 1993.

SUBCHAPTER G. DISCLOSURE OF HEALTH CARE INFORMATION

Sec. 241.151. DEFINITIONS. In this subchapter:

(1) "Directory information" means information disclosing the presence of a person who is receiving inpatient, outpatient, or emergency services from a licensed hospital, the nature of the person's injury, the person's municipality of residence, sex, and age, and the general health status of the person as described in terms of "critical," "poor," "fair," "good," "excellent," or similar terms.

(2) "Health care information" means information recorded in any form or medium that identifies a patient and relates to the history, diagnosis, treatment, or prognosis of a patient.

(3) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

(4) "Institutional review board" means a board, committee, or other group formally designated by an institution or authorized under federal or state law to review or approve the initiation of or conduct periodic review of research programs to ensure the protection of the rights and welfare of human research subjects.

(5) "Legally authorized representative" means:

(A) a parent or legal guardian if the patient is a minor;

(B) a legal guardian if the patient has been adjudicated incapacitated to manage the patient's personal affairs;

(C) an agent of the patient authorized under a durable power of attorney for health care;

(D) an attorney ad litem appointed for the patient;

(E) a person authorized to consent to medical treatment on behalf of the patient under Chapter 313;

(F) a guardian ad litem appointed for the patient;

(G) a personal representative or heir of the patient, as defined by Section 3, Texas Probate Code, if the patient is deceased;

(H) an attorney retained by the patient or by the patient's legally authorized representative; or

(I) a person exercising a power granted to the person in the person's capacity as an attorney-in-fact or agent of the patient by a statutory durable power of attorney that is signed by the patient as principal.

Added by Acts 1995, 74th Leg., ch. 856, Sec. 1, eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 498, Sec. 1, eff. Sept. 1, 1997; Acts 2005, 79th Leg., ch. 1138, Sec. 1, eff. Sept. 1, 2005.

Sec. 241.152. WRITTEN AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION. (a) Except as authorized by Section 241.153, a hospital or an agent or employee of a hospital may not disclose health care information about a patient to any person other than the patient or the patient's legally authorized representative without the written authorization of the patient or the patient's legally authorized representative.

(b) A disclosure authorization to a hospital is valid only if it:

(1) is in writing;

(2) is dated and signed by the patient or the patient's legally authorized representative;

(3) identifies the information to be disclosed;

(4) identifies the person or entity to whom the information is to be disclosed; and

(5) is not contained in the same document that contains the consent to medical treatment obtained from the patient.

(c) A disclosure authorization is valid until the 180th day after the date it is signed unless it provides otherwise or unless it is revoked.

(d) Except as provided by Subsection (e), a patient or the patient's legally authorized representative may revoke a disclosure authorization to a hospital at any time. A revocation is valid only if it is in writing, dated with a date that is later than the date on the original authorization, and signed by the patient or the patient's legally authorized representative.

(e) A patient or the patient's legally authorized representative may not revoke a disclosure that is required for purposes of making payment to the hospital for health care provided to the patient.

(f) A patient may not maintain an action against a hospital for a disclosure made by the hospital in good-faith reliance on an authorization if the hospital's medical record department did not have notice that the authorization was revoked.

(g) Repealed by Acts 1997, 75th Leg., ch. 498, Sec. 5, eff. Sept. 1, 1997.

Added by Acts 1995, 74th Leg., ch. 856, Sec. 1, eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 498, Sec. 2, 5, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 271, Sec. 1, eff. Sept. 1, 1999.

Sec. 241.153. DISCLOSURE WITHOUT WRITTEN AUTHORIZATION. A patient's health care information may be disclosed without the patient's authorization if the disclosure is:

(1) directory information, unless the patient has instructed the hospital not to make the disclosure or the directory information is otherwise protected by state or federal law;

(2) to a health care provider who is rendering health care to the patient when the request for the disclosure is made;

(3) to a transporting emergency medical services provider for the purpose of:

(A) treatment or payment, as those terms are defined by the regulations adopted under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or

(B) the following health care operations described by the regulations adopted under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191):

(i) quality assessment and improvement activities;

(ii) specified insurance functions;

(iii) conducting or arranging for medical reviews; or

(iv) competency assurance activities;

(4) to a member of the clergy specifically designated by the patient;

(5) to a qualified organ or tissue procurement organization as defined in Section 692.002 for the purpose of making inquiries relating to donations according to the protocol referred to in Section 692.013(d);

(6) to a prospective health care provider for the purpose of securing the services of that health care provider as part of the patient's continuum of care, as determined by the patient's attending physician;

(7) to a person authorized to consent to medical treatment under Chapter 313 or to a person in a circumstance exempted from Chapter 313 to facilitate the adequate provision of treatment;

(8) to an employee or agent of the hospital who requires health care information for health care education, quality assurance, or peer review or for assisting the hospital in the delivery of health care or in complying with statutory, licensing, accreditation, or certification requirements and if the hospital takes appropriate action to ensure that the employee or agent:

(A) will not use or disclose the health care

information for any other purpose; and

(B) will take appropriate steps to protect the health care information;

(9) to a federal, state, or local government agency or authority to the extent authorized or required by law;

(10) to a hospital that is the successor in interest to the hospital maintaining the health care information;

(11) to the American Red Cross for the specific purpose of fulfilling the duties specified under its charter granted as an instrumentality of the United States government;

(12) to a regional poison control center, as the term is used in Chapter 777, to the extent necessary to enable the center to provide information and education to health professionals involved in the management of poison and overdose victims, including information regarding appropriate therapeutic use of medications, their compatibility and stability, and adverse drug reactions and interactions;

(13) to a health care utilization review agent who requires the health care information for utilization review of health care under Article 21.58A, Insurance Code;

(14) for use in a research project authorized by an institutional review board under federal law;

(15) to health care personnel of a penal or other custodial institution in which the patient is detained if the disclosure is for the sole purpose of providing health care to the patient;

(16) to facilitate reimbursement to a hospital, other health care provider, or the patient for medical services or supplies;

(17) to a health maintenance organization for purposes of maintaining a statistical reporting system as required by a rule adopted by a state agency or regulations adopted under the federal Health Maintenance Organization Act of 1973, as amended (42 U.S.C. Section 300e et seq.);

(18) to satisfy a request for medical records of a deceased or incompetent person pursuant to Section 74.051(e), Civil Practice and Remedies Code;

(19) to comply with a court order except as provided by Subdivision (20); or

(20) related to a judicial proceeding in which the patient is a party and the disclosure is requested under a subpoena issued under:

(A) the Texas Rules of Civil Procedure or Code of Criminal Procedure; or

(B) Chapter 121, Civil Practice and Remedies Code.

Added by Acts 1995, 74th Leg., ch. 856, Sec. 1, eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 498, Sec. 3, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 847, Sec. 1, eff. Sept. 1, 1997; Acts 2005, 79th Leg., ch. 136, Sec. 1, eff. Sept. 1, 2005; Acts 2005, 79th Leg., ch. 337, Sec. 1, eff. Sept. 1, 2005.

Sec. 241.1531. EXCHANGE OF INMATE'S HEALTH CARE INFORMATION. Notwithstanding any other law of this state, the health care information of a patient who is a defendant or inmate confined in a facility operated by or under contract with the Texas Department of Criminal Justice may be exchanged between health care personnel of the department and health care personnel of The University of Texas Medical Branch at Galveston or the Texas Tech University Health Sciences Center. The authorization of the defendant or inmate is not required for the exchange of information.

Added by Acts 2005, 79th Leg., ch. 1270, Sec. 1, eff. June 18, 2005.

Sec. 241.154. REQUEST. (a) On receipt of a written authorization from a patient or legally authorized representative to examine or copy all or part of the patient's recorded health care information, or for disclosures under Section 241.153 not requiring written authorization, a hospital or its agent, as promptly as required under the circumstances but not later than the 15th day after the date the request and payment authorized under Subsection (b) are received, shall:

(1) make the information available for examination during regular business hours and provide a copy to the requestor, if requested; or

(2) inform the authorized requestor if the information does not exist or cannot be found.

(b) Except as provided by Subsection (d), the hospital or its agent may charge a reasonable fee for providing the health care information and is not required to permit the examination, copying, or release of the information requested until the fee is paid unless there is a medical emergency. The fee may not exceed the sum of:

(1) a basic retrieval or processing fee, which must include the fee for providing the first 10 pages of the copies and which may not exceed $30; and

(A) a charge for each page of:

(i) $1 for the 11th through the 60th page of the provided copies;

(ii) 50 cents for the 61st through the 400th page of the provided copies; and

(iii) 25 cents for any remaining pages of the provided copies; and

(B) the actual cost of mailing, shipping, or otherwise delivering the provided copies; or

(2) if the requested records are stored on any microform or other electronic medium, a retrieval or processing fee, which must include the fee for providing the first 10 pages of the copies and which may not exceed $45; and

(A) $1 per page thereafter; and

(B) the actual cost of mailing, shipping, or otherwise delivering the provided copies.

(c) In addition, the hospital or its agent may charge a reasonable fee for:

(1) execution of an affidavit or certification of a document, not to exceed the charge authorized by Section 22.004, Civil Practice and Remedies Code; and

(2) written responses to a written set of questions, not to exceed $10 for a set.

(d) A hospital may not charge a fee for:

(1) providing health care information under Subsection (b) to the extent the fee is prohibited under Subchapter M, Chapter 161;

(2) a patient to examine the patient's own health care information;

(3) providing an itemized statement of billed services to a patient or third-party payor, except as provided under Section 311.002(f); or

(4) health care information relating to treatment or hospitalization for which workers' compensation benefits are being sought, except to the extent permitted under Chapter 408, Labor Code.

(e) Effective September 1, 1996, and annually thereafter, the fee for providing health care information as specified in this section shall be adjusted accordingly based on the most recent changes to the consumer price index as published by the Bureau of Labor Statistics of the United States Department of Labor that measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone.

Added by Acts 1995, 74th Leg., ch. 856, Sec. 1, eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 498, Sec. 4, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 610, Sec. 1, eff. Sept. 1, 1999.

Sec. 241.155. SAFEGUARDS FOR SECURITY OF HEALTH CARE INFORMATION. A hospital shall adopt and implement reasonable safeguards for the security of all health care information it maintains.

Added by Acts 1995, 74th Leg., ch. 856, Sec. 1, eff. Sept. 1, 1995.

Sec. 241.156. PATIENT REMEDIES. (a) A patient aggrieved by a violation of this subchapter relating to the unauthorized release of confidential health care information may bring an action for:

(1) appropriate injunctive relief; and

(2) damages resulting from the release.

(b) An action under Subsection (a) shall be brought in:

(1) the district court of the county in which the patient resides or in the case of a deceased patient the district court of the county in which the patient's legally authorized representative resides; or

(2) if the patient or the patient's legally authorized representative in the case of a deceased patient is not a resident of this state, the district court of Travis County.

(c) A petition for injunctive relief under Subsection (a)(1) takes precedence over all civil matters on the court docket

except those matters to which equal precedence on the docket is granted by law.
Added by Acts 1995, 74th Leg., ch. 856, Sec. 1, eff. Sept. 1, 1995.

SUBCHAPTER H. PATIENT SAFETY PROGRAM

Sec. 241.201. DUTIES OF DEPARTMENT. (a) The department shall develop a patient safety program for hospitals. The program must:

(1) be administered by the hospital licensing program within the department; and

(2) serve as an information clearinghouse for hospitals concerning best practices and quality improvement strategies.

(b) The department shall group hospitals by size for the reports required by this chapter as follows:

(1) less than 50 beds;

(2) 50 to 99 beds;

(3) 100 to 199 beds;

(4) 200 to 399 beds; and

(5) 400 beds or more.

(c) The department shall combine two or more categories described by Subsection (b) if the number of hospitals in any category falls below 40.
Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.202. ANNUAL REPORT. (a) On renewal of a license under this chapter, a hospital shall submit to the department an annual report that lists the number of occurrences at the hospital or at an outpatient facility owned or operated by the hospital of each of the following events during the preceding year:

(1) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;

(2) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;

(3) the suicide of a patient in a setting in which the patient received care 24 hours a day;

(4) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

(5) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility;

(6) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;

(7) a surgical procedure on the wrong patient or on the wrong body part of a patient;

(8) a foreign object accidentally left in a patient during a procedure; and

(9) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.

(b) The department may not require the annual report to include any information other than the number of occurrences of each event listed in Subsection (a).
Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.203. ROOT CAUSE ANALYSIS AND ACTION PLAN. (a) In this section, "root cause analysis" means the process that identifies basic or causal factors underlying a variation in performance leading to an event listed in Section 241.202 and that:

(1) focuses primarily on systems and processes;

(2) progresses from special causes in clinical processes to common causes in organizational processes; and

(3) identifies potential improvements in processes or systems.

(b) Not later than the 45th day after the date a hospital becomes aware of the occurrence of an event listed in Section 241.202, the hospital shall:

(1) conduct a root cause analysis of the event; and

(2) develop an action plan that identifies strategies to reduce the risk of a similar event occurring in the future.

(c) The department may review a root cause analysis or

action plan related to an event listed in Section 241.202 during a survey, inspection, or investigation of a hospital.

(d) The department may not require a root cause analysis or action plan to be submitted to the department.

(e) The department or an employee or agent of the department may not in any form, format, or manner remove, copy, reproduce, redact, or dictate from any part of a root cause analysis or action plan.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.204. CONFIDENTIALITY; ABSOLUTE PRIVILEGE. (a) Except as provided by Sections 241.205 and 241.206, all information and materials obtained or compiled by the department under this subchapter or compiled by a hospital under this subchapter, including the root cause analysis, annual hospital report, action plan, best practices report, department summary, and all related information and materials, are confidential and:

(1) are not subject to disclosure under Chapter 552, Government Code, or discovery, subpoena, or other means of legal compulsion for release to any person, subject to Section 241.203(c); and

(2) may not be admitted as evidence or otherwise disclosed in any civil, criminal, or administrative proceeding.

(b) The confidentiality protections under Subsection (a) apply without regard to whether the information or materials are obtained from or compiled by a hospital or an entity that has an ownership or management interest in a hospital.

(c) The transfer of information or materials under this subchapter is not a waiver of a privilege or protection granted under law.

(d) Information reported by a hospital under this subchapter and analyses, plans, records, and reports obtained, prepared, or compiled by a hospital under this subchapter and all related information and materials are subject to an absolute privilege and may not be used in any form against the hospital or the hospital's agents, employees, partners, assignees, or independent contractors in any civil, criminal, or administrative proceeding, regardless of the means by which a person came into possession of the information, analysis, plan, record, report, or related information or material. A court shall enforce this privilege for all matters covered by this subsection.

(e) The provisions of this section regarding the confidentiality of information or materials compiled or reported by a hospital in compliance with or as authorized under this subchapter do not restrict access, to the extent authorized by law, by the patient or the patient's legally authorized representative to records of the patient's medical diagnosis or treatment or to other primary health records.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.205. ANNUAL DEPARTMENT SUMMARY. The department annually shall compile and make available to the public a summary of the events reported by hospitals as required by Section 241.202. The summary may contain only aggregated information and may not directly or indirectly identify:

(1) a specific hospital or group of hospitals;

(2) an individual; or

(3) a specific reported event or the circumstances or individuals surrounding the event.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.206. BEST PRACTICES REPORT AND DEPARTMENT SUMMARY. (a) A hospital shall provide to the department at least one report of the best practices and safety measures related to a reported event.

(b) A hospital may provide to the department a report of other best practices and the safety measures, such as marking a surgical site and involving the patient in the marking process, that are effective in improving patient safety.

(c) The department by rule may prescribe the form and format of a best practices report. The department may not require a best practices report to exceed one page in length. The department shall accept, in lieu of a report in the form and format prescribed by the department, a copy of a report submitted by a hospital to a patient safety organization.

(d) The department periodically shall:

(1) review the best practices reports;

(2) compile a summary of the best practices reports

determined by the department to be effective and recommended as best practices; and

(3) make the summary available to the public.

(e) The summary may not directly or indirectly identify:

(1) a specific hospital or group of hospitals;

(2) an individual; or

(3) a specific reported event or the circumstances or individuals surrounding the event.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.207. PROHIBITION. The hospital annual report, the department summary, or the best practices report may not distinguish between an event that occurred at an outpatient facility owned or operated by the hospital and an event that occurred at a hospital facility.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.208. REPORT TO LEGISLATURE. (a) Not later than December 1, 2006, the commissioner of public health shall:

(1) evaluate the patient safety program established under this subchapter; and

(2) report the results of the evaluation and make recommendations to the legislature.

(b) The commissioner of public health shall conduct the evaluation in consultation with hospitals licensed under this chapter.

(c) The evaluation must address:

(1) the degree to which the department was able to detect statewide trends in errors based on the types and numbers of events reported;

(2) the degree to which the statewide summaries of events compiled by the department were accessed by the public;

(3) the effectiveness of the department's best practices summary in improving hospital patient care; and

(4) the impact of national studies on the effectiveness of state or federal systems of reporting medical errors.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.209. GIFTS, GRANTS, AND DONATIONS. The department may accept and administer a gift, grant, or donation from any source to carry out the purposes of this subchapter.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.

Sec. 241.210. EXPIRATION. Unless continued in existence, this subchapter expires September 1, 2007.

Added by Acts 2003, 78th Leg., ch. 569, Sec. 2, eff. June 20, 2003.