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**RULES
OF
DEPARTMENT OF COMMUNITY HEALTH

HEALTHCARE FACILITY REGULATION

CHAPTER 111-8-37
RULES AND REGULATIONS FOR HOSPICES**

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111-8-37-.01 Title and Purpose.

These rules shall be known as the Rules and Regulations for Hospices. The purpose of these rules is to provide for the inspection and issuance of licenses for hospices and to establish minimum requirements for facilities operating under hospice licenses.

Authority: O.C.G.A. § 31-7-170 et seq.

111-8-37-.02 Authority.

The legal authority for this Chapter is O.C.G.A § 31-7-170 et seq., the “Georgia Hospice Law” and O.C.G.A. § 31-2-4 et seq.

Authority: O.C.G.A. §§ 31-2-4 and 31-7-170 et seq.

111-8-37-.03 Definitions.

(1) Unless the context otherwise requires, these identified terms mean the following when used in these rules:

(a) “Administrator” means the person, by whatever title used, to whom the governing body has delegated the responsibility for the day-to-day administration of the hospice, including the implementation of the policies and procedures adopted by the governing body.

(b) “Advanced and progressive disease” means a serious life-threatening medical condition which is irreversible and which will continue indefinitely, where there is no reasonable hope of recovery, but where the patient’s medical prognosis is one in which there is a life expectancy of up to two years. The term does not include terminally ill patients as defined in paragraph (ee) of this rule.

(c) “Attending physician” means the physician identified by the hospice patient or the patient’s representative as having primary responsibility for the hospice patient’s medical care and who is licensed to practice medicine in this state.

(d) “Bereavement services” means the supportive services provided to the family unit to assist it in coping with the patient’s death, including follow-up assessment and assistance through the first year after death.

(e) “Clergy” means an individual representative of a specific spiritual belief who has documentation of ordination or commission by a recognized faith group and who has completed at least one unit of clinical pastoral education from a nationally recognized provider.

(f) “Counseling” means those techniques used to help persons learn how to solve problems and make decisions related to personal growth, vocation, family, social, and other interpersonal concerns.

(g) “Department” means the Georgia Department of Community Health.

(h) “Dietitian” means a specialist in the study of nutrition who is licensed as required by O.C.G.A. § 43-11A-1 et seq., the “Dietetics Practice Act.”

(i) “Family unit” means the terminally ill person or person with an advanced and progressive disease and his or her family, which may include spouse, children, siblings, parents, and other relatives with significant personal ties to the patient.

(j) “Governing body” means the board of directors, trustees, partnership, corporation, association, or person or group of persons who maintain and control the operation of the hospice and who are legally responsible for its operation.

(k) “Home care” means hospice care primarily delivered in the residence of the hospice patient, whether that place is the patient’s permanent or temporary residence. A hospice patient who considers his or her residence to be a licensed assisted living community, licensed nursing home, licensed intermediate care home, licensed personal care home, or residential hospice setting is considered to be receiving home care while a resident of that facility.

(l) “Hospice” means a public agency or private organization or unit of either providing to persons terminally ill and to their families, regardless of ability to pay, a centrally administered and autonomous continuum of palliative and supportive care, directed and coordinated by the hospice care team primarily in the patient’s home but also on an outpatient and short-term inpatient basis and which is classified as a hospice by the Department. In addition, such public agency or private organization or unit of either may also provide palliative care to persons with advanced and progressive diseases and to their families, directed and coordinated by the hospice care team.

(m) “Hospice care” means both regularly scheduled care and care available on a 24 hour on-call basis, consisting of medical, nursing, social, spiritual, volunteer, and bereavement services substantially all of which are provided to the patient and to the patient’s family regardless of ability to pay under a written care plan established and periodically reviewed by the patient’s attending physician, by the medical director of the hospice program, and by the hospice care team.

(n) “Hospice care team” means an interdisciplinary working unit composed of members of the various helping professions (who may donate their professional services), including but not limited to: a physician licensed or authorized to practice in this state, a registered professional nurse, a social worker, a member of the clergy or other counselors, and volunteers who provide hospice care.

(o) “Inpatient care” means short-term, 24-hour medically supervised care for the purpose of adjusting and monitoring the terminally ill patient’s medications for pain control or managing acute or chronic symptoms that cannot be managed in another setting. Inpatient care is provided within the confines of a licensed hospital, a licensed skilled nursing facility, or a licensed inpatient hospice facility.

(p) “Inpatient hospice facility” means a facility that is licensed to provide acute inpatient care for hospice patients in beds that are not included in the certified bed capacity of another licensed facility.

(q) “License” means a license issued by the Department to the governing body to operate a hospice.

(r) “Medical director” means a physician licensed in this state who is a member of the hospice care team and is responsible for the direction and quality of the medical component of the care rendered by the hospice to patients.

(s) “Palliative care” means those interventions by the hospice care team which are intended to achieve relief from, reduction of, or elimination of pain and of other physical,

emotional, social, or spiritual symptoms of distress to achieve the best quality of life for the patients and their families.

(t) “Patient” means a terminally ill individual receiving the hospice continuum of services, regardless of ability to pay and also means an individual with an advanced and progressive disease.

(u) “Patient representative” means an individual who, under applicable laws, has the authority to act on behalf of the patient where the patient is incapable of making decisions related to health care.

(v) “Personal care services” means assistance with activities of daily living, personal care, ambulation and exercise; provision of household services essential to health care at home; assistance with self-administration of medication; and preparation of meals.

(w) “Physician” means an individual who is licensed to practice medicine in this state by the Georgia Composite Medical Board.

(x) “Primary caregiver” means a person or entity designated in writing by the patient or the patient’s representative who agrees to give and/or arrange for continuing support and care and who may advocate on behalf of the patient.

(y) “Professional counselor” means a person licensed or certified as a professional counselor or associate professional counselor as required by O.C.G.A. § 43-10A-1 et seq., the “Professional Counselors, Social Workers, and Marriage and Family Therapists Licensing Law.”

(z) “Registered nurse” means an individual who is currently licensed to practice nursing under the provisions of Article 1 of Chapter 26 of Title 43 of the Official Code of Georgia Annotated.

(aa) “Residential hospice facility” means a small home-like residential facility or unit that is a part of a licensed hospice program, designed, staffed, and organized to provide non-acute hospice care, 24-hours per day, seven days per week, under the supervision of the hospice physician and hospice registered nurses to terminally ill hospice patients and their family units.

(bb) “Respite care” means short-term inpatient or residential care provided for the patient to provide relief for that patient’s family unit from the stress of providing care.

(cc) “Restraint” means any manual, physical, or mechanical method, device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

(dd) “Social worker” means an individual who is qualified by education, training, and experience and licensed as required by law to perform social work for hospice patients and their family units.

(ee) “Terminally ill” means that the individual is experiencing an illness for which therapeutic intervention directed toward cure of the disease is no longer appropriate, and the patient’s medical prognosis is one in which there is a life expectancy of six months or less.

(ff) “Volunteer” means a lay or professional person who provides, without compensation, support and assistance to the patient and the patient’s family under the supervision of a member of the hospice staff unit in accordance with the plan of care developed by the hospice care team.

(2) As used in these rules and regulations, the singular indicates the plural and the plural the singular when consistent with the intent of these rules.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.04 Licensure Procedures.

(1) Operating, establishing or maintaining a hospice in the State of Georgia without first obtaining a valid license from the Department is prohibited.

(2) Use of the term “hospice” to imply or indicate that a person or entity is providing hospice services to patients and their families unless the person or entity holds a valid license to provide hospice care is prohibited.

(3) A governing body desiring to operate a hospice must file with the Department an initial application on forms prescribed and made available by the Department. The application must be complete, accurate, and signed by the hospice administrator or the executive officer of the hospice’s governing body and must include:

(a) The applicant’s name, address, phone number, and business e-mail address for receiving inspection reports and communications concerning the license from the Department.

(b) **Proof of ownership.** In the case of corporations, partnerships, and other entities authorized by law, the applicant must provide a copy of its certificate of incorporation or other acceptable proof of its legal existence and authority to transact business within the state;

(c) A list of counties proposed to be served by the hospice; and

(d) A list of the locations of any additional hospice care facilities operated by the hospice on separate premises, as applicable, and the number of beds at such facilities.

(4) Knowingly supplying materially false, incomplete, or misleading information is grounds for denial or revocation of a license.

(5) Following evidence of substantial compliance with these rules and regulations and any provisions of law as applicable to the construction and operation of the hospice, the Department may issue a license to provide hospice services primarily to terminally ill patients in their own homes.

(6) An initial license may be issued for a period of six months to allow a new hospice to demonstrate its ability to comply with these rules and regulations. After becoming fully operational and demonstrating substantial compliance with the rules and regulations, the hospice shall become eligible for a regular license.

(7) Inpatient and residential services and palliative care services are not eligible to be licensed separately from hospice home care services.

(8) The license must be displayed in a prominent place in the hospice's administrative offices.

(9) Licenses are not transferable from one governing body to another or from one hospice location to another.

(10) Each planned change of ownership or lease or change of location must be disclosed to the Department at least 30 days prior to such change by submitting an application and the required fees from the proposed new owners or lessees for a new license.

(11) Changes in the hospice that require the submission of a new application and the issuance of a new license include a change in name, the addition of another service location, a change in the number of licensed beds if residential services are provided or a change in the scope of services provided. The new application that reflects the proposed change must be filed at least 30 days prior to the proposed change. Hospices licensed before the effective date of these rules desiring to change their scope of service solely to include palliative care to patients with advanced and progressive diseases who are not terminally ill, will not be required to pay an application change processing fee to add palliative care if the Department receives the palliative care change request within 180 days of these rules taking effect.

(12) A license is no longer valid and must be returned to the Department when the hospice ceases to operate, changes locations, is issued a new license or the license is suspended or revoked. The facility must notify referring individuals and entities of the closure and patients' families regarding the location of medical records.

(13) **Temporary Inactive Status.** If the hospice is closing for a period of less than 12 months, and plans to reopen under the same ownership, governing body, and name, the hospice may request to have the license placed on temporary inactive status. The hospice must submit its request in writing and provide a written plan for notifying referring individuals and entities of the closure and patients' families regarding the location of medical records.

(a) When placed on temporary inactive status, the license must be returned to the Department within 10 days of closure and the hospice must not operate until the license has been reactivated.

(b) The hospice must request in writing that the permit be reactivated at least 30 days prior to the desired date of reopening. Prior to reactivation of the license, the hospice may be subject to inspection by the Department. If the license is not reactivated within 12 months, the license is void.

(14) **Multiple Hospice Locations.** Separate applications and licenses are required for hospices operated at separate locations; however, the Department has the option of approving

a single license for multiple hospice locations based on evidence that the hospice meets all of the following requirements:

- (a) All locations are owned and operated by the same governing body and conduct business under the same set of by-laws and the same trade name;
- (b) Each location is responsible to the same governing body and central administration managed together under the same set of policies and procedures;
- (c) The governing body and central administration demonstrate the capacity to adequately manage all locations and ensure the quality of care at all locations as evidenced by a prior history of satisfactory compliance with hospice regulations and appropriate staffing;
- (d) Supervision and oversight at additional locations is sufficient to ensure that hospice care and services meet the needs of patients and the patients' family units;
- (e) The medical director assumes responsibility for the medical component of the hospice's patient care at all locations;
- (f) Additional locations provide the same full range of services and the same level and quality of care including timely responses, that is provided by the primary location;
- (g) Each patient is assigned to a specific hospice care team responsible for ongoing assessment, planning, monitoring, coordination, and provision of care, which has ready access to the patient's clinical record;
- (h) All hospice patients' clinical records that are requested by the Department at the time of inspection must be available at the hospice's primary location; and
- (i) All locations maintain the same Medicare provider number, as applicable.

(15) **Hospice Care Facilities.** Hospices desiring to provide facilities for residential and/or acute inpatient hospice services as a part of the licensed hospice must submit an application to the Department requesting a change in service level. The Department will not approve the change in service level that includes residential and/or inpatient hospice services, unless the hospice:

- (a) Is licensed and in substantial compliance with these rules and regulations that apply to home care hospice services;
- (b) Submits a copy of the certificate of occupancy issued by local building officials for the facility or unit;
- (c) submits evidence of compliance with the applicable provisions of the *Life Safety Code®*, as enforced by the state fire marshal;
- (d) Provides evidence to the Department of compliance or ability to comply with all the applicable requirements of paragraph (14) of this rule relating to multiple hospice locations; and
- (e) Demonstrates substantial compliance with all the applicable requirements of Rule 111-8-37-.24, Hospice Care Facilities, as evidenced by an on-site inspection by the Department.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.05 Inspections and Investigations.

(1) The hospice staff, any facilities where hospice care is being delivered, and the hospice patients must be accessible during all hours of operation to properly identified representatives of the Department for inspections and investigations relating to the hospice's license.

(2) The Department will periodically inspect each hospice to ensure that the licensee is providing quality care to its patients; provided, however, that a hospice is exempt from routine periodic on-site licensure inspection if it is certified as a hospice in accordance with federal regulations. Where the Department receives or becomes aware of a complaint alleging that the hospice is not acting in compliance with the requirements of these rules, the Department may conduct an inspection at any time to determine whether the licensed hospice is in compliance with these rules.

(3) For the purposes of any inspection, investigation, or survey conducted by the Department, the hospice must provide to properly identified representatives of the Department meaningful access to all books, records, papers, or other information related to the initial or continued licensing of the hospice.

(4) The hospice must submit to the Department, in a format acceptable to the Department, a written plan of correction in response to any inspection report of violations identified by the Department. The plan of correction must specify what the hospice will do by a date certain to correct each of the violations identified. The plan of correction must be submitted within 10 days of the hospice's receipt of the inspection report of violations. A plan of correction must be determined to be acceptable by the Department. Hospices may be allowed an additional 48 hours to revise any plan of correction deemed unacceptable by the Department. Failure to submit an acceptable plan of correction may result in the Department commencing enforcement procedures. The hospice must correct all violations cited.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.06 Reports to the Department.

(1) **Patient Incidents Requiring Report.** The hospice must report to the Department, on forms made available by the Department, within 24 hours or the next business day, whenever any of the following incidents involving patients occurs or the hospice has reasonable cause to believe that an incident involving a patient has occurred:

(a) Any death of a hospice patient not related to the natural course of the patient's terminal illness or advanced and progressive disease, or any identified underlying condition;

(b) Any rape, assault, or any abuse, neglect or exploitation of a patient; and

(c) Any time a patient, who is admitted to a residential or inpatient hospice facility cannot be located, where there are circumstances that place the health, safety, or welfare of the patient or others at risk and the patient has been missing for more than eight hours.

(2) Where the hospice staff has reasonable cause to believe that a disabled adult or elder person has been the victim of abuse, other than by accidental means, or has been neglected or exploited, the hospice must report such information to an adult protection agency providing protective services as designated by the Department and to an appropriate law enforcement agency or prosecuting attorney.

(3) The hospice, through its peer review committee, must submit the reports of patient incidents listed in subparagraph (1)(a) through (c) of this rule. The Department will receive and retain such peer review reports concerning the listed incidents in confidence.

(4) Reports of patient incidents made through the peer review process must include:

(a) The name of the hospice, the name of the administrator or site manager, and a contact telephone number for information related to the report;

(b) The date of the incident and the date the hospice became aware of the incident;

(c) The type of incident, with a brief description of the incident; and

(d) Any immediate corrective or preventative action taken by the hospice to ensure against the replication of the incident.

(5) The hospice must conduct an internal investigation of any of the patient incidents listed in subparagraph (1)(a) through (c) and must complete and retain on-site a written report of the results of the investigation within 45 days of the discovery of the incident. The complete report must be made available to the Department for inspection at the hospice office and contain at least:

(a) An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or any other detailed system analysis;

(b) Any findings or conclusions associated with the review; and

(c) A summary of any actions taken to correct identified problems associated with the incident and to prevent recurrence of the incident, and also any changes in procedures or practices resulting from the investigation.

(6) The hospice must report to the Department any pending involuntary discharge of a hospice patient initiated by the hospice. The report must be made no later than the time of notification to the patient of the pending discharge.

(7) Other Events Requiring Report.

(a) The hospice must report in an acceptable format to the Department whenever any of the following events involving hospice operations occur or when the hospice becomes aware that any such events are likely to occur, to the extent that such events are expected to cause or cause a significant disruption of care for hospice patients:

1. An external disaster or other community emergency situation; or

2. An interruption of services vital to the continued safe operation of a hospice facility, such as telephone, electricity, gas, or water services.

(b) The hospice must make a report of the event within twenty-four hours or by the next regular business day from when the reportable event occurred or from when the hospice has reasonable cause to anticipate that the event is likely to occur. The report must include:

1. The name of the hospice, the name of the hospice administrator or site manager, and a contact telephone number for information related to the report;

2. The date of the event, or the anticipated date of the event, and the anticipated duration, if known;

3. The anticipated effect on care and services for hospice patients; and

4. Any immediate plans the hospice has made regarding patient management during the event.

(c) Within 45 days of the discovery of the event, the hospice must complete an internal evaluation of the hospice's response to the event where opportunities for improvement related to the hospice's disaster preparedness plan were identified. The hospice must make changes to the disaster preparedness plan as appropriate. The complete report must be available to the Department for inspection at the hospice office.

(8) While self-reported incidents made through the hospice's peer review process are received by the Department in confidence and not considered open records, where the Department's internal review determines that a rule violation related to any self-reported incident or event has occurred, the Department shall initiate a separate complaint investigation of the incident. The complaint investigation report and the report of any rule violation compiled by the Department arising either from the initial report received from the hospice or an independent source shall be subject to disclosure in accordance with applicable laws.

Authority: O.C.G.A. §§ 31-7-130 et seq., 31-7-170 et seq.

111-8-37-.07 Governing Body.

(1) The hospice must have an established and functioning governing body that is responsible for the conduct of the hospice and that provides for effective hospice governance, management, and budget planning.

(2) The governing body must appoint an administrator and delegate to the administrator the authority to operate the hospice in accordance with these rules and management policies established and approved by the governing body.

(3) The governing body must appoint a medical director and delegate to the medical director the authority to establish and approve, in accordance with current accepted standards of care, all patient care policies related to medical care.

(4) The governing body must ensure that no member of the governing body, administration, staff associated or affiliated with the hospice, or family member of staff causes, encourages or coerces any patient or family member of a patient to:

(a) name any person associated or affiliated with the hospice as a beneficiary under a will, trust, or life insurance policy, or

(b) take out or otherwise secures a life insurance policy on any patient, or

(c) give or loan anything of value to a member of the governing body, administration, staff associated or affiliated with the hospice or family member of staff.

(5) The governing body must be responsible for determining, implementing, and monitoring the overall operation of the hospice, including the quality of care and services, management, and budget planning. The governing body must:

(a) Be responsible for ensuring the hospice functions within the limits of its current license granted by the Department;

(b) Ensure that the hospice provides coordinated care that includes at a minimum medical, nursing, social, spiritual, volunteer, and bereavement services that meet the needs of the patients;

(c) Ensure that the hospice is staffed and equipped adequately to provide the services it offers to patients, whether the services are provided directly by the hospice or under contract;

(d) Develop and make available to patients and their families, a description of services offered by the hospice, including patient eligibility for the various services and whether the hospice provides palliative care to patients who have not been determined to be terminally ill but have been diagnosed with an advanced and progressive disease;

(e) Ensure the development and implementation of effective policies and procedures that address the management, operation, and evaluation of the hospice, including all patient care services and those services provided by independent contractors;

(f) Ensure there is an individual authorized in writing to act for the administrator during any period the administrator is absent;

(g) Appoint an individual to assume overall responsibility for a quality assurance, utilization, and peer review program for monitoring and evaluating the quality and level of patient care in the hospice on an ongoing basis;

(h) Ensure that hospice advertisements are factual and do not contain any element that might be considered coercive or misleading.

(i) Ensure that hospice care to patients who have been determined to be terminally ill is provided regardless of the patient or the family unit's ability to pay; and

(j) Ensure that there are policies and procedures in place that specify the manner in which transitions across care sites and providers (e.g. hospital to home hospice) will be handled to ensure that communications are effective to address continuity of care issues for the patient.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.08 Administrator.

(1) Each hospice must have a qualified administrator, designated by the governing body, who must be responsible for the ongoing and day-to-day operation of the hospice.

(2) The hospice administrator must be either a Georgia-licensed health care professional, who has at least one year of supervisory or management experience in a hospice setting or an individual with education, training and experience in health services administration and at least two years of supervisory or management experience in a hospice setting. The term, licensed health care professional, includes the following who hold Georgia licenses: physicians, nurse practitioners, physicians' assistants, registered professional nurses, clinical social workers, physical therapists and psychologists, but does not include practical nurses.

(3) The hospice administrator must ensure that the hospice:

(a) Implements policies and procedures for the provision of hospice care and palliative care to persons with advanced and progressive diseases, if it offers such services, which have been developed with interdisciplinary participation from the hospice care team;

(b) Employs qualified staff, including physicians, practitioners, nurses, social workers, clergy, volunteers, or other persons providing services at the hospice;

(c) Has implemented policies and procedures related to the management, operation, and evaluation of the overall performance of the hospice;

(d) Has a qualified director of nursing services along with sufficient qualified staff to meet the needs of patients admitted for hospice care and palliative care, if offered to persons with advanced and progressive diseases but who have not been determined to be terminally ill, and as outlined in the patients' plans of care;

(e) Provides an orientation, training, and supervision program for every employee and volunteer that addresses hospice care and palliative care for persons with advanced and progressive diseases, when offered, and the performance of the specific job to which the employee or volunteer is assigned;

(f) Ensures that the staff members complete their annual training and education program; and

(g) Ensures that there are effective mechanisms to facilitate communication among the hospice staff, hospice care team, and patients, their family units, and their legal guardians, if any.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.09 Quality Management.

(1) The hospice must appoint an interdisciplinary quality management committee that reflects the hospice's scope of services. The committee must develop and implement a comprehensive, effective and ongoing quality management, utilization, and peer review program that evaluates, maintains and improves the quality of patient care provided, including the appropriateness of the level of service received by patients, and submits required patient incident reports to the Department.

(2) The quality management, utilization, and peer review program must establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria must be based on accepted standards of care and must include, at a minimum, systematic reviews of:

- (a) Appropriateness of admissions, continued stay, and discharge;
- (b) Appropriateness of professional services and level of care provided;
- (c) Effectiveness of pain control and symptom relief;
- (d) Patient injuries, such as those related to falls, accidents, and restraint use;
- (e) Errors in medication administration, procedures, or practices that compromise patient safety;
- (f) Infection control practices and surveillance data;
- (g) Patient and family complaints and on-call logs;
- (h) Inpatient hospitalizations;
- (i) Staff adherence to the patients' plans of care; and
- (j) Appropriateness of treatment.

(3) Findings of the quality management utilization, and peer review program must be utilized to correct identified problems, revise hospice policies, and improve the care of patients.

(4) There must be an ongoing evaluation of the quality management, utilization, and peer review committee to determine its effectiveness, with the results of the evaluation presented at least annually for review and appropriate action to the medical staff and the governing body.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.10 Patient and Family Rights.

(1) The hospice must ensure that patients and their families receive hospice care and palliative care for persons with advanced and progressive diseases, when offered, in a manner that respects and protects their dignity and ensures all patients' rights to:

- (a) Participate in the hospice voluntarily and sever the relationship with the hospice at any time;
- (b) Receive only the care and services to which the patient and/or the patient's family have consented;
- (c) Receive care in a setting and manner that preserves the patient's dignity, privacy, and safety to the maximum extent possible;
- (d) Receive hospice care in a manner that neither physically nor emotionally abuses the patient, nor neglects the patient's needs;
- (e) Receive care free from unnecessary use of restraints;
- (f) Receive education in the availability and use of the hospice's grievance process for all patients;
- (g) Communicate grievances, concerns or complaints to the hospice for prompt resolution;
- (h) Refuse any specific treatment from the hospice without severing the relationship with the hospice;
- (i) Choose their own private attending physician, so long as the physician agrees to abide by the policies and procedures of the hospice;
- (j) Exercise the religious beliefs and generally recognized customs of their choice, not in conflict with health and safety standards, during the course of their hospice treatment and exclude religion from their treatment if they so choose;
- (k) Have their family unit, legal guardian, if any, and their patient representative present any time during an inpatient stay, unless the presence of the family unit, legal guardian, if any, or patient representative poses a risk to the patient or others;
- (l) Participate in the development of the patient's plan of care and any changes to that plan;
- (m) Have maintained as confidential any medical or personal information about the patient;
- (n) Continue hospice care and not be discharged from the hospice during periods of coordinated or approved appropriate hospital admissions;
- (o) Be provided with a description of the hospice care provided and levels of care to which the patient is entitled depending upon whether the patient is terminally ill or suffering from an advanced and progressive disease, and any charges associated with such services;
- (p) Review, upon request, copies of any inspection report completed by the Department within the two years preceding the request;
- (q) Make self-determinations concerning medical care, which encompass the right to make choices regarding life-sustaining treatment, including resuscitative services;

(r) Continue to receive appropriate hospice care when terminally ill without regard for the ability to pay for such care; and

(s) Have communication of information provided in a method that is effective for the patient. If the hospice cannot provide communications in a method that is effective for the patient, attempts to provide such shall be documented in the patient's medical record.

(2) The hospice must provide to the patient, the patient's representative, and/or the patient's legal guardian oral and written explanations of the rights of the patient and the patient's family unit while receiving hospice care for the terminally ill and palliative care for persons with advanced and progressive diseases. The explanation of rights must be provided at the time of admission into the hospice.

(3) At the time of admission, the hospice must provide to the patient, the patient's representative, and the patient's legal guardian the contact information, including the website address of the Department, for reporting complaints about hospice care to the Department.

(4) The hospice shall post the following information in a public area at the facility:

(a) A copy of the patient rights as outlined in Rule 111-8-37-.10(1) in a public area at the facility; and

(b) Contact information, including the website address of the Department, for reporting complaints about hospice care to the Department.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.11 Disaster Preparedness.

(1) Every hospice must have a current disaster preparedness plan that addresses potential situations where services to patients may be disrupted and outlines appropriate courses of action in the event a local or widespread disaster occurs including communications with patients and their families and emergency management agencies.

(2) The disaster preparedness plan must include at a minimum plans for the following emergency situations:

(a) Local and widespread severe weather emergencies or natural disasters, such as floods, ice or snow storms, tornados, hurricanes, and earthquakes;

(b) Interruption of service of utilities, including water, gas, or electricity, either within the facility or patients' homes or within a local or widespread area; and

(c) Coordination of continued care in the event of an emergency evacuation of the area.

(3) If the hospice offers residential and/or inpatient services, in addition to the procedures specified in paragraph (2) of this rule, the plan must also include:

(a) Fire safety and evacuation procedures and procedures for the provision of emergency power, heat, air conditioning, food, and water; and

(b) Plans for the emergency transport or relocation of all or a portion of the hospice patients, should it be necessary, in vehicles appropriate to the patients' conditions when possible, including written agreements with any facilities which have agreed to receive the hospice's patients in such situations, and notification of the patients' representatives.

(4) The hospice must have plans to ensure sufficient staffing and supplies to maintain safe patient care during the emergency situation.

(5) The plan must be reviewed and revised annually, as appropriate, including any related written agreements.

(6) Disaster preparedness plans for hospice care facilities must be rehearsed at least quarterly. Rehearsals must be documented to include staff and patient participants, a summary of any problems identified, and the effectiveness of the rehearsal. In the event an actual disaster occurs in any given quarter, the hospice may substitute the actual disaster's response in place of that quarter's rehearsal.

(7) Hospices must include emergency management agencies in the development and maintenance of their disaster preparedness plans and also provide copies of such plans to those agencies as requested.

(8) The Department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared that a state of emergency or disaster exists as a result of a public health emergency.

Authority: O.C.G.A. §§ 31-7-170 et seq., 50-13-4.

111-8-37-.12 Infection Control.

The hospice must have an effective infection control program designed to reduce the transmission of infections in patients, health care workers, caregivers, families, visitors and volunteers.

(a) The hospice must develop an infection control surveillance plan that is tailored to meet the needs of the hospice and the hospice patients and includes both outcome and process surveillance.

(b) The hospice must develop and implement effective policies and procedures that address infection control issues in all components of the hospice. These policies and procedures shall be based on accepted standards of infection control, approved by the administrator and the medical director, and shall address at least the following:

1. Hand hygiene;
2. Wound care;
3. Urinary tract care;
4. Respiratory therapy;

5. Enteral therapy;
6. Infusion therapy;
7. Cleaning, disinfecting, and sterilizing patient care equipment;
8. Isolation precautions;
9. Handling, transport, and disposal of medical waste and laboratory specimens;
10. Requirements for initial and annual health screenings for staff, including tuberculosis surveillance and required immunizations;
11. Use of personal protective equipment and exposure reporting/follow-up;
12. Work restrictions for staff with potentially infectious diseases;
13. Evaluation of the patient and the home environment related to infection control risks;
14. Outbreak investigation procedures;
15. Dietary practices in hospice care facilities; and
16. Reporting of communicable diseases, as required by law.

(c) The infection control program must be evaluated at least annually to ensure effectiveness of the program related to the prevention of the transmission of infections to patients, health care workers, caregivers, families, visitors and volunteers.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.13 Human Resources.

(1) All persons providing services for a hospice must be qualified by education, training, and experience to carry out all duties and responsibilities assigned to them.

(2) All persons providing services for a hospice must receive an orientation to the hospice to include, but not be limited to:

- (a) Hospice concepts and philosophy;
- (b) Patient rights including abuse reporting requirements; and
- (c) Hospice policies and procedures, including, but not limited to, disaster preparedness, fire safety and emergency evacuations, and reporting abuse and neglect.

(3) Where a patient does not have a do-not-resuscitate order, the hospice must ensure that all persons providing hands-on care directly to that patient on behalf of the licensed hospice have current certification in basic cardiac life support (BCLS) or cardiopulmonary resuscitation.

(4) The hospice must have an effective annual training and education program for all staff and volunteers who provide hands-on care to patients that addresses at a minimum:

- (a) Emerging trends in infection control;
- (b) Recognizing abuse and neglect and reporting requirements;
- (c) Patient rights; and
- (d) Palliative care.

(5) The administrator and each staff member and volunteer who has direct contact with patients or their family units must receive an initial and annual health screening evaluation, performed by a licensed health care professional in accordance with accepted standards of practice, sufficient in scope to ensure that the staff and volunteers screened are free of communicable and health diseases that pose potential risks to patients, their family units, and other staff and volunteers.

(6) Human resource files must be maintained for the following individuals delivering any services associated with the written plan of care: each staff member, independent contractor, and volunteer. The files must contain the person's application, employment history, emergency contact information, evidence of qualifications, job description, evidence of initial and annual health screening, yearly skills competency assessments, evidence of verified licensure or certification, as appropriate, and evidence of orientation, education, and training. These files must be available for inspection by the appropriate enforcement authorities on the premises.

(7) Where the hospice contracts with a staffing agency to provide any services specified in a plan of care, the written contract must require the contracting agency to verify licensing credentials, where applicable, of contract workers to ensure that such workers meet the same qualifications and licensure requirements as specified for hospice employees providing such services directly. The hospice must retain a copy of the contract.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.14 Admissions, Discharges, and Transfers.

(1) **Admissions.** The hospice must not admit any patients unless the hospice believes that it is capable of meeting the care needs of the patients. The hospice must have written criteria that address the eligibility for admission into home hospice care, residential, or inpatient hospice care and palliative care for persons with advanced and progressive diseases, if such palliative care is offered.

(2) **Terminally Ill Patient Admissions for Home Care.** The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria:

(a) The patient has a referral from a physician who has personally evaluated the patient and diagnosed the patient as terminally ill, where the medical prognosis is less than six months of life if the terminal illness takes its normal course, and in need of hospice care;

(b) The patient has received from the hospice an initial assessment, performed by an appropriate representative of the hospice care team, that reflects a reasonable expectation that the patient's medical, nursing, and psychological needs can be met adequately by the hospice and further reflects that the patient has a need for and can benefit from hospice care;

(c) The patient has been given a description of the scope of services and has personally or through an authorized patient representative given informed consent in writing to receive hospice care;

(d) The patient has been certified in writing by the hospice to have an anticipated life expectancy of six months or less if the terminal illness takes its normal course;

(e) The patient lives within the hospices service area; and

(f) The patient has identified a primary caregiver. In the absence of a primary caregiver, the hospice must develop a detailed plan for meeting the daily care and safety needs of the patient.

(g) The hospice must ensure the development of an initial plan of care, within 24 hours of admission to the hospice, based on the initial assessment and with appropriate input from a physician or registered nurse to meet the immediate needs of the patient.

(h) The hospice must ensure that no terminally ill patient is excluded from participation in or denied benefits of any hospice care because of an inability to pay for such hospice care.

(3) **Inpatient Hospice Admissions.** Hospices must admit to acute inpatient hospice care only those terminally ill patients who meet the following criteria:

(a) The patient has an order from a physician to be transferred to inpatient status and requires any of the following:

1. Nursing care supervised by a registered nurse that cannot feasibly be provided in another hospice setting;

2. Procedures that are necessary for pain control or acute or chronic symptom management;

3. Medication adjustment, observation, or other stabilizing treatment; or

4. Psycho-social monitoring; or

(b) Respite care.

(4) **Residential Hospice Admissions.** In addition to the home care admissions, hospices that elect to offer residential services must admit to a residential facility only those terminally ill patients who do not require acute management of symptoms or stabilization in an inpatient care setting and who meet the following criteria:

(a) The patient lacks a sufficient number of capable and willing caregivers; or

(b) The patient's care needs are too complex and difficult for non-medical caregivers to perform confidently; or

(c) The patient's primary home is not suitable or available and/or the home cannot be adapted to meet the patient's needs; or

(d) The patient has no other home available or desires not to live at home.

(5) **Palliative Care Admission Requirements.** Hospices that elect to provide palliative care to persons with advanced and progressive diseases in any setting, other than an inpatient or residential hospice, must admit only those persons who meet the following criteria:

(a) have an order from a physician indicating the patient has an advanced and progressive disease;

(b) request the intervention of a hospice care team to alleviate suffering and achieve relief from physical, emotional or spiritual symptoms of distress to achieve the best quality of life for the person and his or her family; and

(c) have stated needs that the hospice believes it has the capability to meet.

(6) **Discharge Requirements.**

(a) Once a hospice admits a patient who is terminally ill for hospice care, the hospice at its discretion must not discharge the patient unless either the patient freely and voluntarily requests the discharge or the hospice determines that an involuntary discharge is necessary in accordance with these rules.

(b) No hospice is permitted to require or demand that a terminally ill patient request voluntary discharge from the hospice or require or demand a hospice patient to execute a request for voluntary discharge from the hospice as a condition for admission or continued care.

(c) In situations where the hospice identifies issues where the safety of the terminally ill patient, the patient's family unit, or a hospice staff member or volunteer is compromised, the hospice must make every effort to resolve the issues before considering the option of involuntary discharge.

1. All such efforts for resolution by the hospice must be documented in the patient's record.

2. If involuntary discharge is the elected option, the hospice must give no less than 14 days' notice of discharge to the terminally ill patient and the patient's representative, except in cases of imminent danger or immediate peril to the terminally ill patient, other terminally ill patients, or staff.

3. The hospice must notify the Department of the pending involuntary discharge of a terminally ill patient at the time of patient notification.

(d) No terminally ill patient receiving hospice care may be discharged due to inability to pay for the hospice services.

(e) No hospice is permitted to discontinue hospice care for a terminally ill patient, nor discharge or transfer the patient, during a period of coordinated or approved appropriate hospital admission for the treatment of conditions related to the patient's terminal illness or any other condition.

(f) Hospices must assist in coordinating continued care should any hospice patient be transferred or discharged from the hospice.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.15 Assessment and Plan of Care.

(1) The hospice must designate a hospice care team for each patient admitted by the hospice. The hospice care team must be composed of individuals who provide or supervise the care and services offered by the hospice.

(2) The hospice care team must include at least the following individuals:

- (a) A physician;
- (b) A registered nurse;
- (c) A social worker;
- (d) A member of the clergy or other counselors; and
- (e) Volunteers.

(3) The appropriate members of the hospice care team must provide a comprehensive assessment, as dictated by the identified needs of the patient, no later than five days after admission that includes at least medical, nursing, psychosocial, and spiritual evaluations of the patient, as well as the capability of the family unit in meeting the care needs of the patient and the need for bereavement services.

(a) The assessment must be designed to trigger identification of any referral needed by the patient for additional services, including at a minimum:

1. Professional counseling;
2. Spiritual counseling by a member of the clergy or other counselor;
3. Bereavement services;
4. Dietitian services; and
5. Other therapeutic services, as needed.

(b) If additional services are identified for a terminally ill patient, the hospice must ensure that those services are provided by qualified individuals who must be added to the patient's hospice care team. Such qualified individuals include, but are not limited to:

1. Other appropriately licensed counselors, as applicable to the patient's needs; and
2. Volunteers who provide services for the patient.

(4) Based on the results of the assessment of the patient, the hospice care team must:

(a) Establish the plan of care; and

(b) Provide and supervise hospice care and services in accordance with accepted standards of care and the plan of care.

(5) The hospice care team must establish and maintain a written plan of care for each patient prior to providing care.

(a) The plan of care must be developed with the input of the patient, the patient's family unit if designated by the patient, the patient's caregivers where the patient resides in a licensed facility, and the patient's representative, if any.

(b) The plan of care must detail the scope and frequency of services to be provided to meet the needs of the patient and the patient's family unit.

(c) The hospice care team must meet as a group to review each terminally ill patient's plan of care. The plan of care must be reviewed and updated as the patient's condition changes and as additional service needs are identified. The plan of care for terminally ill patients must be reviewed and updated at intervals of no more than 15 days. All reviews and updates shall be documented in the patient's medical record. Plans of care for patients receiving palliative care who have not been determined to be terminally ill will be reviewed and updated as the patient's condition changes or the patient requests additional services.

(d) Documentation of plan of care review for the terminally ill patient must include a record of those participating and must also include evidence of the attending physician's opportunity to review and approve of any revised plans of care. In the absence of the attending physician's written approval of the revised plan of care, the revised plan of care must have the written approval of the medical director.

(6) The hospice care team must ensure that the patient receives treatment free from restraints, unless use of such restraints has been determined by a physician to be necessary for a temporary period to protect the patient from injury.

(a) Prior to using any restraint with a patient, the hospice care team must attempt less restrictive measures to accomplish the patient's treatment while affording the patient the maximum amount of personal freedom possible. The hospice must document the attempts at use of such less restrictive measures in the patient's medical record.

(b) If it is determined that restraints are necessary to prevent patient injury:

1. The hospice must obtain and document consent, specific to the type of restraint proposed, from the patient and/or the patient's representative for use of the restraint and such consent shall be obtained prior to the use of the restraint;

2. There must be a physician's order for the restraint, specifying the type of restraint to be used and the circumstances under which the restraint is to be applied, which is subject to the following conditions:

(i) The physicians order must be time limited; and

(ii) The order for the restraint must be re-evaluated prior to subsequent orders for the restraint;

3. The plan of care for the patient must include the plan and standard of care for use of the restraint, including the type and frequency of monitoring of the patient when the restraint is used. The plan must include maximum duration for each restraint application, with mandatory release at least every two hours, and a requirement that time, date, and duration of each restraint application are recorded and documented;

4. The plan of care must include procedures to ensure that the patient's comfort and safety needs are addressed during any period of restraint use;

5. The hospice must ensure safe and proper application and monitoring of the use of the restraint by adequately training staff and evaluating competency of each staff member treating patients in the use of the restraint and by directly observing staff performance with patients; and

6. The hospice staff must provide training to other patient caregivers in safe and proper use and monitoring of the restraint. Such training must be documented in the patient's medical record.

(c) A positioning or securing device utilized during medical treatment procedures to temporarily maintain the patient's position or immobilize the patient will not be considered a restraint, provided such necessity is documented in the patient's plan of care and the physician orders it. Such devices must only be applied by trained nursing or medical personnel and the plan of care must require monitoring sufficient to ensure the patient's safety.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.16 Home Care.

(1) The hospice must provide home care services to patients primarily in the patients' home. At least 51 percent of the total of all hospice care days, delivered by the hospice in the fiscal year to terminally ill patients must be delivered in the homes of the terminally ill patients.

(2) During home care visits, the hospice employee must provide continuing education for the patient and the patient's primary caregiver regarding the progression of the patient's illness and the patient's care needs.

(3) If, during the home care visit, there are observed or communicated significant changes in the patient's condition or needs, or if the hospice employee or volunteer observes that the patient's primary caregiver cannot provide the continuing support and care the patient requires, such findings must be communicated to the patient's hospice care team in a sufficiently timely manner to ensure that the patient's care and safety needs are addressed.

(4) When hospice services are provided to a patient who is a resident of a licensed nursing home, licensed intermediate care home, licensed personal care home or licensed assisted living community, or another licensed hospice operating an inpatient unit, there must be written communication evidencing an understanding between the hospice and the licensed facility that makes clear that the hospice takes full responsibility for professional management of the patient's hospice care and that the licensed nursing home, licensed intermediate care home, licensed personal care home or licensed assisted living community takes responsibility for the other services the patient needs or receives that the licensed facility is authorized to provide.

(a) The written communication must clearly specify the patient-care activities and responsibilities that will be performed by the hospice employees and volunteers and those patient care tasks that will be performed by employees of the facility where the hospice patient resides. Hospice employees and volunteers must provide those services for which they are assigned responsibility in the hospice's plan of care for the patient.

(b) The written communication must specify an individual from the hospice and an individual from the facility where the patient resides who shall be responsible for communication between services providers regarding each patient's treatment and condition and for addressing any care issues. Such communication must be ongoing throughout the period of hospice service provision and must be documented in the patient's hospice medical record.

(c) The hospice must provide a copy of any self-determination documentation to the licensed nursing home, licensed intermediate care home, licensed personal care home or licensed assisted living community where the patient resides and must communicate with the facility as to the procedure for the appropriate implementation of any advance directive or physician's order for life sustaining treatment.

(5) If the hospice does not offer inpatient services directly, the hospice must have a contractual agreement with a licensed hospital, a licensed skilled nursing facility, or a licensed inpatient hospice for the provision of short-term, acute inpatient care and respite care for hospice patients.

(6) The hospice must arrange for transport services when necessary to transport hospice patients to and from inpatient hospice care.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.17 Medical Services.

(1) Medical services must be under the direction of the medical director. In addition to palliation and management of the terminal illness and related conditions, physicians of the hospice, including the physician members of the hospice care team, must also address the basic medical needs of the patients to the extent that such needs are not met by each patient's attending physician or other physician of the patient's choice.

(2) **Medical Director.** The medical director for the hospice must be a physician licensed to practice in this state and must have at least one year of documented experience on a hospice care team or in another setting managing the care of terminally ill patients. The medical director must:

- (a) Be either an employee of the hospice or work under a written agreement with the hospice;
- (b) Have admission privileges at one or more hospitals commonly serving patients in the hospice's geographical area;
- (c) Be responsible for the direction and quality of the medical component of the care provided to patients by the hospice care team, including designating a licensed physician, employed by the hospice or working under a written agreement, to act on his or her behalf in the medical director's absence;
- (d) Participate in the interdisciplinary plan of care reviews, patient case review conferences, comprehensive patient assessment and reassessment, and the quality improvement and utilization reviews;
- (e) Review the clinical material of the patient's attending physician that documents basic disease process, prescribed medicines, assessment of patient's health at time of entry and the drug regimen;
- (f) Ensure that each terminally ill patient receives a face-to-face assessment, by either the medical director or the terminally ill patient's attending physician, or is measured by a generally accepted life-expectancy predictability scale for continued admission eligibility at least every six months, as documented by a written certification from the medical director or the terminally ill patient's attending physician that includes:
 - 1. The statement that the terminally ill patient's medical prognosis is for a life expectancy of six months or less if the terminal illness runs its natural course;
 - 2. The specific current clinical finding and other documentation supporting a life expectancy of six months or less if the illness takes its natural course for the terminally ill patient; and
 - 3. The signature of the physician.
- (g) Communicate with each patient's attending physician and act as a consultant to attending physicians and other members of the hospice care team;
- (h) Help to develop and review policies and procedures for delivering care and services to the patients and their family units;
- (i) Serve on appropriate committees and report regularly to the hospice administrator regarding the quality and appropriateness of medical care;
- (j) Ensure written protocols for symptom control and medication management are available; and
- (k) Assist the administrator in developing, documenting and implementing a policy for discharge of patients from hospice care.

(3) In addition to the hospice medical director, the hospice may appoint additional hospice physicians who shall assist the medical director in the performance of his or her duties, as prescribed by the hospice.

(4) The medical director must assist the administrator in developing, documenting, and implementing effective policies and procedures for the delivery of physicians' services, for orientation of new hospice physicians, and for continuing training and support of hospice physicians. These policies and procedures must:

(a) Ensure that a hospice physician is on-call 24 hours a day, seven days a week; and

(b) Provide for the review and evaluation of clinical practices within home care, residential, and inpatient hospices in coordination with the quality management, utilization, and peer review committee.

(5) Verbal orders for medications and controlled substances shall only be given to appropriately licensed staff members, acting within the scope of their licenses, and must be immediately recorded, signed, and dated by the licensed staff member receiving such order.

(a) The individual receiving the order shall immediately repeat the order and the prescribing physician must verify that the repeated order is correct. The individual receiving the order must document in the patient's medical record that the order was "repeated and verified."

(b) The hospice must provide a written copy of the order to the prescribing physician within 24 hours of such order or by the end of the next business day.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.18 Nursing Services.

(1) The hospice shall have a system to make available nursing services 24-hours a day, seven days a week to meet the needs of the patients.

(a) A registered nurse must be available at all times to provide or supervise the provision of nursing care.

(b) On-site nursing services must be made available within one hour of notification where the terminally ill patient and the patient with an advanced and progressive disease who has contracted for nursing services experiences a symptom-management crisis situation.

(c) The hospice must maintain an on-call log for all calls received after normal business hours, the records of which shall be kept for a period of two years.

(2) The hospice must designate a director of nursing who must be a Georgia-licensed registered nurse and who must be responsible for implementing a system for delivery, supervision, and evaluation of nursing and personal care services.

(a) The director of nursing must establish and implement effective policies and procedures for nursing and personal care services based on generally accepted standards of nursing practice.

(b) The director of nursing must ensure that nursing personnel are oriented to nursing policies and procedures and are qualified and competent for their assigned duties.

(c) The director of nursing must ensure the types and numbers of nursing personnel necessary to provide appropriate nursing care for each patient in the hospice.

(d) The director of nursing must ensure patient assignments are made that reflect a consideration of patient needs as well as nursing staff qualifications and competencies.

(3) Nursing staff must administer medications and other treatments in accordance with the physicians' orders, generally accepted standards of practice, and any federal and state laws pertaining to medication administration.

(4) A registered professional nurse licensed in this state and employed by the hospice may make the determination and pronouncement of the death of a patient who is terminally ill or whose death is anticipated and who is receiving hospice care from the licensed hospice at the time of apparent death of such hospice patient in the absence of an attending physician, of said patient; provided, however, that, when a hospice patient is a registered organ donor, only a physician may make the determination or pronouncement of death.

(5) **Personal Care Services.** Personal care services must be available and provided in all components of the hospice to meet the needs of patients. The hospice may utilize licensed nurses or qualified personal care aides for the provision of personal care services.

(a) Personal care aides considered qualified by training and experience to provide services to patients include:

1. Georgia Certified Nursing Aides with current certification as such; or

2. Individuals who have completed and can provide validation or documentation of completion of a home health aide training and competency evaluation program conducted in a Medicare-certified home health agency; or

3. Individuals who have successfully completed a personal care aide-training program, provided by the hospice under the direction of a registered nurse, which meets the following requirements:

(i) The personal care aide-training program must be conducted through classroom and supervised practical training totaling at least 75 hours;

(ii) At least 16 of the 75 hours of training shall be devoted to supervised practical training;

(iii) The individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training;

(iv) Supervised practical training must be provided either in a laboratory setting or in one of the components of the hospice in which the trainee demonstrates knowledge while performing tasks on an individual or patient under the direct supervision of a registered nurse or licensed practical nurse; and

(v) The personal care aide-training program must address each of the following subject areas:

(I) Communications skills;

(II) Observation, reporting, and documentation of patient status and the care or service furnished;

(III) Reading and recording temperature, pulse, and respiration;

(IV) Basic infection control procedures;

(V) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;

(VI) Maintenance of a clean, safe, and healthy environment;

(VII) Recognizing emergencies and knowledge of emergency procedures;

(VIII) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, the patient's privacy, and the patient's property;

(IX) Appropriate and safe techniques in personal hygiene and grooming that include:

I. Bed bath;

II. Sponge, tub, or shower bath;

III. Shampooing in the sink, tub, or bed;

IV. Nail and skin care;

V. Oral hygiene; and

VI. Toileting and elimination;

(X) Safe transfer techniques and ambulation;

(XI) Normal range of motion and positioning;

(XII) Adequate nutrition and fluid intake, including preparing and assisting with eating;

(XIII) Any other task that the hospice may choose to have the personal care aide perform, as authorized by law; and

(XIV) Patient rights, including effectuating advance directives and abuse reporting requirements.

(b) Prior to providing care independently to patients, a registered nurse must observe personal care aides actually delivering care to patients and complete an initial competency evaluation for all personal care tasks assigned to the aide.

(c) Personal care aides must receive at least 12 hours of continuing education annually regarding applicable aspects of hospice care and services.

(d) A registered nurse must prepare for each personal care aide written instructions for patient care that are consistent with the interdisciplinary plan of care and must make and document supervisory visits to the terminally ill patient's residence or living facility at least every two weeks to assess the performance of the personal care aide services.

(e) At least annually, there must be written evidence for each personal care aide that reflects that the personal care aide's performance of required job tasks was directly observed by a registered nurse and such performance was determined to be competent for all job tasks required to be performed.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.19 Other Services.

Hospices must make supportive services available to both the patient and the patient's family unit, including, but not limited to, bereavement services provided both prior to and after the patient's death, as well as spiritual counseling and any other counseling services identified in the interdisciplinary plan of care for the patient and the patient's family unit.

(a) **Bereavement Services.** Hospices must have an organized program for the provision of bereavement services under the supervision of a licensed professional counselor or licensed social worker or other professional determined, in compliance with applicable laws, to be qualified by training and education to provide the required supportive services. Bereavement services must be a part of the interdisciplinary plan of care and shall address the needs of the patient and the patient's family unit, the services to be provided, and the frequency of services. Bereavement services, including educational and spiritual materials and individual and group support services, must be available to the terminally ill patient's family unit for a period of at least one year following the terminally ill patient's death. Hospices must maintain documentation of all bereavement services.

(b) **Spiritual Counseling.** Hospices must make available spiritual counseling and must notify patients and patients' family units as to the availability of clergy. In the delivery of spiritual counseling services, hospices must not impose any value or belief system on the patient or the patient's family unit.

(c) **Other Counseling.** Additional counseling for the patient or the patient's family unit may be provided by other qualified members of the hospice care team as well as by other qualified professionals in accordance with state practice acts. Such counseling includes, but is not limited to, access to a licensed clinical social worker or professional counselor for the provision of counseling to the patient or the patient's family unit or primary caregiver on a short-term basis to resolve assessed clear or direct impediments to the treatment of the patient's medical condition.

(d) **Physical Therapy, Occupational Therapy, and Speech Language Pathology Services.** Physical therapy services, occupational therapy services, and speech language pathology services must be available to the patient and, when provided, offered by qualified personnel, in accordance with state practice acts, in a manner consistent with accepted standards of practice.

(e) **Dietary and Nutritional Services.** Dietary and nutritional services, as required, must be available to all patients in all components of hospice care and provided or supervised by a licensed dietitian. Hospices must develop, document, and implement effective written policies and procedures for dietary and nutritional services.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.20 Volunteer Services.

(1) The hospice must establish a program that utilizes volunteers to provide services to terminally ill patients and family units in accordance with patients' plans of care and/or to provide administrative support services for the hospice.

(2) The hospice must designate a coordinator of volunteer services who assists the administrator in developing, documenting, and implementing a volunteer services program.

(3) The hospice volunteer coordinator must establish and implement effective written policies and procedures relating to volunteer services. These policies and procedures must address at a minimum:

- (a) Recruitment and retention;
 - (b) Screening;
 - (c) Orientation;
 - (d) Scope of function;
 - (e) Supervision;
 - (f) Basic infection control;
 - (g) Ongoing training and support; and
 - (h) Documentation of volunteer activities; and
 - (i) Patient rights and reporting abuse and other serious incidents.
- (4) Volunteer services must be provided without compensation.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.21 Pharmaceutical Services.

(1) The hospice must provide for the procurement, storage, administration, and destruction of drugs and biologicals utilized for hospice care in accordance with accepted professional principles and in compliance with all applicable state and federal laws.

(2) The hospice must:

(a) Ensure medication and pharmacy procedures are approved by a licensed pharmacist who is either employed directly or has a formal arrangement with the hospice;

(b) Ensure the availability of a licensed pharmacist on a 24-hour per day basis to advise the hospice staff regarding medication issues and to dispense medications;

(c) Ensure that any emergency drug kit placed in the hospice is in accordance with all applicable laws and rules and regulations;

(d) Ensure that drugs and biologicals are labeled in accordance with current accepted standards of practice;

(e) Ensure effective procedures for control and accountability of all drugs and biologicals throughout the hospice, including records of receipt, disposition, destruction, and reconciliation of all controlled substances and dangerous drugs; and

(f) Ensure that only licensed nurses or physicians, acting within the scope of their licenses, administer medications on behalf of the hospice.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.22 Medical Supplies.

The hospice must make available sufficient medical supplies and equipment for the palliative care and management of the illness or conditions directly attributable to the terminal diagnosis of terminally ill patients.

(a) If the hospice directly provides medical supplies and equipment, the hospice must:

1. Develop and implement effective policies and procedures to maintain the supplies and equipment in good working order per the manufacturers' recommendations;

2. Ensure the safe handling and storage of supplies and equipment to ensure function and cleanliness;

3. Instruct the caregiver on the use and maintenance of the equipment; and

4. Replace supplies and equipment as essential for the care of terminally ill patients.

(b) If the hospice contracts for medical supplies and equipment services, the hospice must ensure that contract agreements include requirements consistent with subparagraph (a) of this rule and must ensure that contractors adhere to such agreements.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.23 Medical Records.

(1) In accordance with accepted standards of practice, the hospice must establish and maintain a medical record for every patient admitted for care and services. The medical record must be complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval and to support the provision of patient care.

(2) Entries must be made for all services provided and must be signed and dated on the day of delivery by the individual providing the services for inclusion in the patient's medical record within seven days. The record must include all services whether furnished directly or under arrangements made by the hospice.

(3) Each patient's medical record must contain:

(a) Identification data;

(b) The initial and subsequent assessments;

(c) Pertinent medical and psychosocial history;

(d) Consent and authorization forms;

(e) The interdisciplinary plan of care;

(f) The name of the patient's attending physician; and

(g) Complete documentation of all services and events, including evaluations, treatments, progress notes, transfers, discharges, etc.

(4) The hospice must have the patient's medical record readily accessible and must safeguard the medical record against loss, destruction, and unauthorized use.

(5) Medical records must be preserved as original records, microfilms, or other usable forms and must be such as to afford a basis for complete audit of professional information. Hospices must retain all medical records at least until the sixth anniversary of the patient's death or discharge, and as otherwise required by law. If the patient is a minor, medical records must be retained for at least five years past the age of majority or, in the event the minor patient dies, for at least five years past the year in which the patient would have reached the age of majority. In the event the hospice ceases operation, the hospice must provide prior notice to the local community, referring providers and the Department of the location of the medical records and how such records may be retrieved.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.24 Hospice Care Facilities.

(1) Hospices providing home care services may establish, as optional services, small home-like residential facilities or units, in order to provide 24-hour non-acute palliative hospice care, and/or inpatient units, in order to provide short-term, 24-hour acute hospice care to terminally ill hospice patients. Residential hospices built, or undergoing major renovations after the effective date of these rules must meet the Facility Guidelines Institute, Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, including the provisions specifically applicable to hospices.

(2) The environment of the hospice care facility must be designed, equipped, and maintained in accordance with applicable life safety code requirements to provide for the comfort, privacy, and safety of no more than 25 patients and family members in any one self-contained, home-like unit. A hospice may operate multiple self-contained, home-like units of no more than 25 beds each, either at the same location or separate locations, provided that each unit is fully staffed to meet the needs of the hospice patients in that unit, the locations are within 35 miles of the principal location and the governing body does not have a history of poor compliance with licensure requirements. Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide:

(a) An emergency power source capable of providing electrical service for communication systems, alarm systems, egress lighting, and patient care areas;

(b) Décor and room configuration that is home-like in design and function;

(c) Space accommodations, other than patient rooms, for private patient/family visiting and grieving;

(d) Accommodations for at least one family member to remain with the patient throughout the night;

(e) Separate restrooms for staff and public use;

(f) A program to inspect, monitor and maintain biomedical, electrical equipment in proper and safe working order;

(g) Procedures that prevent infestations of insects, rodents, or other vermin or vectors;

(h) Security procedures sufficient for the protection of patients;

(i) Procedures for the safe management of medical gases;

(j) Procedures for infection control, including isolation of patients, in accordance with accepted standards;

(k) An environment that is clean, in good repair, and designed and equipped to minimize the spread of infection;

(l) Adequate lighting, ventilation, and control of temperature and air humidity; and

(m) An alternative power source to support the needs of the patients.

(3) Patient rooms and bathrooms must be designed and equipped to allow for easy access to the patient and for the comfort and safety of patients.

(4) Each residential and/or inpatient hospice care facility must provide rooms that:

(a) Measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multi-patient room;

(b) Are private rooms, unless consent for a roommate is obtained and then only if the following requirements are met:

1. The hospice must provide an alternative temporary accommodation for a patient whose roommate is in a crisis situation;

2. In no case shall more than two patients share a room;

(c) Are equipped with a bathroom with an adequate supply of hot water and with automatically regulated temperature control of the hot water;

(d) Are at or above grade level and have a window to the outside;

(e) Contain a suitable bed and mattress for each patient, suitable furniture that allows family to remain in the room overnight, chairs for seating, and closets or furniture for storage of personal belongings;

(f) Are equipped with a system for patients to summon for assistance when needed;

(g) Are equipped with a telephone in each room or telephones located in private areas convenient to bedrooms; and

(h) Have an adequate amount of clean bed linens, towels, and washcloths.

(5) In addition to complying with all other requirements of these rules and regulations, each facility that is newly constructed or expands its existing facility after the date these rules and regulations take effect shall also provide a tub or shower in each patient room.

(6) In addition to the hospice's applicable home-care policies and procedures, hospice care facilities must develop and implement additional policies and procedures for post-mortem care and for pronouncement of deaths, in accordance with applicable law.

(7) Hospice care facilities must have policies regarding smoking which apply to employees, volunteers, patients, and visitors.

(8) Hospice care facilities must ensure adequate staff are on duty at all times in order to meet the needs of patients, in accordance with patients' plans of care and in accordance with accepted standards of nursing and hospice care. Residential and/or inpatient hospice care facilities must provide:

(a) At least two staff members on duty 24 hours per day, seven days per week, with additional staff as needed to meet the needs of patients; and

(b) A registered nurse must direct and supervise all patient care in accordance with the needs of patients and the individual plans of care.

1. Residential hospice care facilities may utilize licensed practical nurses for patient care provided that a registered nurse supervises the care and is available on call at all times.

2. Inpatient hospice care facilities must have a registered nurse present during each shift who provides direct patient care.

(9) Meals must be provided in accordance with established dietary practice and the dietary needs and wishes of patients. The hospice must:

(a) Serve three meals a day with not more than 14 hours between a substantial evening meal and breakfast, unless medically contraindicated;

(b) Have a system for providing meals for patients outside the normal meal service hours, when requested;

(c) Have snacks available between meals and at night, as appropriate to each patient's needs and medical condition;

(d) Purchase, store, prepare, and serve food in a manner that prevents food borne illness;

(e) Ensure patient diets follow the orders of physicians;

(f) Ensure that a qualified staff member plans and supervises meals to ensure meals meet patient's nutritional needs and to ensure meals follow recommended dietary allowances and menu plans; and

(g) Ensure the services of a licensed dietitian to review meal plans and to consult in practical freedom of choice diets to ensure that patients' favorite foods are included in their diets whenever possible.

Authority: O.C.G.A. §§ 31-7-170 et seq.

111-8-37-.25 Waivers and Variances.

(1) A hospice may request a waiver or variance of a specific rule by application on forms provided by the Department.

(2) The Department may grant or deny the request for waiver or variance at its discretion. If the waiver or variance is granted, the Department may establish conditions that must be met by the hospice in order to operate under the waiver or variance. Waivers or variances may be granted with consideration of the following:

(a) **Variance.** A variance may be granted by the Department, at its discretion, upon a showing by the applicant that the particular rule or regulation that is the subject of the variance

request should not be applied as written because strict application would cause undue hardship. The applicant must also show that adequate standards exist for affording protection for the health, safety, and care of patients, and these existing standards would be met in lieu of the exact requirements of the rule or regulation.

(b) **Waiver.** The Department may, at its discretion, dispense altogether with the enforcement of a rule or regulation by granting a waiver upon a showing by the applicant that the purpose of the rule or regulation is met through equivalent standards affording equivalent protection for the health, safety, and care of the patients.

(c) **Experimental Waiver or Variance.** The Department may grant a waiver or variance, at its discretion, to allow experimentation and demonstration of new and innovative approaches to delivery of services upon a showing by the applicant that the intended protections afforded by the rule or regulation in question are met and that the innovative approach has the potential to improve service delivery.

(3) Waivers and variances granted by the Department must be for a time certain, as determined by the Department.

(4) The hospice may request a final review of the initial waiver or variance decision made by program staff to the chief of the Division of Healthcare Facility Regulation by filing a written request for review of the initial decision and providing any additional information which supports the request for review. The chief of the Division will issue a final decision on behalf of the Department.

(5) Where the Department has denied the application for a waiver or variance in writing, the Department will not consider a subsequent application for the same waiver or variance from the same hospice unless the applicant includes new evidence of a substantial change in the circumstances which formed the basis for the initial request.

Authority: O.C.G.A. §§ 31-2-47 and 31-7-170 et seq.

111-8-37-.26 Enforcement.

A hospice that fails to comply with licensing requirements as contained in the Rules and Regulations for Hospices, Chapter 111-8-37 and the Rules and Regulations for General Licensing and Enforcement Requirements, Chapter 111-8-25, is subject to civil and administrative actions brought by the Department to enforce licensing requirements as provided by applicable laws and rules. Such actions will be initiated in compliance with the Georgia Administrative Procedures Act, O.C.G.A. §§50-13-1 et seq., 31-2-8 and the Rules and Regulations for General Licensing and Enforcement Requirements, Chapter 111-8-25.

However, the Department may suspend any requirements of these rules and the enforcement of any rules when the Governor of the State of Georgia has declared a public health emergency.

Authority: O.C.G.A. §§ 31-2-8, 31-7-170 et seq. and 50-13-1 et seq.

111-8-37-.27 Severability.

In the event that any rule, sentence, clause, or phrase of any of these rules and regulations may be construed by any court of competent jurisdiction to be invalid, illegal, unconstitutional, or otherwise unenforceable, such determination or adjudication shall in no manner affect the remaining rules or portion thereof. The remaining rules or portions of rules shall remain in full force and effect, as if such rule or portions thereof so determined, declared, or adjudged invalid or unconstitutional were not originally a part of these rules.

Authority: O.C.G.A. §§ 31-2-4 and 31-7-170 et seq.