

**RULES OF
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION DIVISION
REVISE CHAPTER 111-8-22
RULES FOR END STATE RENAL DISEASE FACILITIES**

SYNOPSIS OF PROPOSED RULE CHANGES

STATEMENT OF PURPOSE: The Georgia Department of Community Health proposes to revise the Rules and Regulations for End Stage Renal Disease Facilities, Chapter 111-8-22. These changes are being proposed pursuant to the authority granted the Department of Community Health in O.C.G.A. § 31-6-21 and O.C.G.A. § 31-6-21.1.

MAIN FEATURE OF THE PROPOSED RULE: Revision of the care plan requirements to mirror the federal regulations.

**RULES
OF
DEPARTMENT OF COMMUNITY HEALTH**

**CHAPTER 111-8
HEALTHCARE FACILITY REGULATION**

**111-8-22
END STAGE RENAL DISEASE FACILITIES**

TABLE OF CONTENTS

111-8-22-.09	Medical Staff and Medical Services
111-8-22-.11	Patient Care Services
111-8-22-.12	Patient Care Plans
111-8-22-.14	Medical Records

111-8-22-09 Medical Staff and Medical Services

(2) Medical Services. The medical director shall ensure that each patient at the facility receives medical care and supervision appropriate to the patient's dialysis needs.

(a) Each patient shall have an attending physician who is responsible on a continuing basis for the patient's medical care. Each patient's records shall clearly indicate the name and contact number for the patient's physician.

1. The facility shall require a history and physical examination of each patient following admission, prior to the development of the patient's ~~short-term~~ care plan, and at least annually thereafter.

2. The facility shall require each patient to have a medical plan of care, prescribed by a physician, to include indicated dialysis or related treatments, dialysis orders, medications, diet, criteria for discharge and any other special services needed.

3. The facility shall require that the patient's physician participate in the development of the ~~long-term and short-term~~ care plans for the patient, and shall assure that the plan for the patient's medical care is based on the assessment of the patient's individual needs.

4. The facility shall require and the medical director shall ensure that the patient's medical progress at the facility is monitored by a physician on-site at least monthly. The facility shall require that each patient have a scheduled opportunity to see a physician at least once per month. Medical patient monitoring and physician visits shall be documented by progress note entries in the patient's medical record.

11-8-22-11 Patient Care Services

(6) Home Training Services for Hemodialysis or Peritoneal Dialysis

(a) If the facility provides services for training and support of home dialysis, the facility shall meet the requirements for ~~long and short term~~ care plans for those patients, to include interdisciplinary conferences.

111-8-22-12 Patient Care Plans.

(1) The facility shall coordinate services for each patient through an interdisciplinary treatment team approach. An interdisciplinary treatment team shall be identified at the time of admission for each patient and shall consist of at least:

(a) The patient and any family member(s) or other(s) designated as a representative of the patient who wishes to participate and is invited by the patient to participate;

(b) Either the patient's attending physician or the medical director of the end stage renal disease facility;

(c) A qualified registered nurse, who is responsible for nursing services at the facility;

(d) A licensed social worker;

(e) A licensed dietician; and

(f) ~~For the long-term care plan, a~~ A transplant surgeon or surgeon-designee.

(2) There shall be documentation of the participation of the patient (or their representative) in the development and review of the patient's ~~long and short term plans~~ of care, with consideration given to the patient's preferences. If participation is declined, the declination shall be documented, and there shall be evidence that the content of the plan(s) or decisions were reviewed with the patient or their representative.

(3) ~~Long Term Care Plan.~~ The treatment team shall develop a written, individualized ~~long term~~ plan of care for each patient, designating a selected treatment modality and a selected setting for treatment.

(a) The ~~long term~~ care plan shall be developed within 30 days of admission to the facility.

(b) All suitable treatment modalities shall be considered by the treatment team, regardless of their availability at the current facility, and there shall be consideration of the patient's preferences as well as clinical and psychosocial needs.
~~Transplant status shall be reviewed with each patient quarterly.~~

(c) The ~~long term~~ care plan for patients deemed unsuitable for transplant shall indicate the specific rationale for the

Formatted: Font: Not Bold

unsuitability.

(d) For patients for whom transplant referral has been selected, educational and rehabilitation needs shall be addressed as a part of the ~~long-term~~ care plan.

(e) The ~~long-term~~ care plan shall be reviewed and updated at least annually, or sooner if there has been a change in the selected treatment modality or setting.

~~(4) Short Term Care Plan. The treatment team shall develop a written, individualized, short term care plan for each patient, defining goals and objectives for treatment in the selected treatment modality. If home dialysis support services are provided by the facility, home dialysis patients shall also have a short term care plan developed.~~

~~(a) The initial short term care plan shall be completed within thirty (30) days of admission, based on the medical, psychosocial, and dietary information available on or immediately following admission.~~

~~(b) Goals and objectives for treatment shall be stated in measurable terms. Goals and objectives for the initial short term care plan shall include, but need not be limited to, completion of needed assessments. Subsequent short term care plans shall include goals and objectives based on the results from assessments of dietary, psychosocial, medical, and rehabilitation needs.~~

~~(c) The short term care plan for all patients deemed stable by the interdisciplinary team, including transplant patients, shall be reviewed at least quarterly by the interdisciplinary team, to assess the patient's progress and update the short term care plan to reflect the needs of the patient. Stability shall be determined by written criteria developed by the interdisciplinary team. Plans for unstable patients shall be reviewed monthly as changes in condition require changes in the short term care plan to ensure that appropriate care is provided.~~

~~(d) Any significant change in the patient's condition, which renders the patient unstable, shall require an immediate notation in the medical record with an updated short term care plan developed within one week. The notation in the medical record must address any immediate changes that are being made in care to address the change in the patient's condition.~~

~~(e) For home dialysis patients, the short term care plan shall identify support services to be supplied by the facility, and the frequency with which they are to be provided.~~

111-8-22-14 Medical Records

(5) Medical records shall be available for inspection only to members of the professional staff, the patient, representatives of the Department acting in an official capacity, or persons authorized in writing by the patient to have access to the medical record.

(a) The facility shall release copies of all or part of a patient's medical record to an authorized representative of the Department at no cost to the Department when the Department determines that said records are necessary in connection with the Department's licensing and certification responsibilities of a facility.

(b) The facility shall arrange for the prompt transfer of a courtesy copy of the following parts of a patient's medical record to the receiving facility: the patient's ~~carelong and short-treatment~~ plan, the last two weeks of run sheets and flow charts, a list of current medications, current treatment orders and the last three months of clinical laboratory test results to the receiving facility.

(c) The facility shall have a mechanism to release copies of all or part of a patient's medical records to the patient or to others with the written consent of the patient or the patient's legal guardian and to others where required by law. The facility may charge a reasonable fee for the copies so produced.

(d) The medical record for each patient shall contain at a minimum:

1. Patient identifying information (name, address, age, sex, marital status);
2. Dates of admission, transfer, and discharge, as applicable;
3. Names of referring and attending physicians;
4. Evaluation and assessment reports, including the history and physical examination administered prior to the initial treatment;
5. Reports from any special examinations and consultations, and laboratory and x-ray results;
6. Physician's orders;

7. ~~Long and short term patient e~~Care plans;
8. Signed consent forms, as applicable;
9. Progress notes, including dialysis flow sheets; and
10. The discharge summary, including cause of death, if applicable.