

**RULES OF
DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION**

AMEND CHAPTER 290-9-43

AND

REPLACE WITH NEW CHAPTER 111-8-37

**RULES AND REGULATIONS FOR
HOSPICES**

SYNOPSIS OF PROPOSED RULE CHANGES

STATEMENT OF PURPOSE: The Department of Community Health proposes to amend the Rules for Hospices by replacing the Chapter number, 290-9-43 with a new Chapter number, 111-8-37. This change is necessary to reflect that hospices are subject to regulation by the Department of Community Health rather than the Department of Human Resources, which has since been renamed as the Department of Human Services. These rules are being proposed pursuant to the authority granted the Department of Community Health in O.C.G.A. §§ 31-2-4, 31-2-5, 31-2-7 and 31-7-1 et seq.

In the formulation of the proposed new rules, the Department has considered the economic costs associated with the regulations and the impact on small businesses in the state. To the extent possible, the proposed rules do not impose excessive regulatory costs on the regulated entities while supporting the quality of care being delivered and the health and safety of the participants receiving care.

MAIN FEATURES OF THE PROPOSED RULES: The proposed Rules for Hospices, Chapter 111-8-37, set forth the existing standards for licensure as a hospice authorized to provide hospice care. These proposed rules do not change the existing rules except to replace the Chapter number, the name of the Department, correct rule numbering and grammatical errors and update legal references throughout. The proposed rules include the following features:

- Restatement of existing Title and Purpose in Rule 111-8-37-.01.

- Restatement of existing Authority and the inclusion of additional legal authority in Rule 111-8-37-.02.
- Restatement of existing Definitions in Rule 111-8-37-.03. except for the substitution of Community Health for Human Resources in the definition of the Department, correcting Georgia Code references and the modification of the definition of hospice in the rules to conform to the amended definition of hospice in the law.
- Restatement of existing provisions for Licensure Procedures in Rule 111-8-37-.04 and updating cross-reference to another hospice rule.
- Restatement of existing provisions for Inspections and Investigations in Rule 111-8-37-.05.
- Restatement of existing provisions for Reports to the Department in Rule 111-8-37-.06, removing outdated reference to delayed effective date and adjusting rule numbers.
- Restatement of existing requirements for Governing Body in Rule 111-8-37-.07.
- Restatement of existing requirements for Administrator in Rule 111-8-37-.08.
- Restatement of existing requirements for Quality Management in Rule 111-8-37-.09.
- Restatement of existing requirements for Patient and Family Rights in Rule 111-8-37-.10.
- Restatement of existing provisions for Disaster Preparedness in Rule 111-8-37-.11.
- Restatement of existing provisions for Infection Control in Rule 111-8-37-.12.
- Restatement of existing requirements for Human Resources in Rule 111-8-37-.13.
- Restatement of existing requirements for Admissions, Discharges and Transfers in Rule 111-8-37-.14.
- Restatement of existing requirements for Assessment and Plan of Care in Rule 111-8-37-.15.
- Restatement of existing requirements for Home Care in Rule 111-8-37-.16.
- Restatement of existing requirements for Medical Services in Rule 111-8-37-.17.
- Restatement of existing requirements for Nursing Services in Rule 111-8-37-.18.
- Restatement of existing requirements for Other Services in Rule 111-8-37-.19.
- Restatement of existing requirements for Volunteer Services in Rule 111-8-37-.20.
- Restatement of existing requirements for Pharmaceutical Services in Rule 111-8-37-.21.

- Restatement of existing requirements for Medical Supplies in Rule 111-8-37-.22
- Restatement of existing requirements for Medical Records in Rule 111-8-37-.23
- Restatement of existing requirements for Hospice Care Facilities in Rule 111-8-37-.24.
- Restatement of existing requirements for Waivers and Variances in Rule 111-8-37-.25.
- Restatement of existing requirements for Enforcement in Rule 111-8-37-.26.
- Restatement of existing requirements for Severability in Rule 111-8-37-.27.
- Inclusion of updated references to the Official Code of Georgia Annotated throughout.

**RULES
OF
DEPARTMENT OF ~~HUMAN RESOURCES~~ COMMUNITY HEALTH
~~OFFICE OF REGULATORY SERVICES~~**

HEALTHCARE FACILITY REGULATION

**CHAPTER ~~290-9-43~~ 111-8-37
RULES AND REGULATIONS FOR HOSPICES**

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~~290-9-43~~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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Title and Purpose” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

~~290-9-43~~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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Authority” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

~~290-9-43~~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) “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.

(c) “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.

(d) “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.

|(e) “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.

|(f) “Department” means the Georgia Department of ~~Human Resources~~Community Health.

|(g) “Dietitian” means a specialist in the study of nutrition who is licensed as required by ~~Chapter 43-11A of the Official Code of Georgia Annotated~~ O.C.G.A. Sec. 43-11A-1 et seq., the “Dietetics Practice Act.”

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

|(i) “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.

|(j) “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 nursing home, licensed intermediate care home, licensed personal care home, or residential hospice setting shall be considered to be receiving home care while a resident of that facility.

|(k) “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.

|(l) “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, and by the hospice care team.

|(m) “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.

- | (n) “Inpatient care” means short-term, 24-hour medically supervised care for the purpose of adjusting and monitoring the 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.
- | (o) “Inpatient hospice facility” means a facility that provides inpatient care for hospice patients and is not a part of a licensed skilled nursing facility or a licensed hospital.
- | (p) “License” means a license issued by the Department to the governing body to operate a hospice.
- | (q) “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.
- | (r) “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.
- | (s) “Patient” means a terminally ill individual receiving the hospice continuum of services, regardless of ability to pay.
- | (t) “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.
- | (u) “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.
- | (v) “Physician” means an individual who is licensed to practice medicine in this state by the Georgia Composite State Board of Medical Examiners.
- | (w) “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.
- | (x) “Professional counselor” means a person licensed or certified as a professional counselor or associate professional counselor as required by ~~Chapter 43-10A of the Official Code of Georgia Annotated~~O.C.G.A. Sec. 43-10A-1 et seq., the “Professional Counselors, Social Workers, and Marriage and Family Therapists Licensing Law.”
- | (y) “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.
- | (z) “Residential hospice facility” means a small home-like residential facility or unit that is a part of a licensed hospice, designed, staffed, and organized to provide non-acute palliative hospice care, 24-hours per day, seven days per week, under the supervision of

the hospice physician and hospice registered nurses to hospice patients and their family units.

- | (aa) “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.
- | (bb) “Restraint” means any manual, physical, or mechanical method, device, material, or equipment attached or adjacent to the patient’s body, which he or she cannot easily remove, that restricts freedom of movement or normal access to that person’s body.
- | (cc) “Social worker” means an individual who is qualified by education, training, and experience and licensed when required by law to perform social work for hospice patients and their family units and who has at least a bachelor’s degree in social work from a school accredited by the Council on Social Work Education.
- | (dd) “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.
- | (ee) “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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Definitions” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

290-9-43111-8-37-.04 Licensure Procedures.

- | (1) No entity shall establish, operate, or maintain a hospice in the State of Georgia without first obtaining a valid license.
- | (2) No entity shall use the term “hospice” to imply or indicate that it is providing hospice services to patients and their families unless the entity holds a valid license.
- | (3) A governing body desiring to operate a hospice shall file with the Department, not later than 30 days prior to the anticipated date of the opening of the hospice, an initial application on a form prescribed and furnished by the Department. The application shall be complete, accurate, and signed by the hospice administrator or the executive officer of the hospice’s governing body and shall include:
 - | (a) The applicant’s name, address, phone number, and e-mail address or other viable form of electronic communication;

- | **_(b) Proof of ownership.** In the case of corporations, partnerships, and other entities authorized by law, the applicant shall 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.
- | **_(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)** A license shall be issued to the legal owner of the hospice as disclosed in the application for licensure and proof of ownership documents. Inpatient and residential services shall not be licensed separately from home care services.
- | **_(8)** The license shall 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 shall be reported to the Department at least 30 days prior to such change along with an application from the proposed new owners or lessees for a new license.
- | **_(11)** Changes in the hospice that require a new application and the issuance of a new license include a change in name, an addition of another location, or a change in the scope of services provided. A written amendment to the current application shall be filed at least 30 days prior to a change in information previously reported in the application.
- | **_(12)** A license shall no longer be valid and shall be returned to the Department when the hospice ceases to operate, changes locations, or the license is suspended or revoked.
- | **_(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.
- | **_(a)** When placed on temporary inactive status, the license shall be returned to the Department within 10 days of closure and the hospice shall not operate until the license has been reactivated.

| (b) The hospice shall 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 shall be subject to inspection by the Department. If the license is not reactivated within 12 months, the license shall be considered abandoned.

| (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 shall be able to adequately manage all locations and ensure the quality of care at all locations;

| (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 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;

| (h) All hospice patients' clinical records that are requested by the Department at the time of inspection shall 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 shall have the option of providing residential and/or inpatient hospice services as a part of the licensed hospice; provided, however, that prior to being issued a license that includes residential and/or inpatient hospice services, the hospice shall:

| (a) Be regularly licensed and in substantial compliance with all sections of these rules and regulations that apply to home care hospice services;

| (b) Complete and submit a new application to the Department requesting the additional services;

| (c) Submit a copy of the certificate of occupancy issued by local building officials for the facility or unit;

| (d) Submit evidence of compliance with the applicable provisions of the *Life Safety Code*®, as enforced by the state fire marshal;

| (e) Provide 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

| (f) Be in substantial compliance with all the applicable requirements of Rule ~~290-9-43111-8-37~~-.24, Hospice Care Facilities, as evidence by an on-site inspection by the Department.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Licensure Procedures” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| ~~290-9-43111-8-37~~-.05 **Inspections and Investigations.**

| (1) The hospice staff, any facilities, and the hospice patients shall 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, prior to licensure and periodically thereafter, shall inspect each hospice to ensure that the licensee is providing quality care to its patients; provided, however, that the hospice shall be exempt from additional on-site licensure inspection if certified as a hospice in accordance with federal regulations. Where the Department has reason to believe that the hospice may not be in compliance with these rules, the hospice shall make all records, staff, and patients, as determined necessary by the Department, immediately accessible to properly identified representatives of the Department for purposes of a complaint investigation.

| (3) For the purposes of any inspection, investigation, or survey conducted by the Department, the hospice shall 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 shall submit to the Department a written plan of correction in response to any inspection report of violations that states what the hospice will do and when to correct each of the violations identified. The plan of correction shall 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 shall 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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Inspections and Investigations” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

290-9-43111-8-37-.06 Reports to the Department.

(1) Patient Incidents Requiring Report. ~~This paragraph takes effect three months after the Department provides written notification of the effective date to all hospices.~~

(a) The hospice shall report to the Department, on forms provided 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:

1.(a) Any death of a hospice patient not related to the natural course of the patient's terminal illness or any identified underlying condition;

2.(b) Any patient rape that occurs in a residential or inpatient hospice facility or in a patient's home at the time a hospice employee or volunteer is in the patient's home;

3.(c) Any assault on a patient by a hospice employee or volunteer, or any abuse or neglect of a patient by a hospice employee or volunteer;

4.(d) Any serious injury to a patient resulting from the malfunction or intentional or accidental misuse of patient care equipment; and

5.(e) In a residential or inpatient hospice facility, any time a patient 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.

(b) The hospice, through its peer review committee, shall submit the reports of patient incidents listed in subparagraph (a) of this paragraph to be received and retained in confidence by the Department together with any documentation generated by the Department of its initial review of the reported incident.

(e) Reports of patient incidents shall include:

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

2. The date of the incident and the date the hospice became aware of the incident;

3. The type of incident, with a brief description of the incident; and

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

(d) The hospice shall conduct an internal investigation of any of the patient incidents listed in subparagraph (a) of this paragraph and shall 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 shall be available to the Department for inspection at the hospice office and shall contain at least:

1. An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or any other system analysis;

2. Any findings or conclusions associated with the review; and

3. 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.

| (ei) The hospice shall report to the Department any pending involuntary discharge of a hospice patient initiated by the hospice. The report shall be made at the time of notification to the patient of the pending discharge.

| (2) Other Events/Incidents Requiring Report. This paragraph takes effect three months after the Department provides written notification of the effective date to all hospices.

| (a) The hospice shall report to the Department whenever any of the following events involving hospice operations occurs or when the hospice becomes aware that it is likely to occur, to the extent that the event is expected to cause or causes 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 shall 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 shall 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 shall 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 shall make changes to the disaster preparedness plan as appropriate. The complete report shall be available to the Department for inspection at the hospice office.

| (3) Where the Department 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. Secs. 31-7-130 et seq., 31-7-170 et seq. **History.** Original Rule entitled “Reports to the Department” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

290-9-43111-8-37-.07 Governing Body.

|(1) The hospice shall 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 shall appoint an administrator and delegate to the administrator the authority to operate the hospice in accordance with management policies established and approved by the governing body.

|(3) The governing body shall 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 shall ensure that no member of the governing body, administration, staff associated or affiliated with the hospice, or family member of staff causes, encourages, or persuades any patient to name any person associated or affiliated with the hospice as a beneficiary under a will, trust, or life insurance policy or takes out or otherwise secures a life insurance policy on any patient.

|(5) The governing body shall 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 shall:

|(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 a description of services offered by the hospice, including patient eligibility for the various services, and ensure patients and families are informed about the availability of the services;

|(e) Ensure the development and implementation of 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. Any written advertisement describing services offered by the hospice shall contain notification that services are available regardless of ability to pay, and include the hospice license number; and

| (i) Ensure that hospice care shall be provided regardless of the patient or the family unit's ability to pay and without regard to race, creed, color, religion, sex, national origin, or handicap.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Governing Body" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.08 Administrator.**

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

| (2) The hospice administrator shall be:

| (a) A health care professional licensed to practice in this state who has at least one year of supervisory or management experience in a hospice setting; or

| (b) An individual with education, training, and experience in health service administration who has at least two years of supervisory or management experience in a hospice setting.

| (3) The hospice administrator shall ensure that the hospice:

| (a) Has policies and procedures for the provision of hospice care that 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 as outlined in the patients' plans of care;

| (e) Provides an orientation, training, and supervision program for every employee and volunteer that addresses the hospice services 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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Administrator” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.09 Quality Management.**

| (1) The hospice shall appoint a multidisciplinary quality management committee that reflects the hospice’s scope of services. The committee shall develop and implement a comprehensive and ongoing quality management, utilization, and peer review program that evaluates the quality and appropriateness 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 shall establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria shall be based on accepted standards of care and shall 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 patient’s plans of care; and

| (j) Appropriateness of treatment.

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

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

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Quality Management” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-10 Patient and Family Rights.**

| (1) The hospice shall ensure that patients and their families receive hospice services 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 services 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) Have addressed and resolved promptly any grievances, concerns, or complaints and receive education in the availability and use of the hospice’s grievance process;

| (g) Refuse any specific treatment from the hospice without severing the relationship with the hospice;

| (h) Choose their own private attending physician, so long as the physician agrees to abide by the policies and procedures of the hospice;

| (i) 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;

| (j) 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;

| (k) Participate in the development of the patient’s plan of care and any changes to that plan;

- | (l) Have maintained as confidential any medical or personal information about the patient;
- | (m) Continue hospice care and not be discharged from the hospice during periods of coordinated or approved appropriate hospital admissions;
- | (n) Be provided with a description of the hospice services and levels of care to which the patient is entitled and any charges associated with such services;
- | (o) Review, upon request, copies of any inspection report completed within two years of such request;
- | (p) Self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services;
- | (q) Continue to receive appropriate care without regard for the ability to pay for such care; and
- | (r) 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 shall 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. Upon request, copies of such rights shall be provided to patients. The explanation of rights shall be provided at the time of admission into the hospice.
- | (3) The hospice shall 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.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Patient and Family Rights" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

290-9-43111-8-37-.11 Disaster Preparedness.

- | (1) Every hospice shall have a current disaster preparedness plan that addresses potential situations where services to patients may be interrupted and outlines an appropriate course of action in the event a local or widespread disaster occurs.
- | (2) The disaster preparedness plan shall 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 shall 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 shall 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 shall be rehearsed at least quarterly. Rehearsals shall be documented to include staff 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 shall include their local emergency management agencies in the development of their disaster preparedness plans and also provide a copy of such plans to those agencies.

| (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. Secs. 31-7-170 et seq., 50-13-4. **History.** Original Rule entitled "Disaster Preparedness" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.12 Infection Control.**

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

| (a) The hospice shall 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 shall develop and implement 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 communicable disease health screening, 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 shall 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, and volunteers.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Infection Control" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| ~~290-9-43~~111-8-37**.13 Human Resources.**

| (1) All persons providing services for a hospice shall 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 shall receive an orientation to the hospice to include, but not be limited to:

| (a) Hospice concepts and philosophy;

| (b) Patient rights; 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 shall ensure that all persons providing hands-on services directly to that patient have current certification in basic cardiac life support (BCLS) or cardiopulmonary resuscitation.

| (4) The hospice shall have an effective annual training and education program for all staff and volunteers who provide direct 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 shall 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 staff and volunteers 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 shall be maintained for each staff member, contractor, and volunteer that contains that person's application, employment history, emergency contact information, evidence of qualifications, job description, evidence of initial and annual health screening, yearly performance evaluations, evidence of verified licensure or certification, as appropriate, and evidence of orientation, education, and training. These files shall be available for inspection by the appropriate enforcement authorities on the premises.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Human Resources" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.14 Admissions, Discharges, and Transfers.**

| (1) **Admissions.** The hospice shall have written criteria that address the eligibility for admission into home care, residential, or inpatient hospice services.

| (a) The hospice home care program shall admit only patients that meet the following minimum criteria:

1. 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;

2. 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;

3. 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;

4. 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;

5. The patient lives within the hospices service area; and

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

| (b) The hospice shall 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.

| (c) The hospice shall ensure that no person on the grounds of race, color, national origin, handicap, or ability to pay is excluded from participation in, denied benefits of, or otherwise subjected to discrimination from the provision of any hospice care or service.

| (2) Inpatient Hospice Admissions. In addition to the home care admissions requirements, hospices shall admit to inpatient care only those patients who meet the following criteria:

| (a) The patient has an order from a physician to be transferred to inpatient status and requires short-term management of 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) The patient has an order from a physician to be transferred to inpatient status for the provision of respite care.

| (3) Residential Hospice Admissions. In addition to the home care admissions, hospices that elect to offer residential services shall admit to a residential facility only those patients who do not require acute management of symptoms or stabilization 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.

| (4) **Discharge Requirements.**

| (a) Once a hospice admits a patient, the hospice at its discretion shall not discharge the patient.

| (b) No hospice shall require or demand that a 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 patient, the patient's family unit, or a hospice staff member or volunteer is compromised, the hospice shall make every effort to resolve the issues before considering the option of involuntary discharge.

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

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

3. The hospice shall notify the Department of the pending involuntary discharge at the time of patient notification.

| (d) No patient may be discharged due to inability to pay for the hospice services.

| (e) No hospice shall discontinue hospice care, nor shall a patient be discharged or transferred, 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 shall assist in coordinating continued care should the patient be transferred or discharged from the hospice.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Admissions, Discharges, and Transfers" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-15 Assessment and Plan of Care.**

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

|(2) The hospice care team shall 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 shall provide a comprehensive assessment, as dictated by the identified needs of the patient, no later than seven 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 shall 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 patient, the hospice shall ensure that those services are provided by qualified individuals who shall be added to the patient's hospice care team and who shall include, but not be 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 patient's assessment, the hospice care team shall:

(a) Establish of 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 shall establish and maintain a written plan of care for each hospice patient prior to providing care.

- | (a) The plan of care shall be developed with the input of the patient, the patient's family unit, the patient's caregivers where the patient resides in a licensed facility, and the patient's representative, if any.
- | (b) The plan of care shall detail the scope and frequency of services needed to meet the needs of the patient and the patient's family unit.
- | (c) The hospice care team shall meet as a group to review each patient's plan of care. The plan of care shall be reviewed and updated as the patient's condition changes and as additional service needs are identified, but at intervals of no more than 30 days. All reviews and updates shall be documented in the patient's medical record.
- | (d) Documentation of plan of care review shall include a record of those participating and shall 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 shall ensure that the patient receives hospice 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 hospice patient, the hospice care team shall attempt less restrictive measures to accomplish the patient's treatment while affording the patient the maximum amount of personal freedom possible. The hospice shall 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 shall 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 shall 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 shall be subject to the following conditions:
 - (i) The physicians order must be time limited; and
 - (ii) The order for the restraint shall be re-evaluated prior to subsequent orders for the restraint;
 3. The plan of care for the patient shall 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 shall 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 shall include procedures to ensure that the patient's comfort and safety needs are addressed during any period of restraint use;

5. The hospice shall 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 shall provide training to other patient caregivers in safe and proper use and monitoring of the restraint. Such training shall 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 shall not be considered a restraint, but, if necessary, such necessity shall be documented in the patient's plan of care. Such devices shall only be applied by trained nursing or medical personnel and the plan of care shall require monitoring sufficient to ensure the patient's safety.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Assessment and Plan of Care" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.16 Home Care.**

| (1) The hospice shall provide home care services to patients primarily in the patients' home. At least 51 percent of patients' hospice care days in the fiscal year shall be home care days.

| (2) During home care visits, the hospice employee shall 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 shall 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, or licensed personal care home, there shall be written communication evidencing agreement that specifies 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, or licensed personal care home takes responsibility for the other services the patient needs or receives that the licensed facility is authorized to provide.

| (a) The written communication shall 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. Only hospice employees and volunteers shall provide those services for which they are assigned responsibility in the hospice's plan of care for the patient.

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| (b) The written communication shall 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 shall be ongoing throughout the period of hospice service provision and shall be documented in the patient's hospice medical record.

| (c) The hospice shall provide a copy of any self-determination documentation to the licensed nursing home, licensed intermediate care home, or licensed personal care home where the patient resides and shall communicate with the facility as to the procedure for implementation of any advance directive.

| (5) If the hospice does not offer inpatient services directly, the hospice shall 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 shall arrange for transport services when necessary to transport hospice patients to and from inpatient hospice care.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Home Care" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.17 Medical Services.**

| (1) Medical services shall 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 shall be a physician licensed to practice in this state and shall 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 shall:

| (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 patient receives a face-to-face assessment, by either the medical director or the 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 patient's attending physician that includes:
 1. The statement that the individual'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 terminal illness takes its natural course; 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 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 shall assist the administrator in developing, documenting, and implementing 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 shall:
 - | (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 be given to appropriately licensed staff members, acting within the scope of their licenses, and shall 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 shall verify that the repeated order is correct. The individual receiving the order shall document in the patient's medical record that the order was "repeated and verified."

| (b) The hospice shall 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. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Medical Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.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 shall be made available within one hour of notification where the patient experiences a symptom-management crisis situation.

| (c) The hospice shall 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 shall designate a director of nursing who shall be a registered nurse and who shall be responsible for implementing a system for delivery, supervision, and evaluation of nursing and personal care services.

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

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

| (e) Nursing staff shall 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.

|(3) **Personal Care Services.** Personal care services shall 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 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 shall 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 shall complete at least 16 hours of classroom training before beginning the supervised practical training;

(iv) Supervised practical training shall 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 shall 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; and

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

| (b) Prior to providing care independently to patients, a registered nurse shall 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 shall receive at least 12 hours of continuing education annually regarding applicable aspects of hospice care and services.

| (d) A registered nurse shall prepare for each personal care aide written instructions for patient care that are consistent with the interdisciplinary plan of care and shall make and document supervisory visits to the 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 shall reflect 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. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Nursing Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.19 Other Services.**

| Hospices shall make support 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 shall 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 to be qualified by training and education to provide the required supportive services. Bereavement services shall 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, shall be available to the patient's family unit for a period of at least one year following the patient's death. Hospices shall maintain documentation of all bereavement services.

| (b) **Spiritual Counseling.** Hospices shall make available spiritual counseling and shall notify patients and patients' family units as to the availability of clergy. In the delivery of spiritual counseling services, hospices shall 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 shall be available 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, shall be available to all patients in all components of hospice care and shall be provided or supervised by a licensed dietitian. Hospices shall develop, document, and implement written policies and procedures for dietary and nutritional services.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Other Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.20 Volunteer Services.**

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

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

| (3) The hospice volunteer coordinator shall establish and implement written policies and procedures relating to volunteer services. These policies and procedures shall 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.

| (4) Volunteer services shall be provided without compensation.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Volunteer Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.21 Pharmaceutical Services.**

| (1) The hospice shall 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 shall:

| (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 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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Pharmaceutical Services” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.22 Medical Supplies.**

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

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

1. Develop and implement 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 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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Medical Supplies” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.23 Medical Records.**

| (1) In accordance with accepted standards of practice, the hospice shall 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 shall be made for all services provided and shall 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 shall include all services whether furnished directly or under arrangements made by the hospice.

(3) Each patient's medical record shall 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 shall have the medical record readily accessible and shall safeguard the medical record against loss, destruction, and unauthorized use.

(5) Medical records shall be preserved as original records, microfilms, or other usable forms and shall be such as to afford a basis for complete audit of professional information. Hospices shall retain all medical records at least until the sixth anniversary of the patient's death or discharge. 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 shall cease operation, the Department shall be advised of the location of said records.

Authority O.C.G.A. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Medical Records" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

290-9-43111-8-37-24 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.

(2) The environment of the hospice care facility must be designed, equipped, and maintained to provide for the comfort, privacy, and safety of patients and family members. Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide:

| (a) No more than 25 beds, except for those facilities whose licensed bed capacity exceeds 25 beds as of the date these rules and regulations take effect and then only for the duration of such license;

| (b) Décor that is homelike 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 shall 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 shall 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 shall 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 that shall 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 shall have a registered nurse present during each shift who provides direct patient care.

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

| (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. Sec. 31-7-170 et seq. **History.** Original Rule entitled "Hospice Care Facilities" adopted. F. July 27, 2005; eff. Aug. 16, 2005.

290-9-43111-8-37-.25 Waivers and Variances.

| A hospice may request a waiver or variance of a specific rule by application on forms provided by the Department. A waiver or variance may be granted in accordance with the following considerations:

| (a) 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:

1. **Variance.** A variance may be granted by the Department 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;

2. **Waiver.** The Department may 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; and

3. **Experimental Waiver or Variance.** The Department may grant a waiver or variance 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;

| (b) Waivers and variances granted by the Department shall be for a time certain, as determined by the Department; and

| (c) Waivers and variances granted to a hospice shall be recorded and shall be available to interested parties upon request.

| Authority O.C.G.A. Secs. 31-2-~~47~~, 31-7-170 et seq. **History.** Original Rule entitled “Waivers and Variances” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **290-9-43111-8-37-.26 Enforcement.**

| (1) The hospice shall notify patients and patients’ representatives and family units of the Department’s actions to revoke the license or seek an emergency suspension of the hospice’s license to operate.

| (2) The official notice of the revocation or emergency suspension action and any final resolution, together with the Department’s complaint intake phone number and website address, shall be provided to current and prospective patients and to their representatives and family units.

| (3) The hospice shall ensure the posting of the official notice at the hospice in an area that is visible to the patients and to the patients’ family units and representatives.

| (4) The hospice shall ensure that the official notice continues to be visible to the patients and to the patients’ representatives and family units throughout the pendency of the revocation and emergency suspension actions, including any appeals.

| (5) The hospice shall have posted at the hospice in an area that is readily visible to the patients and to the patients’ representatives and family units any inspection reports that are prepared by the Department during the pendency of any revocation or emergency suspension action.

| (6) It shall be a violation of these rules for the hospice to permit the removal or obliteration of any posted notices of revocation, emergency suspension action, resolution, or inspection survey during the pendency of any revocation or emergency suspension action.

| (7) The Department may post an official notice of the revocation or emergency suspension action on its website or share the notice of the revocation or emergency suspension action and any information pertaining thereto with any other agencies that may have an interest in the welfare of the patients in care at the hospice.

| (8) A hospice shall be subject to the imposition of administrative fines as established by the Department for any violation of these rules and regulations or of any provision of Article 9 of Chapter 7 of Title 31 of the Official Code of Georgia Annotated.

| (9) 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 a public health emergency.

|(10) So long as any enforcement action is currently ongoing against a hospice, there shall be no expansion of services or additional services added.

| Authority O.C.G.A. Secs. 31-2-~~68~~ and, 31-7-170 et seq. **History.** Original Rule entitled “Enforcement” adopted. F. July 27, 2005; eff. Aug. 16, 2005.

| **~~290-9-43~~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. Sec. 31-7-170 et seq. **History.** Original Rule entitled “Severability” adopted. F. July 27, 2005; eff. Aug. 16, 2005.