Chapter 82. Minimum Standards for Licensure of Hospice Agencies

Subchapter A. General Provisions

§8201. Definitions

A. The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Activities of Daily Living (ADL's)—the following functions or tasks performed either independently or with supervision or assistance:

a. mobility;

b. transferring;

c. walking;

d. grooming;

e. bathing;

f. dressing and undressing;

g. eating; and

h. toileting.

Acute/General Inpatient Care—short-term, intensive hospice services provided in an appropriately licensed facility to meet the patient's need for skilled nursing, symptom management or complex medical treatment.

Advance Directives—an instruction given to the patient/family (see definition of family) such as a durable power of attorney for health care, a directive pursuant to patient self-determination initiatives, a living will, or an oral directive which either states a person's choices for medical treatment or, in the event the person is unable to make treatment choices, designates who shall make those decisions.

Attending/Primary Physician—a person who is a doctor of medicine or osteopathy fully licensed to practice medicine in the State of Louisiana, who is designated by the patient as the physician responsible for his/her medical care.

Bereavement Services—organized services provided under the supervision of a qualified professional to help the family cope with death related grief and loss issues. This is to be provided for at least one year following the death of the patient.

Branch—a location or site from which a hospice agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the parent hospice agency and is located within a 50 mile radius of the parent agency and shares administration and supervision.

Bureau—Bureau of Health Services Financing of the Department of Health and Hospitals.

Care Giver—the person whom the patient designates to provide his/her emotional support and/or physical care.

Chaplain—a member of the clergy.

Community—a group of individuals or a defined geographic area served by a hospice.

Continuous Home Care—care provided by the hospice during a period of crisis as necessary to maintain the terminally ill individual at home. A minimum of eight hours of care must be furnished on a particular day to be considered continuous home care. Nursing care must be provided for more than one half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Services may be provided by a homemaker or home health aide to supplement the nursing care. A registered nurse must complete an assessment of the patient and determine that the patient requires continuous home care prior to assigning a licensed practical nurse, homemaker, or a home health aide to a patient requiring continuous home care. This assignment must comply with accepted professional standards of practice.

Contracted Services—services provided to a hospice provider or its patients by a third party under a legally binding agreement that defines the roles and responsibilities of the hospice and service provider.

Core Services—nursing services, physician services, medical social services, and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

Department—the Department of Health and Hospitals (DHH).

Discharge—the point at which the patient's active involvement with the hospice program is ended and the program no longer has active responsibility for the care of the patient.

Do Not Resuscitate Orders—orders written by the patient's physician which stipulate that in the event the patient has a cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated or carried out.

Emotional Support—counseling provided to assist the person in coping with stress, grief, and loss.

Employee—an individual whom the hospice pays directly for services performed on an hourly or per visit basis and the hospice is required to issue a form W-2 on his/her behalf. If a contracting service or another agency pays the individual, and is required to issue a form W-2 on the individual's behalf, or if the individual is self-employed, the individual is not considered a hospice employee. An individual is also considered a hospice employee if the individual is a volunteer under the jurisdiction of the hospice.

Facility-Based Care—hospice services delivered in a place other than the patient's home, such as an inpatient hospice facility, nursing home or hospital inpatient unit.

Family—a group of two or more individuals related by ties of blood, legal status, or affection who consider themselves a family.

Geographic Area—area around location of licensed agency which is within 50 mile radius of the agency premises. Each hospice must designate the geographic area in which the agency will provide services.

Governing Body—the person or group of persons that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation. The governing body must designate an individual who is responsible for the day-to-day management of the hospice program, and must also insure that all services provided are consistent with accepted

standards of practice. Written minutes and attendance of *governing body* meetings are to be maintained.

Home—a person's place of residence.

Homemaker—an individual who provides light housekeeping services to patients in their homes.

Hospice—an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his family. It employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospice Inpatient Facility—organized facilities where specific levels of care ranging from residential to acute, including respite, are provided in order to meet the needs of the patient/family.

Hospice Physician—a person who is a doctor of medicine or osteopathy, and is currently and legally authorized to practice medicine in the State of Louisiana, designated by the hospice to provide medical care to hospice patients in lieu of their primary physician.

Hospice Premises—the physical site where the hospice maintains staff to perform administrative functions, and maintains its personnel records, or maintains its client service records, or holds itself out to the public as being a location for receipt of client referrals.

Hospice Services—a coordinated program of palliative and supportive care, in a variety of appropriate settings, from the time of admission through bereavement, with the focus on keeping terminally ill patients in their place of residence as long as possible.

Informed Consent—a documented process in which information regarding the potential and actual benefit and risks of a given procedure or program of care is exchanged between provider and patient.

Inpatient Services—care available for pain control, symptom management and/or respite purposes that is provided in a participating facility.

Interdisciplinary Group (IDG)—an interdisciplinary group or groups designated by the hospice, composed of representatives from all the core services. The IDG must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The interdisciplinary group is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the establishment of policies governing the day-to-day provision of hospice care and services.

Interdisciplinary Group Conferences—regularly scheduled periodic meetings of specific members of the interdisciplinary group to review the most current patient/family assessment, evaluate care needs, and update the plan of care.

Level of Care—hospice care is divided into four categories of care rendered to the hospice patient:

a. routine home care;

b. continuous home care;

c. inpatient respite care;

d. general inpatient care.

License (Hospice)—a document permitting an organization to practice *hospice care* for a specific period of time under the rules and regulations set forth by the State of Louisiana.

Life-Threatening—causes or has the potential to cause serious bodily harm or death of an individual.

Medical Social Services—include a comprehensive psychosocial assessment; ongoing support for the patient and family; and assistance with coping skills, anticipatory grief, and grief reactions.

Non-Core Services—services provided directly by hospice employees or under arrangement. These services include, but are not limited to:

a. home health aide and homemaker;

b. physical therapy services;

c. occupational therapy services;

d. speech-language pathology services;

e. inpatient care for pain control and symptom management and respite purposes; and

f. medical supplies and appliances including drugs and biologicals.

Period of Crisis—a period in which a patient requires predominately nursing care to achieve palliation or management of acute medical problems.

Plan of Care (POC)—a written document established and maintained for each individual admitted to a hospice program. Care provided to an individual must be in accordance with the plan. The plan includes an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief.

Representative—an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated.

Residential Care—hospice care provided in a nursing facility or any residence or facility other than the patient's private residence.

Respite Care—short-term care generally provided in a nursing facility or hospice facility to provide relief for the family from daily care of the patient.

Spiritual Services—providing the availability of clergy as needed to address the patient's/family's spiritual needs and concerns.

Sub-Unit—a semi-autonomous organization, licensed separately, which serves patients in a different geographic location from that of the parent agency. The *sub-unit* is located outside of the 50-mile radius and does not share administration/staff/services on a daily basis with the parent agency.

Terminally Ill—a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2257 (December 1998).

§8203. Licensing

A. Except to the extent required by §8205.A.1, it shall be unlawful to operate or maintain a hospice without first obtaining a license from the department. The Department of Health and Hospitals is the only licensing authority for hospice in the State of Louisiana.

B. A separately licensed hospice may not use a name which is substantially the same as the name of another hospice licensed by the department unless the agency is part of a corporation or is chain affiliated.

C. Issuance of a License. The licensing agency shall have authority to issue two licenses as described below.

1. Full license is issued only to those agencies that are in substantial compliance with applicable federal, state, and local laws. The license shall be valid until the expiration date shown on the license.

2. Provisional license is issued to those existing licensed agencies which do not meet criteria for Full licensure. The license shall be valid for six months or until termination date.

a. An agency with a provisional license shall pay an additional amount equal to the annual licensing renewal fee for each follow-up survey. Fee shall be paid to the state agency prior to the follow-up survey being performed and is non-refundable.

b. An agency with a provisional license may be issued a full license, if at the follow-up survey the agency has corrected the violations. A full license will be issued for the remainder of the year until the hospice agency's license anniversary date.

c. DHH may re-issue a provisional license or initiate licensing revocation of a provisional license when the hospice fails to correct violations within 60 days of being cited, or at the time of the follow-up survey, whichever occurs first.

d. A provisional license may be issued by DHH for the following non-exclusive reasons:

i. agency has more than five violations of hospice regulations during one survey;

ii. agency has more than three valid complaints in a one year period;

iii. there is a documented incident that places a patient at risk;

iv. agency fails to correct violations within 60 days of being cited, or at the time of a follow-up survey, whichever occurs first;

v. agency has an inadequate referral base, other than at the time of the initial survey for licensure, has less than 20 new patients admitted since the last annual survey.

e. Agency fails to submit assessed fees after notification by DHH.

f. Documented evidence that agency has bribed, or harassed any person to use the services of any particular hospice agency.

D. Display of License. The current license shall be displayed in a conspicuous place inside the hospice program office at all times. A license shall be valid only in the possession of the agency to which it is issued. A license shall not be subject to sale, assignment, or other transfer, voluntary or involuntary. A license shall not be valid for any hospice other than the hospice for which originally issued. If an agency is also licensed as a hospice inpatient facility, both licenses shall be displayed.

E. Initial Licensure. All requirements of the application process must be completed by the applicant before the application will be processed by DHH.

1. No application will be reviewed until payment of the application fee.

2. An initial applicant shall, as a condition of licensure, submit the following:

a. a complete and accurate Hospice Application Packet. (This packet is purchased from DHH and contains the forms required for initial hospice licensure. The fee for this packet is set by DHH). The address provided on the application must be the address from which the agency will be operating;

b. current licensing fee by certified check, company check, or money order. Refer to the Fees section of this manual for information on fees;

c. line of credit from a federally insured, licensed, lending agency for at least $50,000 as proof of adequate

finances to sustain the hospice agency for at least six months;

d. proof of general and professional liability insurance, and worker's compensation of at least $300,000. The certificate holder shall be The Department of Health and Hospitals;

e. documentation of qualifications for administrator, director of nursing, and medical director. Any changes in the individuals designated or in their qualifications must be submitted to and approved by DHH prior to the initial survey;

f. disclosure of any financial and/or familial relationship with any other entity receiving third party payor funds, or any entity which has previously been licensed in Louisiana;

g. proof of criminal background investigations on the administrator and all owners. If a corporation, submit proof of criminal background investigations on all Board of Directors and principal owners;

F. Denial of Initial Licensure. An applicant may be denied a license for the following reasons:

1. failure to comply with applicable federal, state, and local laws;

2. failure to complete the application process;

3. conviction of a felony by an owner, administrator, or director of nursing, as shown by a certified copy of the record of the court, of the conviction of the above individual; or if the applicant is a firm or corporation, conviction of any of its members or officers, or of the person(s) designated to manage or supervise the Hospice agency.

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§8205. Survey

A. Initial Survey. An initial on-site survey will be conducted to assure compliance with all hospice minimum standards.

1. Within 90 days after submitting its application and fee, the hospice must complete the application process, must become operational to the extent of providing care to two and only two patients, must be in substantial compliance with applicable federal, state, and local laws, and must be prepared for the initial survey. If the applicant fails to meet this deadline, the application shall be considered closed and the agency shall be required to submit a new application packet including the license application fee.

2. The initial survey will be scheduled after the agency notifies the department that the agency has become operational and is ready for the survey as provided in §8205.A.1. In cases of a vast number of requests for surveys by different applicants, agencies will be surveyed according to the date the request is received by DHH.

3. If, at the initial licensure survey, the agency is in substantial compliance with all regulations, a Full license will be issued.

4. If, at the initial licensing survey, an agency has more than five violations of any minimum standards or if any of the violations are determined to be of such a serious nature that they may cause or have the potential to cause actual harm, DHH shall deny licensing.

5. If, at the initial licensure survey, an agency has more than five violations of any minimum standards or if the violations are determined to be of such a serious nature that they may cause or have the potential to cause actual harm, DHH shall deny licensure and the agency may not re-apply for a period of two years from the date of the survey.

B. Annual Licensing Survey. An unannounced annual on-site visit, or any other survey, which may include home visits, will be conducted to assure compliance with all applicable federal, state, and local laws and/or any other requirements.

C. Follow-up Survey. An on-site follow-up may be conducted whenever necessary to assure correction of violations. When applicable, DHH may clear violations at exit interview and/or by mail.

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§8207. Revocation or Denial of Renewal of License

A. The Secretary of DHH may deny an application for a license, or refuse to renew a license or revoke a license in accordance with R.S. 40:2187-2188. An agency's license may not be renewed and/or may be revoked for any of the following:

1. failure to be in substantial compliance with the hospice minimum standards;

2. failure to provide services essential to the palliative care of terminally ill individuals;

3. failure to uphold patient rights whereby violations may result in harm or injury;

4. failure of agency to protect patients/persons in the community from harmful actions of the agency employees; including, but not limited to, health and safety, coercion, threat, intimidation, and harassment;

5. failure to notify proper authorities of all suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause harm to the patient;

6. failure to maintain staff adequate to provide necessary services to current active patients;

7. failure to employ qualified personnel;

8. failure to remain fully operational at any time for any reason other than a disaster;

9. failure to submit fees including, but not limited to, annual fee, renewal fee, provisional follow-up fee, or change of agency address or name, or any fines assessed by DHH;

10. failure to allow entry to hospice agency or access to any requested records during any survey;

11. failure to protect patient from unsafe skilled and/or unskilled care by any person employed by the agency;

12. failure of agency to correct violations after being issued a provisional license;

13. agency staff or owner has knowingly, or with reason to know, made a false statement of a material fact in:

a. application for licensure;

b. data forms;

c. clinical record;

d. matter under investigation by the department;

e. information submitted for reimbursement from any payment source;

f. the use of false, fraudulent or misleading advertising;

g. that the agency staff misrepresented or was fraudulent in conducting hospice business;

h. convictions of a felony by an owner, administrator, director of nursing or medical director as shown by a certified copy of the record of the court of conviction of the above individual; or if the applicant is a firm or corporation, of any of its members or officers, or of the person designated to manage or supervise the hospice agency;

14. failure to maintain proper insurance; and

15. failure to comply with all reporting requirements in a timely manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2260 (December 1998), LR 29:2800 (December 2003).

§8209. License Renewal Process

A. License must be renewed at least annually.

B. Renewal packet includes forms required for renewal of license.

C. An agency seeking a renewal of its hospice license shall:

1. request a renewal packet from the bureau if one is not received at least 45 days prior to license expiration;

2. complete all forms and return to bureau at least 30 days prior to license expiration;

3. submit the current annual licensure fees with packet. An application is not considered to have been submitted unless the licensure fees are received.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2261 (December 1998).

§8211. Notice and Appeal Procedure

A. Notice shall be given in accordance with the current State Statutes.

B. Administrative Reconsideration. The hospice agency may request an administrative reconsideration of the violation(s) which support the departments actions. This reconsideration shall be conducted by a designated official(s) of the department who did not participate in the initial decision to impose the actions taken. Reconsideration shall be made solely on the basis of documents before the official and shall include the survey report and statement of violations and all documentation the agency submits to the department at the time of the agency's request for reconsideration. Correction of a violation shall not be a basis for reconsideration. A hearing shall not be held. Oral presentations can be made by the department's spokesperson(s) and the agency's spokesperson(s). This process is not in lieu of the appeals process and does not extend the time limits for filing an administrative appeal. The designated official shall have authority only to affirm the decision, to revoke the decision, to affirm part and revoke part, or to request additional information from either the department or the agency.

C. Administrative Appeal Process. Upon refusal of the DHH to grant a license as provided in the current State Statutes, or upon revocation or suspension of a license, or the imposition of a fine, the agency, institution, corporation, person, or other group affected by such action shall have the right to appeal such action by submitting a written request to the Secretary of the Department within 30 days after receipt of the notification of the refusal, revocation, suspension of a license, or imposition of a fine.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2261 (December 1998).

§8213. Fees

A. Any remittance submitted to DHH in payment of a required fee must be in the form of a company or certified check or money order made payable to the Department of Health and Hospitals.

B. Fee amounts are determined by DHH. (Check with DHH to determine the current required fees.)

C. Fees paid to DHH are not refundable.

D. A licensing fee is required for:

1. an initial application;

2. a renewal;

3. a change of controlling ownership.

E. Additional licensure fees are required for inpatient hospice facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2261 (December 1998).

§8215. Changes

A. DHH shall be notified, in writing, of any of the following within five working days following the occurrence:

1. address/location (An Inpatient Hospice facility must notify and receive approval by DHH prior to a change of address/location) - fee required;

2. agency name - fee required;

3. phone number;

4. hours of operation/24 hour contact procedure;

5. ownership (Controlling) - fee required;

6. change in address or phone number of any branch office;

7. administrator (completed Key Personnel Change Form, obtained from DHH, is required); and

8. director of nursing (completed Key Personnel Change Form required);

9. cessation of business. (See §8245.)

B. Change of Ownership. A representative of the buyer must request approval for a change of ownership prior to the sale.

1. Submit a written request to DHH for written approval to undergo a Change of Ownership. Change of Ownership (CHOW) Packets may be obtained from DHH. If the hospice had less than two active patients at the time of the most recent survey, and less than twenty new patients admitted since the last annual survey, the department may have issued a provisional license. Only an agency with a full license shall be approved to undergo a change of ownership.

2. Submit the following with the request for CHOW:

a. a new license application and the current licensing fee. The purchaser of the agency must meet all criteria required for initial licensure for hospice;

b. any changes in the name and or address of the agency;

c. any changes in administrative personnel;

d. disclosure of ownership forms.

3. Within five working days after the act of sale, submit a copy of the Bill of Sale and Articles of Incorporation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2262 (December 1998).

Subchapter B. Organization and Staffing

§8217. Personnel Qualifications/Responsibilities

A. Administrator. A person who is designated, in writing, by the Governing Body as administratively responsible for all aspects of hospice operations. When the administrator serves more than one licensed agency, he/she shall designate, in writing, an alternate to serve as administrator for each site where he/she is not physically housed continuously. The alternate shall be a full-time, on-site employee of the hospice and shall meet the same qualifications as the administrator. The administrator and the Director of Nurses/Alternates may be the same individual if that individual is dually qualified.

NOTE: A Director of Nurses, while employed by the hospice, may not be employed by any other licensed health care agency.

1. Qualifications. The administrator must be a licensed physician, a licensed registered nurse, a social worker with a masters degree, or a college graduate with a bachelor's degree, and must have at least three years of documented management experience in health care service delivery. However, a person who was employed by a licensed Louisiana hospice as the administrator as of December 20, 1998 shall be exempt from these requirements as long as he/she remains employed by that hospice as the administrator. If the hospice is sold to, acquired by, or merged into another legal entity, such transaction shall have no effect on the exemption provided in the preceding sentence.

2. Responsibilities. The Administrator shall be responsible for compliance with all regulations, laws, policies and procedures applicable to hospice specifically and to Medicare/Medicaid issues when applicable:

a. ensure the hospice employs qualified individuals;

b. be on-site during business hours or immediately available by telecommunications when off-site conducting the business of the hospice, and available after hours as needed;

c. be responsible for and direct the day-to-day operations of the hospice;

d. act as liaison among staff, patients, and governing board;

e. ensure that all services are correctly billed to the proper payer source;

f. designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the hospice if the administrator is unavailable; and

g. designate in advance the IDG he/she chooses to establish policies governing the day-to-day provisions of hospice care.

B. Counselor—Bereavement

1. Qualifications. Documented evidence of appropriate training, and experience in the care of the bereaved received under the supervision of a qualified professional.

2. Responsibilities. Under the supervision of a qualified professional, and as part of an organized program for the provision of bereavement services, the counselor shall implement bereavement counseling in a manner consistent with standards of practice. Services include, but are not limited to the following:

a. assess grief counseling needs;

b. provide bereavement information and referral services to the bereaved, as needed, in accordance with the POC;

c. provide bereavement support to hospice staff as needed;

d. attend hospice IDG meetings; and

e. document bereavement services provided and progress of bereaved on a clinical progress note to be incorporated in the clinical record.

C. Counselor—Dietary

1. Qualifications. A registered dietician or person who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association.

2. Responsibilities. The dietitian shall implement dietary services based on initial and ongoing assessment of dietary needs in a manner consistent with standards of practice including, but not limited to, the following:

a. evaluate outcomes of interventions and document findings on a clinical progress note which is to be incorporated into the clinical record within one week of the visit;

b. collaborate with the patient/family, physician, registered nurse, and/or the IDG in providing dietary counseling to the patient/family;

c. instruct patient/family and/or hospice staff as needed;

d. evaluate patient socioeconomic factors to develop recommendations concerning food purchasing, preparation and storage;

e. evaluate food preparation methods to ensure nutritive value is conserved, flavor, texture and temperature principles are adhered to in meeting the individual patient's needs;

f. participate in IDG conference as needed; and

g. be an employee of the hospice agency.

D. Counselor—Spiritual

1. Qualifications. Documented evidence of appropriate training and skills to provide spiritual counseling, such as Bachelor of Divinity, Master of Divinity or equivalent theological degree or training.

2. Responsibilities. The counselor shall provide spiritual counseling based on the initial and ongoing assessment of spiritual needs of the patient/family, in a manner consistent with standards of practice including, but not limited to, the following:

a. serve as a liaison and support to community chaplains and/or spiritual counselors;

b. provide consultation, support, and education to the IDG members on spiritual care;

c. supervise spiritual care volunteers assigned to family/care givers; and

d. attend IDG meetings.

E. Director of Nurses (DON). A person designated, in writing, by the Governing Body to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and responsible for compliance with regulatory requirements. The DON, or alternate, shall be immediately available to be on site, or on site, at all times during operating hours, and additionally as needed. If the DON is unavailable he/she shall designate a Registered Nurse to be responsible during his/her absence.

1. Qualifications. A registered nurse must be currently licensed to practice in the State of Louisiana:

a. with at least three years' experience as a registered nurse. One of these years shall consist of full-time experience in providing direct patient care in a hospice, home health, or oncology setting; and

b. be a full time, salaried employee of only the hospice agency. The Director of Nurses is prohibited from simultaneous/concurrent employment. While employed by the hospice, he or she may not be employed by any other licensed health care agency.

2. Responsibilities. The registered nurse shall supervise all patient care activities to assure compliance with current standards of accepted nursing and medical practice including, but not limited to, the following:

a. the POC;

b. implement personnel and employment policies to assure that only qualified personnel are hired. Verify licensure and/or certification (as required by law) prior to

employment and annually thereafter; maintain records to support competency of all allied health personnel;

c. implement hospice policies and procedures that establish and support quality patient care, cost control, and mechanisms for disciplinary action for infractions;

d. supervise employee health program;

e. assure compliance with local, state, and federal laws, and promote health and safety of employees, patients and the community, using the following non-exclusive methods:

i. resolve problems;

ii. perform complaint investigations;

iii. refer impaired personnel to proper authorities;

iv. provide for orientation and in-service training to employees to promote effective hospice services and safety of the patient, to familiarize staff with regulatory issues, and agency policy and procedures;

v. orient new direct health care personnel;

vi. perform timely annual evaluation of performance of health care personnel;

vii. assure participation in regularly scheduled appropriate continuing education for all health professionals and home health aides and homemakers;

viii. assure that the care provided by the health care personnel promotes effective hospice services and the safety of the patient; and

ix. assure that the hospice policies are enforced.

F. Governing Body

1. The hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation.

2. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

3. The governing body shall:

a. designate an individual who is responsible for the day to day management of the hospice program;

b. ensure that all services provided are consistent with accepted standards of practice;

c. develop and approve policies and procedures which define and describe the scope of services offered;

d. review policies and procedures at least annually and revise them as necessary; and

e. maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

G. Home Health Aide/Homemaker. A qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered nurse.

1. Qualifications. The home health aide/homemaker must meet one of the training requirements listed in §8217.F.a, b, and c and meet all other requirements:

a. have current nursing assistant certification and have successfully completed a Home Health Aide competency evaluation; or

b. have successfully completed a Home Health Aide training program and have successfully completed a competency evaluation; or

c. have successfully completed a Home Health Aide competency evaluation; and

d. exhibit maturity, a sympathetic attitude toward the patient, ability to provide care to the terminal patient, and ability to deal effectively with the demands of the job;

e. have the ability to read, write, and carry out directions promptly and accurately; and

f. when employed by more than one agency, inform all employers and coordinate duties to assure highest quality when providing services to the patients.

NOTE: The Home Health Aide competency evaluation is to be completed by a registered nurse prior to the Home Health Aide being assigned to provide patient care.

2. Responsibilities. The home health aide/homemaker shall provide services established and delegated in POC, record and notify the primary registered nurse of deviations according to standard practice including, but not limited to, the following:

a. perform simple one-step wound care if written documentation of in-service for that specific procedure is in the aide's personnel record. All procedures performed by the aide must be in compliance with current standards of nursing practice;

b. provide assistance with mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, toileting, and/or housekeeping needs. Some examples of assistance include:

i. helping the patient with a bath, care of the mouth, skin and hair;

ii. helping the patient to the bathroom or in using a bed pan or urinal;

iii. helping the patient to dress and/or undress;

iv. helping the patient in and out of bed, assisting with ambulating;

v. helping the patient with prescribed exercises which the patient and home health aide have been taught by appropriate personnel; and

vi. performing such incidental household services essential to the patient's health care at home that are necessary to prevent or postpone institutionalization;

d. complete a clinical note for each visit, which must be incorporated into the record at least on a weekly basis.

3. Restrictions. The home health aide/homemaker shall not:

a. perform any intravenous procedures, procedures involving the use of Levine tubes or Foley catheters, or any other sterile or invasive procedures, other than rectal temperatures or enemas;

b. administer medications to any patient.

4. Initial Orientation. The content of the basic orientation provided to home health aides shall include the following:

a. policies and objectives of the agency;

b. duties and responsibilities of a home health aide/homemaker;

c. the role of the home health aide/homemaker as a member of the health care team;

d. emotional problems associated with terminal illness;

e. the aging process;

f. information on the process of aging and behavior of the aged;

g. information on the emotional problems accompanying terminal illness;

h. information on terminal care, stages of death and dying, and grief;

i. principles and practices of maintaining a clean, healthy and safe environment;

j. ethics; and

k. confidentiality.

NOTE: The orientation and training curricula for home health aides/homemakers shall be detailed in a policies and procedures manual maintained by the hospice agency and provision of orientation and training shall be documented in the employee personnel record.

5. Initial Training shall include the following areas of instruction:

a. assisting patients to achieve optimal activities of daily living;

b. principles of nutrition and meal preparation;

c. record keeping;

d. procedures for maintaining a clean, healthful environment; and

e. changes in the patients' condition to be reported to the supervisor.

6. In-service Training. Home Health Aide/homemaker must have a minimum of 12 hours of appropriate in-service training annually. Six of these hours of in-service training must be provided each six months. In-service training may be prorated for employees working a portion of the year. However, part-time employees who worked throughout the year must attend all twelve hours of in-service training. The in-service may be furnished while the aide is providing service to the patient, but must be documented as training.

H. Licensed Practical Nurse. The L.P.N. must work under the direct supervision of a registered nurse and perform skilled nursing services as delegated by the registered nurse. The role of the L.P.N. in hospice is limited to stable hospice patients.

1. Qualifications. A licensed practical nurse must be currently licensed by the Louisiana State Board of Practical Nurse Examiners with no restrictions:

a. with at least two years of full time experience as an L.P.N.

b. be an employee of the hospice agency; and

c. when employed by more than one agency the LPN must inform all employers and coordinate duties to assure quality provision of services.

2. Responsibilities. The L.P.N. shall perform skilled nursing services under the supervision of a registered nurse, in a manner consistent with standards of practice, including but not limited to, such duties as follows:

a. observe, record, and report to the registered nurse or director of nurses on the general physical and mental conditions of the patient;

b. administer prescribed medications and treatments as permitted by State or Local regulations;

c. assist the physician and/or registered nurse in performing specialized procedures;

d. prepare equipment for treatments, including sterilization, and adherence to aseptic techniques;

e. assist the patient with activities of daily living;

f. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;

g. perform complex wound care if in-service is documented for specific procedure;

h. perform routine venipuncture (phlebotomy) if written documentation of competency is in personnel record. Competency must be evaluated by an RN even if LPN has completed a certification course; and

i. receive orders from the physician and follow those that are within the realm of practice for an LPN and within the standards of hospice practice.

3. Restrictions. An LPN shall not:

a. access any intravenous appliance for any reason;

b. perform supervisory aide visit;

c. develop and/or alter the POC;

d. make an assessment visit;

e. evaluate recertification criteria;

f. make aide assignments; or

g. function as a supervisor of the nursing practice of any registered nurse.

I. Medical Director/Physician Designee. A physician, currently and legally authorized to practice medicine in the State, and knowledgeable about the medical and psychosocial aspects of hospice care. The Medical Director reviews, coordinates, and is responsible for the management of clinical and medical care for all patients.

NOTE: The Medical Director or Physician Designee may be an employee or a volunteer of the hospice agency. The hospice agency may also contract for the services of the Medical Director or Physician Designee.

1. Qualifications. A Doctor of Medicine or Osteopathy licensed to practice in the state of Louisiana.

2. Responsibilities. The Medical Director or Physician designee assumes overall responsibility for the medical component of the hospice's patient care program and shall include, but not be limited to:

a. serve as a consultant with the attending physician regarding pain and symptom control as needed;

b. serve as the attending physician if designated by the patient/family unit;

c. review patient eligibility for hospice services;

d. serve as a medical resource for the hospice interdisciplinary group;

e. act as a liaison to physicians in the community;

f. develop and coordinate procedures for the provision of emergency care;

g. provide a system to assure continuing education for hospice medical staff as needed;

h. participate in the development of the POC prior to providing care, unless the POC has been established by an attending physician who is not also the Medical Director or Physician Designee; and

i. participate in the review and update of the POC, unless the plan of care has been reviewed/updated by the attending physician who is not also the Medical Director or Physician Designee. These reviews must be documented.

J. Social Worker

1. Qualifications. A master's degree from a school of social work accredited by the Council on Social Work Education:

a. documented clinical experience appropriate to the counseling and casework needs of the terminally ill.

b. must be an employee of the hospice; and

c. when the Social Worker is employed by one or more agencies he/she must inform all employers and cooperate and coordinate duties to assure the highest performance of quality when providing services to the patient.

2. Responsibilities. The social worker shall assist the physician and other IDG members in understanding significant social and emotional factors related to the patient's health status and shall include, but not be limited to:

a. assessment of the social and emotional factors having an impact on the patient's health status;

b. assist in the formulation of the POC;

c. provide services within the scope of practice as defined by state law and in accordance with the POC;

d. coordination with other IDG members and participate in IDG conferences;

e. prepare clinical and/or progress notes and incorporate them into the clinical record within one week of the visit;

f. participate in discharge planning, and in-service programs related to the needs of the patient;

g. acts as a consultant to other members of the IDG; and

h. when medical social services are discontinued, submit a written summary of services provided, including an assessment of the patient's current status, to be retained in the clinical record.

K. Occupational Therapist

1. Qualifications. A occupational therapist must be licensed by the State of Louisiana and registered by the American Occupational Therapy Association.

2. Responsibilities. The occupational therapist shall assist the physician in evaluating the patient's level of functioning by applying diagnostic and prognostic procedures including, but not limited to, the following:

a. provide occupational therapy in accordance with a physician's orders and the POC;

b. guide the patient in his/her use of therapeutic, creative, and self-care activities for the purpose of improving function, in a manner consistent with accepted standards of practice;

c. observe, record, and report to the physician and/or interdisciplinary group the patient's reaction to treatment and any changes in the patient's condition;

d. instruct and inform other health team personnel including, when appropriate, home health aides/homemakers and family members in certain phases of occupational therapy in which they may work with the patient;

e. document each visit made to the patient and incorporate notes into the clinical record within one week of the visit;

f. participate in IDG conference as needed with hospice staff; and

g. prepare written discharge summary when applicable, with a copy retained in patient's clinical record and a copy forwarded to the attending physician.

3. Supervision of an Occupational Therapy Assistant

a. The occupational therapist shall conduct the initial assessment and establish the goals and treatment plan before the licensed and certified occupational therapy assistant may treat the patients on site without the physical presence of the occupational therapist.

b. The occupational therapist and the occupational therapy assistant must schedule joint visits at least once every two weeks or every four to six treatment sessions.

c. The occupational therapist must review and countersign all progress notes written by the licensed and certified occupational therapy assistant.

d. In the occupational therapist/occupational therapy assistant relationship, the supervising occupational therapist retains overall personal responsibility to the patient, and accountability to the Louisiana Board of Medical Examiners for the patients' care.

e. The supervising occupational therapist is responsible for:

i. assessing the competency and experience of the occupational therapy assistant;

ii. establishing the type, degree and frequency of supervision required in the home health care setting.

L. Occupational Therapy Assistant (OTA)

1. Qualifications. The occupational therapist assistant must be licensed by the Louisiana Board of Medical Examiners to assist in the practice of occupational therapy under the supervision of a licensed Registered Occupational Therapist and have at least two years experience as a licensed OTA before starting hospice caseload.

M. Physical Therapist (PT). The physical therapist when provided must be available to perform in a manner consistent with accepted standards of practice.

1. Qualifications. The physical therapist must be currently licensed by the Louisiana State Board of Physical Therapy Examiners and have graduated from a physical therapy curriculum approved by:

a. the American Physical Therapy Association; or

b. the Council on Medical Education and Hospitals of the American Medical Association; or

c. the Council on Medical Education of the American Medical Association and the American Physical Therapy Association.

2. Responsibilities. The physical therapist shall assist the physician in evaluating the patient's functional status and physical therapy needs in a manner consistent with standards of practice to include, but is not limited to, the following:

a. assist in the formation of the POC;

b. provide services within the scope of practice as defined by state law governing the practice of physical therapy, in accordance with the POC, and in coordination with the other members of the IDG;

c. observe, and report to the physician and the IDG, the patient's reaction to treatment and any changes in the patient's condition;

d. instruct and inform participating members of the IDG, the patient, family/care givers, regarding the POC, functional limitations and progress toward goals;

e. prepare clinical and progress notes for each visit and incorporate them into the clinical record within one week of the visit;

f. when physical therapy services are discontinued, prepare written discharge summary, with a copy retained in the patient's clinical record and a copy forwarded to the attending physician;

g. participate in IDG conference as needed with hospice staff.

3. Supervision of Physical Therapy Assistant (PTA)

a. The physical therapist shall be readily accessible by telecommunications.

b. The physical therapist shall evaluate and establish a written treatment plan on the patient prior to implementation of any treatment program.

c. The physical therapist shall treat and reassess the patient on at least every sixth visit, but not less than once per month.

d. The physical therapist shall conduct, once weekly, a face-to-face patient care conference with each PTA to review progress and modification of treatment programs for all patients.

e. The physical therapist shall assess the final treatment rendered to the patient at discharge and write a discharge summary.

N. Physical Therapy Assistant (PTA)

1. Qualifications. A physical therapy assistant must be licensed by the Physical Therapy Board of Louisiana and supervised by a Physical Therapist.

2. Responsibilities. The physical therapy assistant shall:

a. provide therapy in accordance with the POC;

b. document each visit made to the patient and incorporate notes into the clinical record at least weekly; and

c. participates in IDG conference as needed with hospice staff.

O. Registered Nurse (RN). The hospice must designate a registered nurse to coordinate the implementation of the POC for each patient.

1. Qualifications. A licensed registered nurse must be currently licensed to practice in the state of Louisiana with no restrictions:

a. have at least two years of full time experience as a registered nurse. However, two years of full time clinical experience in hospice care as a licensed practical nurse may be substituted for the required two years of experience as a registered nurse;

b. have at least two years' full time experience as a registered nurse (however, a person who was employed by a hospice as a registered nurse as of December 20, 1998 shall be exempt from this requirement as long as he/she remains employed by a hospice as a registered nurse); and

c. be an employee of the hospice. If the registered nurse is employed by more than one agency, he or she must inform all employers and coordinate duties to assure quality service provision.

2. Responsibilities. The registered nurse shall identify the patient/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days:

a. provide nursing services in accordance with the POC;

b. document problems, appropriate goals, interventions, and patient/family response to hospice care;

c. collaborate with the patient/family, attending physician and other members of the IDG in providing patient and family care;

d. instruct patient/family in self-care techniques when appropriate;

e. supervise ancillary personnel and delegates responsibilities when required;

f. complete and submit accurate and relevant clinical notes regarding the patient's condition into the clinical record within one week of the visit;

g. if a home health aide/homemaker is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN in charge of that patient;

h. supervise and evaluate the home health aide/homemaker's ability to perform assigned duties, to relate to the patient and to work effectively as a member of the health care team;

i. perform supervisory visits to the patient's residence at least every 14 days to assess relationships and determine whether goals are being met. A supervisory visit with the aide present must be made at least once every three months;

j. document supervision, to include the aide/homemaker-patient relationships, services provided and instructions and comments given as well as other requirements of the clinical note; and

k. annual performance review for each aide/homemaker documented in the individual's personnel record.

P. Speech Pathology Services

1. Qualifications. A speech pathologist must:

a. be licensed by the State of Louisiana and certified by the American Speech and Hearing Association; or

b. completed the academic requirements and is in the process of accumulating the necessary supervised (as directed by the State Certifying body) work experience required for certification. Evidence of this supervision will be retained in the non-certified speech pathologist's personnel folder.

2. Responsibilities. The speech pathologist shall assist the physician in evaluation of the patient to determine the type of speech or language disorder and the appropriate corrective therapy in a manner consistent with standards of practice to include, but is not limited to, the following:

a. provide rehabilitative services for speech and language disorders;

b. observe, record and report to the physician and the IDG the patient's reaction to treatment and any changes in the patient's condition;

c. instruct other health personnel and family members in methods of assisting the patient to improve and correct speech disabilities;

d. communicate with the registered nurse, director of nurses, and/or the IDG the need for a continuation of speech pathology services for the patient;

e. participate in IDG conferences;

f. document each visit made to the patient and incorporate notes into the clinical record within one week of the visit; and

g. prepare written discharge summary as indicated, with a copy retained in patient's clinical record and a copy forwarded to the attending physician.

Q. Volunteers. The volunteer may and are designed to play a vital role in enhancing the quality of care delivered to the patient/family by encouraging community participation in the overall hospice program. Volunteers that provide patient care and support services according to their experience and training must be in compliance with agency policies, and under the supervision of a designated hospice employee.

1. Qualifications. A mature, non-judgmental, caring individual supportive of the hospice concept of care, willing to serve others, and appropriately oriented and trained. Volunteers who are qualified to provide professional services must meet all standards associated with their specialty area.

2. Responsibilities. The volunteer shall:

a. provide assistance to the hospice program, and/or patient/family in accordance with designated assignments;

b. provide input into the plan of care and interdisciplinary group meetings, as appropriate;

c. document services provided as trained and instructed by the hospice agency;

d. maintain strict patient/family confidentiality; and

e. communicate any changes or observations to the assigned supervisor.

3. Training. The volunteers must receive appropriate documented training which shall include at a minimum:

a. an introduction to hospice;

b. the role of the volunteer in hospice;

c. concepts of death and dying;

d. communication skills;

e. care and comfort measures;

f. diseases and medical conditions;

g. psychosocial and spiritual issues related to death and dying;

h. the concept of the hospice family;

i. stress management;

j. bereavement;

k. infection control;

l. safety;

m. confidentiality;

n. patient rights;

o. the role of the IDG; and

p. additional supplemental training for volunteers working in specialized programs (i.e. Nursing homes, AIDS facilities).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR:15:482 (June 1989), amended LR 24:2262 (December 1998), LR 25:2409 (December 1999), LR 29:2801 (December 2003).

Subchapter C. Patient Care Services

§8219. Patient Care Standard

A. Patient Certification. To be eligible for hospice care, an individual, or his/her representative, must sign an election statement with a licensed hospice; the individual must have a certification of terminal illness and must have a plan of care (POC) which is established before services are provided.

B. Admission criteria. The hospice shall have written policies to be followed in making decisions regarding acceptance of patients for care. Decisions are based upon medical, physical and psychosocial information provided by the patient's attending physician, the patient/family and the interdisciplinary group. The admission criteria shall include:

1. the ability of the agency to provide core services on a 24-hour basis and provide for or arrange for non-core services on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

2. certification of terminal illness signed by the attending physician and the medical director of the agency;

3. assessment of the patient/family needs and desires for hospice services;

4. informed consent signed by patient or representative who is authorized in accordance with state law to elect the hospice care, which will include the purpose and scope of hospice services; and

5. patient meets all other criteria required by any applicable payor sources.

C. Admission procedure. Patients are to be admitted only upon the order of the patient's attending physician.

1. An assessment visit shall be made by a Registered Nurse, who will assess the patient's needs with emphasis on pain and symptom control. This assessment shall occur within 48 hours of referral for admission, unless otherwise ordered by physician or unless a request for delay is made by patient/family.

2. Documentation at admission will be retained in the clinical record and shall include:

a. signed consent forms;

b. signed patient's rights statement;

c. clinical data including physician order for care;

d. patient Release of Information;

e. orientation of the patient/care giver, which includes:

i. advanced directives;

ii. agency services;

iii. patient's rights; and

iv. agency contact procedures;

f. for an individual who is terminally ill, certification of terminal illness signed by the medical director or the physician member of the IDG and the individual's attending physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2268 (December 1998).

§8221. Plan of Care (POC)

A. Prior to providing care, a written plan of care is developed for each patient/family by the attending physician, the Medical Director or physician designee and the IDG. The care provided to an individual must be in accordance with the POC.

1. The initial plan of care (IOPC) will be established on the same day as the assessment if the day of assessment is to be a covered day of hospice.

2. The IDG member who assesses the patient's needs must meet or call at least one other IDG member before writing the IPOC. At least one of the persons involved in developing the IPOC must be a registered nurse or physician. Within 2 days of the assessment, the other members of the IDG must review the IPOC and provide their input. This input may be by telephone. The IPOC is signed by the attending physician and an appropriate member of the IDG.

3. At a minimum the POC will include the following:

a. an assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;

b. in detail, the scope and frequency of services needed to meet the patient's and family's needs;

c. identification of problems with realistic and achievable goals and objectives;

d. medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions;

e. patient/family understanding, agreement and involvement with the POC; and

f. recognition of the patient/family's physiological, social, religious and cultural variables and values.

4. The POC is incorporated into the individual clinical record.

5. The hospice will designate a Registered Nurse to coordinate the implementation of the POC for each patient.

B. Review and Update of the Plan of Care. The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes, and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDG and the attending physician.

1. Agency shall have policy and procedures for the following:

a. the attending physician's participation in the development, revision, and approval of the POC is documented. This is evidenced by change in patient orders and documented communication between Hospice Staff and the attending physician;

b. physician orders must be signed and dated in a timely manner, not to exceed 14 days, unless the hospice has documentation that verifies attempts to get orders signed; in this situation up to 30 days will be allowed.

2. The agency shall have documentation that the patient's condition and POC is reviewed and the POC updated, even when the patient's condition does not change.

C. Coordination and Continuity of Care. The hospice shall adhere to the following additional principles and responsibilities:

1. an assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;

2. nursing services, physician services, and drugs and biologicals are routinely available to hospice patients on a 24-hour basis, seven days a week;

3. all other covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

4. case-management is provided and an accurate and complete documented record of services and activities describing care of patient/family is maintained;

5. collaboration with other providers to ensure coordination of services;

6. maintenance of professional management responsibility and coordination of the patient/family care regardless of the setting;

7. maintenance of contracts/ agreements for the provision of services not directly provided by the hospice, including but not limited to:

a. radiation therapy;

b. infusion therapy;

c. inpatient care;

d. consulting physician;

8. provision or access to emergency medical care;

9. when home care is no longer possible, assistance to the patient in transferring to an appropriate setting where hospice care can be delivered;

10. when the patient is admitted to a setting where hospice care cannot be delivered, hospice adheres to standards, policies and procedures on transfer and discharge and facilitates the patient's transfer to another care provider;

11. maintenance of appropriately qualified IDG health care professionals and volunteers to meet patients need;

12. maintenance and documentation of a volunteer staff to provide administrative or direct patient care. The hospice must document a continuing level of volunteer activity;

13. coordination of the IDG, as well as of volunteers, by a qualified health care professional, to assure continuous

assessment, continuity of care and implementation of the POC;

14. supervision and professional consultation by qualified personnel, available to staff and volunteers during all hours of service;

15. hospice care provided in accordance with accepted professional standards and accepted code of ethics;

16. each member of the IDG accepts a fiduciary relationship with the patient/family, maintaining professional boundaries and an understanding that it is the responsibility of the IDG to maintain appropriate agency/patient/family relationships;

17. written policy to follow at the time of death of the patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health ServicesFinancing, LR 15:482 (June 1989), amended LR 24:2268 (December 1998).

§8223. Pharmaceutical Services

A. Hospice provides for the pharmaceutical needs of the patient, consistent with the Board of Pharmacy regulations.

1. Agency shall institute procedures which protect the patient from medication errors.

2. Agency shall provide verbal and written instruction to patient and family as indicated.

3. Drugs and treatments are administered by agency staff only as ordered by the physician.

B. Hospice ensures the appropriate monitoring and supervision of pharmaceutical services and has written policies and procedures governing prescribing, dispensing, administering, controlling, storing and disposing of all biologicals and drugs in compliance with applicable laws and regulations.

C. Hospice ensures timely pharmaceutical services on a 24 hour a day/seven day a week basis that include provision of drugs, biologicals and infusion services which are consistent with patient's individual drug profile.

D. Hospice provides the IDG and the patient/family with coordinated information and instructions about individual drug profiles.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998).

§8225. Pathology and Laboratory Services

A. Hospice provides or has access to pathology and laboratory services which comply with CLIA guidelines; and meet patient's needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998).

§8227. Radiology Services

A. Radiology services provided by hospice either directly; or under arrangements that must comply with Federal and State regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998).

§8229. Discharge/Revocation/Transfer

A. Hospice provides adequate and appropriate patient/family information at discharge, revocation, or transfer.

B. Discharge. Patient shall be discharged only in the following circumstance:

1. change in terminal status;

2. patient relocates from the hospice's geographically defined service area;

3. if the safety of the patient or of the hospice staff is compromised. The hospice shall make every effort to resolve these problems satisfactorily before discharge. All efforts by the hospice to resolve the problem must be documented in detail in the patient's clinical record; and

4. if the patient enters a non-contracted nursing home or hospital and all options have been exhausted (a contract is not attainable, the patient chooses not to transfer to a facility with which the hospice has a contract, or to a hospice with which the SNF has a contract), the hospice shall then discharge the patient. The hospice must notify the payor source to document that all options have been pursued and that the hospice is not “dumping” the patient;

5. the hospice must clearly document why the hospice found it necessary to discharge the patient.

C. Revocation. Occurs when the patient or representative makes a decision to discontinue receiving hospices services:

1. a recipient may revoke hospice care at any time. This is a right that belongs solely and exclusively to the patient or representative;

2. an effective date earlier than the actual date the revocation is made and signed cannot be designated;

3. if a patient or representative chooses to revoke from hospice care, the patient must sign a statement that he or she is aware of the revocation and stating why revocation is chosen.

D. Non Compliance. When a patient is non-compliant, the hospice may counsel the patient/family on the option to

revoke and any advantages or disadvantages of the decision that is made. A patient is considered non-compliant if:

1. the patient seeks or receives curative treatment for the illness; or

2. the patient seeks treatment related to the terminal illness in a facility that does not have a contract with the hospice;

3. the patient seeks treatment related to the terminal illness that is not in the POC, or is not pre-approved by the hospice.

E. Transfer. To change the designation of hospice programs, the individual must file with the hospice from which he/she has received care and with the newly designated hospice, a signed statement which includes the following information:

1. the name of the hospice from which the individual has received care;

2. the name of the hospice to which he/she plans to receive care;

3. the date of discharge from the first hospice and the date of admission to the second hospice; and

4. the reason for the transfer;

5. appropriate discharge plan/summary is to be written, and appropriate continuity of care is to be arranged.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998).

§8231. Patient Rights and Responsibilities

A. The hospice shall insure that the patient has the right to:

1. be cared for by a team of professionals who provide high quality comprehensive hospice services as needed and appropriate for patient/family;

2. have a clear understanding of the availability of hospice services and the hospice team 24 hours a day, seven days a week;

3. receive appropriate and compassionate care, regardless of diagnosis, race, age, gender, creed, disability, sexual orientation, place of residence, or the ability to pay for the services rendered;

4. be fully informed regarding patient status in order to participate in the POC. The hospice professional team will assist patient/family in identifying which services and treatments will help attain these goals;

5. be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as appropriate to patient/family personal wishes;

6. be treated with respect and dignity;

7. have patient/family trained in effective ways of caring for patient;

8. confidentiality with regard to provision of services and all client records, including information concerning patient/family health status, as well as social, and/or financial circumstances. The patient information and/or records may be released only with patient/family's written consent, and/or as required by law;

9. voice grievances concerning patient care, treatment, and/or respect for person or privacy without being subject to discrimination or reprisal, and have any such complaints investigated by the hospice; and

10. be informed of any fees or charges in advance of services for which patient/family may be liable. Patient/family has the right to access any insurance or entitlement program for which patient may be eligible.

B. Informed Consent. An informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness shall be obtained, either from the individual or representative.

C. The patient has the responsibility to:

1. participate in developing the POC and update as his or her condition/needs change;

2. provide hospice with accurate and complete health information;

3. remain under a doctor's care while receiving hospice services; and

4. assist hospice staff in developing and maintaining a safe environment in which patient care can be provided.

D. The agency shall have written policies and procedures to address these concerns identified under §8231.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2270 (December 1998).

§8233. Clinical Records

A. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record for every individual receiving care and services. The record shall be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social, and other therapeutic information, including the current POC under which services are being delivered.

B. Hospice records must be maintained in a distinct location and not mingled with records of other types of health care related agencies.

C. Original clinical records shall be kept in a safe and confidential area which provides convenient access to clinicians.

D. The agency shall have policies addressing who is permitted access to the clinical records. No unauthorized person shall be permitted access to the clinical records.

E. All clinical records shall be safeguarded against loss, destruction and unauthorized use.

F. Records shall be maintained for five years from the date of discharge, unless there is an audit or litigation affecting the records. Records for individuals under the age of majority shall be kept in accordance with current state and federal law.

G. When applicable, the agency will obtain a signed "release of information" from the patient and/or the patient's family; a copy will be retained in the record.

H. The clinical record shall contain a comprehensive compilation of information including, but not limited to, the following:

1. initial and subsequent Plans of Care and initial assessment;

2. certifications of terminal illness;

3. written physician's orders for admission and changes to the POC;

4. current clinical notes (at least the past 60 days);

5. Plan of Care;

6. signed consent, authorization and election forms;

7. pertinent medical history; and

8. identifying data, including name, address, date of birth, sex, agency case number; and next of kin.

I. Entries are made for all services provided and are signed by the staff providing the service.

J. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2270 (December 1998).

Subchapter D. Administration

§8235. Agency Operations

A. Premises (see definition of Hospice Premises).

1. Staff must be able to distinguish and describe the scope and delineation of all activities being provided by the hospice.

2. Staff working areas are to be designed so that when planning for services, patient confidentiality is maintained.

3. The hospice must have a distinct telephone number. If the telephone number is shared with other health care related agencies, the telephone operator(s) must demonstrate knowledge and ability to distinguish and direct calls to the appropriate persons. If an answering service is used after normal hours, there must be evidence of distinct hospice staff and the answering service should be able to direct calls to the appropriate persons for each service.

4. The hospice shall not share office space with a non-health care related entity. When office space is shared with another health care related entity the hospice agency must operate separate and apart.

B. Hours of Operation

1. The hospice shall be required to have regular posted (in a prominent and easily accessible manner) business hours and be fully operational at least eight hours a day, five days a week between 7:00 a.m. and 6:00 p.m. Hospice services are available 24 hours per day, seven days a week, which include, at a minimum:

a. professional Registered Nurse services;

b. palliative medications;

c. other services, equipment or supplies necessary to meet the patient’s immediate needs.

2. Hospice provides on-call medical and nursing services to assess and meet changing patient/family needs, provide instruction and support, and conduct additional on-site assessment or treatment, 24 hours a day, seven days per week.

C. Policies and Procedures:

1. must be written, current, and annually reviewed by appropriate personnel;

2. must contain policies and procedures specific to agency addressing personnel standards and qualifications, agency operations, patient care standards, problem and complaint resolution, purpose and goals of operation, the hospice's defined service area, as well as regulatory and compliance issues; and

3. must meet or exceed requirements of the Minimum Standards and all applicable federal, state, and local laws.

D. Operational Requirements

1. Hospice’s responsibility to the community:

a. shall not accept orders to assess or admit from any source other than licensed physician or authorized physician representative (e.g. hospital discharge planner). Although the hospice may provide care to relatives of employees, the order to admit to the hospice must be initiated by the primary attending physician;

b. shall use only factual information in advertising;

c. shall not participant in door to door solicitation;

d. shall not accept as a patient any person who is not terminally ill;

e. shall develop policy/procedure for patients with no or limited payor source;

f. shall have policy and procedures and a written plan for emergency operations in case of disaster;

g. provide all services needed in a timely manner, at least within 24 hours, unless physicians orders indicate otherwise. However, admission time-frames shall be followed as indicated in the Admission Procedures subsection;

h. is prohibited from harassing or coercing a prospective patient or staff member to use a specific hospice or to change to another hospice;

i. must have policy and procedures for post-mortem care in compliance with all applicable federal, state, and local laws;

j. may participate as community educators in community/health fairs; and

k. may provide free non-invasive diagnostic tests, such as blood pressure screening.

2. Hospice's responsibility to the patient shall include, but is not limited to, the following:

a. be in compliance with Minimum Standards and all applicable federal, state, and local laws at all times;

b. provide all Core services directly by the hospice agency and any non-core services required to meet the patient/family's needs;

c. act as the patient advocate in medical decisions affecting the patient;

d. protect the patient from unsafe skilled and unskilled practices;

e. protect the patient from being harassed, bribed, and/or any form of mistreatment by any employee or volunteer of the agency;

f. provide patient information on the patient's rights and responsibilities;

g. provide information on advanced directives in compliance with all applicable federal, state, and local laws;

h. protect and assure that patient's rights are not violated;

i. focus on enabling the patient remaining in the familiar surroundings of his/her place of residence as long as possible and appropriate;

j. encourage the patient/family to participate in developing the POC and provision of hospice services;

k. with the permission of the patient, include in the POC specific goals for involving the patient/family;

l. make appropriate referrals for family members outside the hospice's service area for bereavement follow-up;

m. whenever a hospice program manages and/or delivers care in a facility, ensure that an appropriate standard of care is provided to the patient in the facility, regardless of whether or not hospice is responsible for the direct provision of those services;

n. ensure that any facility where hospice care is provided meets appropriate licensing requirements and any payor source requirements when applicable;

o. ensure that any facility in which hospice care is provided have the following:

i. areas that are designed and equipped for the comfort and privacy of each patient and family member;

ii. physical space for private patient/family visiting;

iii. accommodations for family members to remain with the patient throughout the night;

iv. accommodations for family privacy after a patient's death;

v. decor which is homelike in design and function; and

vi. patients must be permitted to receive visitors at any hour, including small children.

3. Responsibility of the hospice to the staff shall include, but is not limited to, the following:

a. provide safe environment whenever the hospice knows or has reason to know that environment might be dangerous;

b. have safety and emergency preparedness programs that conform with federal, state, and local requirements and that include:

i. a plan for reporting, monitoring, and follow-up on all accidents, injuries, and safety hazards;

ii. documentation of all reports, monitoring activity, and follow-up actions, education for patient/family, care givers, employees and volunteers on the safe use of medical equipment;

iii. evidence that equipment maintenance and safety requirements have been met;

iv. policies and procedures for storing, accessing, and distributing abusable drugs, supplies and equipment;

v. a safe and sanitary system for identifying, handling, and disposing of hazardous wastes; and

vi. a policy regarding use of smoking materials in all care settings;

c. have policies which encourage realistic performance expectations;

d. maintain insurance and workman's compensation at all times;

e. provide adequate time on schedule for required travel;

f. meet or exceed Wage and Hour Board requirements;

g. provide adequate information, in-service training, supplies, and other support for all employees to perform to the best of their ability; and

h. provide in-service training to promote effective, quality hospice care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2271 (December 1998).

§8237. Contract Services

A. When the hospice provides services on a contractual basis to a patient the hospice is responsible for all actions of the contract personnel.

B. The hospice shall not at any time use contract employees as administrator/alternate or for the provision of core services, except that physician services may be provided through contract.

C. Whenever services are provided by an organization/individual other than the hospice, a written agreement will delineate services available and procedures for accessing those services.

D. Whenever services are provided by an outside agency or individual, a legally binding written agreement must be effected. The legally binding written agreement shall include at least the following items:

1. identification of the services to be provided;

2. a stipulation that services may be provided only with the express authorization of the hospice;

3. the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;

4. the delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment, and the IDG conferences;

5. requirements for documenting that services are furnished in accordance with the agreement;

6. the qualifications of the personnel providing the services;

7. assurance that the personnel contracted complete the clinical record in the same timely manner as required by the staff personnel of the hospice;

8. payment fees and terms; and

9. statement that the hospice retains responsibility for appropriate hospice care training of the personnel who provide care under the agreement.

E. The hospice shall document review of its contracts on an annual basis.

F. The hospice is to coordinate services with contract personnel to assure continuity of patient care.

G. Hospice maintains professional management responsibilities for those services and ensures that they are furnished in a safe and effective manner by qualified persons and in accordance with the patient's POC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2272 (December 1998), LR 29:2801 (December 2003).

§8239. Quality Assurance

A. Agency shall have an on-going, comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care, including inpatient care, home care, and care provided by arrangement, is provided at all times in compliance with accepted standards of professional practice.

B. The hospice shall have written plans, policies and procedures addressing quality assurance.

C. Hospice monitors and evaluates its resource allocation regularly to identify and resolve problems with the utilization of its services, facilities and personnel.

D. Hospice follows a written plan for continually assessing and improving all aspects of operations which include:

1. goals and objectives;

2. the identity of the person responsible for the program;

3. a system to ensure systematic, objective regular reports are prepared and distributed to appropriate areas;

4. the method for evaluating the quality and the appropriateness of care;

5. a method for resolving identified problems; and

6. application to improving the quality of patient care.

E. The plan is reviewed at least annually and revised as appropriate.

F. The governing body and administration strive to create a work environment where problems can be openly addressed and service improvement ideas encouraged.

G. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes:

1. services provided by professional and volunteer staff;

2. outcome audits of patient charts;

3. reports from staff, volunteers, and clients about services;

4. concerns or suggestions for improvement in services;

5. organizational review of the hospice program;

6. patient/family evaluations of care; and

7. high-risk, high-volume and problem-prone activities.

H. When problems are identified in the provision of hospice care, there shall be evidence of corrective actions, including ongoing monitoring, revisions of policies and procedures, educational intervention and changes in the provision of services.

I. The effectiveness of actions taken to improve services or correct identified problems is evaluated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2273 (December 1998).

§8241. Branch Offices

A. No branch office may be opened without written approval from DHH.

B. No branch office may be opened unless the parent office has had full licensure for at least the immediately preceding 12 months and has a current census of at least 10 active patients.

C. Each branch must serve the same or part of the geographic area approved for the parent.

D. Each branch office must have a registered nurse immediately available to be on site, or on site in the branch office at all times during operating hours.

E. All services provided by the parent agency must be available in the branch.

F. The branch site shall retain all Clinical Records for its patients. Duplicate records need not be maintained at the parent agency, but shall be made available to federal/state surveyors during any review upon request.

G. Original personnel files are to be kept at the parent agency, but shall be made available to federal/state surveyors during any review upon request.

H. A statement of personnel policies is maintained in each branch for staff usage.

I. Approval for branch offices will be issued, in writing, by DHH for one year and will be renewed at time of re-licensure if the branch office meets the following criteria:

1. is operational and providing hospice services;

2. serve only patients who are geographically nearer to branch than to parent office;

3. offer exact same services as the parent agency; and

4. parent office meets requirements for full licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2273 (December 1998), LR 25:2409 (December 1999).

§8243. Sub-Units

A. A sub-unit shall have:

1. a separate license; and

2. not serve the same geographical area as the parent agency.

B. Sub-unit shall be:

1. administratively independent; and

2. must meet full licensure requirements independently of the parent agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2274 (December 1998).

§8245. Cessation of Business

A. If at any time the agency is no longer operational, the license shall be deemed to be invalid and shall be returned to DHH within five working days.

B. The agency owner is responsible for notifying DHH of the location of all records.

C. In order to be operational, an agency must:

1. have had at least twenty new patients admitted since the last annual survey;

2. be able to accept referrals at any time;

3. have adequate staff to meet the needs of their current patients;

4. have required designated staff on the premises at all times during business hours;

5. be immediately available by telecommunications 24 hours per day. A registered nurse must answer calls from patients and other medical personnel after hours;

6. be open for the business of providing Hospice services to those who need assistance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2274 (December 1998).

Subchapter E. Hospice Inpatient Facility

§8247. Requirements for Licensure of Inpatient Hospice

A. Hospice inpatient services may be provided directly by the hospice or through arrangements made by the hospice. An agency is prohibited from providing hospice inpatient services only. A hospice that elects to provide hospice inpatient services directly is required to be licensed

both as a hospice inpatient facility and as a hospice (These are two separate licenses which require separate applications and fees). The application process to establish a hospice inpatient facility may be completed simultaneously with an application to provide hospice services.

B. An application packet shall be obtained from DHH.

1. A completed application packet for a hospice inpatient facility shall be submitted to and approved by DHH prior to an agency providing hospice services.

2. The application submitted shall include the current licensing fee plus any bed fees. All fees shall be in the form of a company check, certified check or money order made payable to DHH. All fees submitted are non-refundable. All state owned facilities are exempt from fees.

3. The license shall be conspicuously displayed in the hospice inpatient facility.

4. Each initial applicant or an existing hospice inpatient facility requesting a change of address must have approval from the following offices prior to an on-site survey by this department.

a. Office of Public Health—Local Health Unit. All hospice inpatient facilities shall comply with the rules, Sanitary Code and enforcement policies as promulgated by the Office of Public Health. It shall be the primary responsibility of the Office of Public Health to determine if applicants are complying with those requirements. No initial license shall be issued without the applicant furnishing a certificate from the Office of Public Health that such an applicant is complying with their provisions. A provisional license may be issued to the applicant if the Office of Public Health issues the applicant a conditional certificate.

b. Office of the State Fire Marshal. All hospice inpatient facilities shall comply with the rules, established fire protection standards and enforcement policies as promulgated by the Office of State Fire Marshal. It shall be the primary responsibility of the Office of State Fire Marshal to determine if applicants are complying with those requirements. No license shall be issued or renewed without the applicant furnishing a certificate from the Office of State Fire Marshal that such applicant is complying with their provisions. A provisional license may be issued to the applicant if the Office of State Fire Marshal issues the applicant a conditional certificate.

C. New constructions must be reviewed by DHH Engineering and Plans Review Section.

1. All new construction, other than minor alterations for a hospice inpatient facility, shall be done in accordance with the specific requirements of the Office of State Fire Marshal and the Department of Health and Hospitals covering new construction in hospitals, including submission of preliminary plans and the final work drawings and specifications shall also be submitted prior to any change in facility type.

2. No new hospice inpatient facility shall be constructed, nor shall major alterations be made to existing hospice inpatient facilities, or change in facility type be made without the prior written approval of, and unless in accordance with plans and specifications approved in advance by the Department of Health and Hospitals and the Office of State Fire Marshal. The review and approval of plans and specifications shall be made in accordance with the publication entitled *Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1992-93 Edition* published by the American Institute of Architects Press, Box 753, Waldorf, MD 20601 and the current *Standard Plumbing Code*. Before any new hospice inpatient facility is licensed or before any alteration or expansion of a licensed hospice inpatient facility can be approved, the applicant must furnish one complete set of plans and specifications to the Department of Health and Hospitals and one complete set of plans to the Office of State Fire Marshal, with fees and other information as required. Plans and specifications for new construction other than minor alterations shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.

3. In the event that submitted materials do not appear to satisfactorily comply with the *Guidelines for Construction and Equipment of Hospital and Medical Facilities -1992-1993 Edition*, the Department of Health and Hospitals shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

4. Notice of satisfactory review from the Department of Health and Hospitals and the Office of State Fire Marshal constitutes compliance with this requirement if construction begins within 180 days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes, or rules of any responsible agency.

D. An agency seeking to renew its license shall:

1. request a renewal application packet from DHH if one is not received at least 45 days prior to the license expiration date;

2. submit a renewal application packet annually accompanied by the current licensing fee plus any applicable bed fees.

E. An inpatient hospice facility shall maintain proof of compliance with all applicable local codes and ordinances governing health, fire, safety, and zoning regulations.

F. An agency shall notify DHH, in writing, prior to a change in name of the agency, address change, or a change in the number of beds.

1. A fee shall be submitted for a replacement license when a change occurs such as name change, address change, or a bed change.

2. The new facility location must meet the same licensing requirements as those required for an initial survey including approval of building plans by DHH Engineering

and Plans Review Section, Office of State Fire Marshal, and Office of Public Health.

G. A hospice that provides inpatient hospice services directly is required to provide or make arrangements for all hospice services on both an outpatient and an inpatient level including routine home care, continuous home care, respite care, and general inpatient care.

H. Hospice inpatient facilities and any facility that provides hospice services shall be maintained in a manner which provides for maintaining personal hygiene of the patients and implementation of infection control procedures.

I. Equipment and furnishings in an inpatient facility must provide for the health care needs of the resident while providing a home-like atmosphere.

J. Services provided in the inpatient facility are consistent with the plan of care prepared for that patient and areconsistent with services provided by the hospice program in other settings.

K. The hospice provider shall ensure that each patient residing in an inpatient facility has an identified hospice staff member who will serve as that patient's principle advocate and contact person.

L. The hospice inpatient facility shall ensure the following:

1. the facility meets appropriate licensing, regulatory, and certification requirements;

2. the facility has an acceptable, written emergency preparedness plan. The plan shall include:

a. the frequency/schedule for periodically rehearsing the plan with the staff;

b. the assignment of personnel for specific responsibilities;

c. the procedures for prompt identification and transfer of patients and records to an appropriate facility;

d. fire and/or other emergency drills, in accordance with the *Life Safety Code*;

e. procedures covering persons in the facility and in the community in case of external disasters, i.e., hurricanes, tornadoes, floods; and

f. arrangements with community resources in the event of a disaster.

3. the facility must design and equip areas for the comfort and privacy of each patient and family members. The facility must have the following:

a. physical space for private patient/family visiting;

b. accommodations for family members to remain with the patient throughout the night;

c. accommodations for family privacy after a patient’s death;

d. decor which is homelike in design and function;

e. patients must be permitted to receive visitors at any hour, including small children;

4. patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. Each patient’s room shall:

a. be equipped with or conveniently located near toilet and bathing facilities;

b. be equipped with a lavatory in each patient’s toilet room or in each bedroom;

c. be at or above grade level;

d. contain room decor that is homelike and noninstitutional in design and function. Room furnishings for each patient shall include a bed with side rails, a bedside stand, an over-the-bed table, an individual reading light easily accessible to each patient and a comfortable chair. The patient shall be permitted to bring personal items of furniture or furnishings into their rooms unless medically inappropriate;

e. have closet space that provides security and privacy for clothing and personal belongings;

f. contain no more than 4 beds;

g. measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multi patient room; and

h. be equipped with a device for calling the staff member on duty. A call bell or other communication mechanism shall be placed within easy reach of the patient and shall be functioning properly. A call bell shall be provided in each patient toilet, bath, and shower room;

5. the hospice inpatient facility shall:

a. provide an adequate supply of hot water at all times for patient use;

b. have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients; and

c. designate a staff member responsible for monitoring and logging water temperatures at least monthly. This person is responsible for reporting any problems to the administrator;

6. the hospice inpatient facility shall have available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection. The facility shall have a clean linen storage area;

a. the linen supply shall be adequate to accommodate the number of beds and the number of incontinent patients on a daily basis, including week-ends and holidays;

b. soiled linen and clothing shall be collected and enclosed in suitable bags or containers in well ventilated

areas, separate from clean linen and not permitted to accumulate in the facility;

c. the hospice inpatient facility shall have policies and procedures that address:

i. frequency of linen changes;

ii. storage of clean linen; and

iii. storage of soiled linen;

7. the hospice inpatient facility shall make provisions for isolating patients with infectious diseases. The hospice should institute the most current recommendations of The Centers for Disease Control and Prevention (CDC) relative to the specific infection(s) and communicable disease(s). The hospice provisions for isolating patients with infectious diseases shall include:

a. definition of nosocomial infections and communicable diseases;

b. measures for assessing and identifying patients and health care workers at risk for infections and communicable diseases;

c. measures for prevention of infections, especially those associated with immunosupressed patients and other factors which compromise a patient's resistance to infection;

d. measures for prevention of communicable disease outbreaks, especially tuberculosis;

e. provision of a safe environment consistent with the current CDC recommendations for the identified infection and/or communicable disease;

f. isolation procedures and requirements for infected or immunosupressed patients;

g. use and techniques for universal precautions;

h. methods for monitoring and evaluating practice of asepsis;

i. care of contaminated laundry, i.e., clearly marked bags and separate handling procedures;

j. care of dishes and utensils, i.e., clearly marked and handled separately;

k. use of any necessary gowns, gloves or masks posted and observed by staff, visitors, and anyone else in contact with the patient; and

l. techniques for hand washing, respiratory protection, asepsis sterilization, disinfection, needle disposal, solid waste disposal, as well as any other means for limiting the spread of contagion;

m. orientation of all new hospice personnel to infections, to communicable diseases and to the infection control program; and

n. employee health policies regarding infectious diseases, and when infected or ill employees must not render direct patient care;

8. the hospice inpatient facility should isolate infected patients only to the degree needed to isolate the infecting organism. The method should be the least restrictive possible while maintaining the integrity of the process and the dignity of the patient;

9. the hospice inpatient facility shall provide the following:

a. storage for administrative supplies;

b. hand washing facilities located convenient to each nurses' station and drug distribution station;

c. charting facilities for staff at each nurses' station;

d. a "clean" workroom which contains a work counter, sink, storage facilities and covered waste receptacles;

e. a "soiled" workroom for receiving and cleanup of equipment;

f. parking for stretchers and wheelchairs in an area out of the path of normal traffic and of adequate size for the facility;

g. a janitor's closet which contains a floor receptor with mop hooks over the sink and storage space for housekeeping equipment and supplies;

h. a multi-purpose lounge or lounges shall be provided suitable and furnished for: reception, recreation, dining, visitation, group social activities, and worship. Such lounge or lounges shall be located convenient to the patient rooms designed to be served;

i. a conference and consultation room shall be provided which is suitable and furnished for family privacy, including conjugal visit rooms, clergy visitations, counseling, and viewing of a deceased patient's body during bereavement. The conference and consultation room shall be located convenient to the patient rooms it is designed to serve;

j. public telephone and restrooms shall be provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2274 (December 1998).

§8249. Governing Body for Inpatient Hospice

A. The hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation.

B. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

C. The governing body shall:

1. designate an individual who is responsible for the day to day management of the hospice program;

2. ensure that all services provided are consistent with accepted standards of practice;

3. develop and approve policies and procedures which define and describe the scope of services offered;

4. review policies and procedures at least annually and revise them as necessary; and

5. maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2276 (December 1998).

§8251. Medical Director

A. The hospice inpatient facility shall have a Medical Director who is a doctor of medicine or osteopathy and is currently licensed to practice medicine in Louisiana. The Medical Director must ensure and assume the overall responsibility for the medical component of the hospice's in-patient care program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2277 (December 1998).

§8253. Nursing Services

A. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction of a Director of Nursing, who is a registered nurse licensed to practice in Louisiana, employed full-time by only one licensed agency. There shall be a similarly qualified registered nurse available to act in the absence of the Director of Nursing.

B. The inpatient facility has staff on the premises on a 24 hour a day, seven day a week basis. There shall be a registered nurse on duty at all times when there are patients in the facility and the facility shall provide nursing services which are sufficient to meet the total nursing needs of the patients in the facility. When there are no patients in the hospice inpatient facility, the hospice shall have a registered nurse on-call to be immediately available to the hospice inpatient facility. The services provided must be in accordance with the patient's plan of care. Each shift shall include two direct patient care staff, one of which must be a registered nurse who provides direct patient care. The nurse to patient ratio shall be at least one nurse to every 8 patients. In addition there shall be sufficient number of direct patient care staff on duty to meet the patient care needs.

C. Written nursing policies and procedures shall define and describe the patient care provided. There shall be a written procedure to ensure that all licensed nurses providing care in the inpatient hospice facility have a valid and current license to practice prior to providing any care.

D. Nursing services are either furnished and/or supervised by a registered nurse and all nursing services shall be evaluated by a registered nurse.

E. A registered nurse shall assign the nursing service staff for each patient in the inpatient hospice facility. The facility shall provide 24-hour nursing services which are sufficient to meet the total nursing needs of the patient and which are in accordance with the patient's plan of care. Staffing shall be planned so that each patient receives treatments, medication, and diet as prescribed, and is kept clean, well-groomed, and protected from accident, injury, and infection. Nursing services staff shall be assigned clinical and/or management responsibilities in accordance with education, experience and the current Louisiana Nurse Practice Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2277 (December 1998).

§8255. Nutritional Services

A. Nutritional services shall be under the supervision of a registered dietitian, licensed to practice in Louisiana, who is employed either full-time, part-time or on a consulting basis. If the registered dietitian is not full-time, there shall be a full-time dietary manager who is responsible for the daily management of dietary services.

1. The registered dietician shall be responsible for assuring that quality nutritional care is provided to patients by providing and supervising the nutritional aspects of patient care. The registered dietician is also responsible for:

a. recording the nutritional status of the patient;

b. plan menus for those patients who require medically prescribed special diets; and

c. supervise the preparation and serving of meals to ensure that the patient accepts the special diet.

2. The hospice inpatient facility shall have a dietary manager who is responsible for:

a. planning menus that meet the nutritional needs of each patient, following the orders of the patient's physician and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences. There shall be a current therapeutic diet manual approved by the dietician and medical staff, and readily available to all medical, nursing, and food service personnel, which shall be the guide used for ordering and serving diets.

b. supervising the meal preparation and service to ensure that the menu plan is followed.

3. A dietary manager is someone who meets one of the following:

a. a graduate of a dietetic technician or dietetic assistant training program by correspondence or classroom, approved by the American Dietetic Association;

b. a graduate of a State approved course that provides 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or

c. has training and experience in food service supervision and management in the military service equivalent in content to a dietetic technician or dietetic assistant training program by correspondence or classroom, approved by the American Dietetic Association.

4. The hospice shall employ sufficient support personnel to meet the needs of the patients in the hospice inpatient facility.

5. The hospice shall have policies and procedures to ensure support personnel are competent to perform their respective duties within the dietary services department.

6. The hospice inpatient facility shall:

a. serve at least three meals or their equivalent each day at regular times, with not more than 14 hours between a substantial evening meal and breakfast;

b. include adequate nutritional services to meet the patient's dietary needs and food preferences, including the availability of frequent, small, or mechanically-altered meals 24 hours a day;

c. be designed and equipped to procure, store, prepare, distribute, and serve all food under sanitary conditions; and

d. provide a nourishment station which contains equipment to be used between scheduled meals such as a warming device, refrigerator, storage cabinets and counter space. There shall be provisions made for the use of small appliances and storage. This area shall be available for use by the patient, the patient's family, volunteers, guests and staff.

B. Sanitary Conditions

1. Food shall be in sound condition, free from spoilage, filth, or other contamination and shall be safe for human consumption.

a. All food shall be procured from sources that comply with all laws and regulations related to food and food labeling.

b. The use of food in sealed containers that was not prepared in a food processing establishment is prohibited.

c. All food shall be stored, prepared, distributed and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink at or below 40 degrees F, except when being prepared and served. Refrigerator temperatures shall be maintained at 40 degrees F or below; freezers at 0 degrees F or below.

d. Hot foods shall leave the kitchen or steam table at or above 140 degrees F. In-room delivery temperatures shall be maintained at 120 degrees F, or above for hot foods and 50 degrees F or below for cold items. Food shall be covered during transportation and in a manner that protects it from contamination while maintaining required temperatures.

e. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized and stored. This includes maintaining a water temperature in dish washing machines at 140 degrees F during the wash cycle (or according to the manufacturer's specifications or instructions) and 180 degrees F for the final rinse. Low temperature machines shall maintain a water temperature of 120 degrees F with 50 ppm (parts per million) of hypochlorite (household bleach) on dish surfaces. For manual washing in a 3-compartment sink, a wash water temperature of 75 degrees F with 50 ppm of hypochlorite or equivalent, or 12.5 ppm of iodine; or a hot water immersion at 170 degrees F for at least 30 seconds shall be maintained. An approved lavatory shall be convenient and equipped with hot and cold water tempered by means of a mixing valve or combination faucet for dietary services staff use. Any self-closing, slow-closing, or metering faucet shall be designed to provide a flow of water for at least fifteen seconds without the need to reactivate the faucet. Effective with the promulgation of these requirements, an additional lavatory shall be provided in the dishwasher area in newly constructed hospices or in existing hospices undergoing major dietary alterations.

f. No staff, including dietary staff, shall store personal items within the food preparation and storage areas.

g. Dietary staff shall use good hygienic practices. Staff with communicable diseases or infected skin lesions shall not have contact with food if that contact may transmit the disease.

h. Toxic items such as insecticides, detergents, polishes and the like shall be properly stored, labeled and used.

i. Garbage and refuse shall be kept in durable, easily cleanable, insect and rodent-proof containers that do not leak and do not absorb liquids. Containers used in food preparation and utensil washing areas shall be kept covered after they are filled.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2277 (December 1998).

§8257. Pharmaceutical Services of Inpatient Hospice

A. The hospice shall provide pharmaceutical services that meets the needs of the patients.

B. The hospice shall ensure that pharmaceutical services are provided by appropriate methods and procedures for the storage, dispensing and administering of drugs and

biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the hospice facility is responsible for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws.

C. If a pharmacy is to be constructed within the hospice inpatient facility, plans shall be submitted to the Board of Pharmacy for Licensing and Registration. The pharmacy shall have a pharmacy permit issued by the Louisiana Board of Pharmacy to allow ordering, storage, dispensing, and delivering of legend prescriptive orders. The hospice inpatient facility pharmacy shall have a current controlled dangerous substance license to dispense controlled substances to patients in the facility. The pharmacy shall be directed by a registered pharmacist licensed to practice in Louisiana.

D. Licensed pharmacist. The hospice must employ a licensed pharmacist or have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and record keeping of drugs and biologicals.

E. Orders for medications. A physician must order all medication for the patient.

1. If the medication order is verbal, the physician must give it only to a licensed nurse, pharmacist, or another physician; and the individual receiving the order must record and sign it immediately.

2. All orders (to include telephone and/or verbal) are to be signed by the prescribing physician in a timely manner, not to exceed 30 days.

F. Administering Medications. Patients must be accurately identified prior to administration of a medication.

1. Medications are administered only by a physician, a licensed nurse; or the patient, if his or her attending physician has approved.

2. Physicians' orders are checked at least daily to assure that changes are noted.

3. Drugs and biologicals are administered as soon as possible after dose is prepared for distribution, not to exceed 2 hours.

4. Each patient has an individual medication administration record (MAR) on which the dose of each drug administered shall be properly recorded by the person administering the drug to include:

a. name, strength, and dosage of the medication;

b. method of administration to include site, if applicable;

c. times of administration;

d. the initials of persons administering the medication, except that the initials shall be identified on the MAR to identify the individual by name;

e. medications administered on a "PRN" or as needed basis shall be recorded in a manner as to explain the reason for administration and the results obtained. The Hospice shall have a procedure to define its methods of recording these medications;

f. medications brought to the Hospice by the patient or other individuals for use by that patient shall be accurately identified as to name and strength, properly labeled, stored in accordance with facility policy and shall be administered to the patient only upon the written orders of the attending physician;

g. medications shall not be retained at the patients bedside nor shall self-administration be permitted except when ordered by the physician. These medications will be appropriately labeled and safety precautions taken to prevent unauthorized usage;

h. medication errors and drug reactions are immediately reported to the Director of Nurses, Pharmacist and Physician and an entry made in the patients' medical record and/or an incident report. This procedure shall include recording and reporting to the physician the failure to administer a drug, for any other reason than refusal of a patient to take a drug. The refusal of a patient to take a drug should be reported during IDG conferences. If there is adverse consequence resulting from the refusal, this is to be immediately reported to the Director of Nurses, Pharmacist and Physician and an entry made in the patients' medical record and/or an incident report;

i. the nurses station or medicine room for all hospice inpatient facilities shall have readily available items necessary for the proper administration and accounting of medications;

j. each hospice shall have available current reference materials that provide information on the use of drugs, side effects and adverse reactions to drugs and the interactions between drugs.

G. Conformance with Physicians' Drug Orders. Each hospice inpatient facility shall have a procedure for at least quarterly monitoring of medication administration. This monitoring may be accomplished by a registered nurse or a pharmacist, to assure accurate administration and recording of all medications.

1. Each hospice shall establish procedures for release of patient's own medications upon discharge or transfer of the patient.

2. Medications shall be released upon discharge or transfer only upon written authorization of the attending physician.

3. An entry of such release shall be entered in the medical record to include drugs released, amounts, who received the drugs and signature of the person carrying out the release.

H. Storage of Drugs and Biologicals. Procedures for storing and disposing of drugs and biologicals shall be

established and implemented by the inpatient hospice facility.

1. In accordance with State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

2. Controlled drugs no longer needed by the patient are disposed of in compliance with State requirements. In the absence of State requirements, the pharmacist and a registered nurse dispose of the drugs and prepare a record of the disposal.

3. There shall be a drug or medicine room/drug preparation area at each nurses' station of sufficient size for the orderly storage of drugs, both liquid and solid dosage forms and for the preparation of medications for patient administration within the unit. In the event that a drug cart is used for storage and administration of drugs, the room shall be of sufficient size to accommodate placement of the cart.

4. There shall be a separate area or cubicle for the storage of each patient's medication, except where a cart is used for the administration of drugs and biologicals.

5. There shall be an operable sink provided with hot and cold water in or near the medicine room or medication preparation area for washing hands or cleaning containers used in medicine preparation. Paper towels and soap dispenser shall be provided.

6. Sufficient artificial lighting shall be provided and the temperature of the medicine storage area shall not be lower than 48 degrees F or above 85 degrees F and the room must be provided with adequate ventilation.

7. Drugs and biologicals, including those requiring refrigeration, shall be stored within the medicine room or shall have separate locks if outside the medicine room. The refrigeration shall have a thermometer and be capable of maintaining drugs at the temperature recommended by the manufacturer of the drug.

8. No foods may be stored in the same storage area (i.e., cupboard, refrigerator, or drawer) with drugs and biologicals. The areas designated for drug and biological storage should be clearly marked.

9. Medication refrigerators shall not be used to store laboratory solutions or materials awaiting laboratory pickup.

10. The drug or medicine rooms shall be provided with safeguards to prevent entrance of unauthorized persons including locks on doors and bars on accessible windows.

a. Only authorized, designated personnel shall have access to the medicine storage area.

b. External use only drugs must be plainly labeled and stored separate from drugs and biologicals. No poisonous substance shall be kept in the kitchen, dining area, or any public spaces or rooms. This section shall not prohibit storage within the drug or medicine room of approved poisonous substances intended for legitimate medicinal use, provided that such substances are properly labeled in accordance with applicable federal and state law.

11. First aid supplies shall be kept in a place readily accessible to the person or persons providing care in the inpatient hospice.

12. Each hospice may maintain one "STAT" medicine cabinet for the purpose of keeping a minimum amount of stock medications that may be needed quickly or after regular duty hours. The following rules apply to such a cabinet.

a. The contents of the "STAT" medicine cabinet shall be approved by the hospice pharmacist and members of the medical and clinical staff responsible for the development of policies and procedures.

b. There shall be a minimum number of doses of any medication in the "STAT" cabinet based upon the established needs of the hospice.

c. There shall be a list of the contents of the “STAT” medicine cabinet, including the name and strength of the drug and the quantity of each.

d. There shall be records available to show amount received, name of patient and amount used, prescribing physician, time of administration, name of individual removing and using the medication, and the balance on hand.

e. There shall be written procedures for utilization of the "STAT" medicine cabinet with provisions for prompt replacement of used items.

f. The pharmacist shall inspect the "STAT" medicine cabinet at least monthly, replacing outdated drugs and reconciliation of its prior usage. Information obtained shall be included in a monthly report.

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