

Article 1. Definitions

Administrator.

“Administrator” means a person who is appointed in writing by the governing body of the program to organize and direct the services and functions of the hospice.

Attending Physician.

“Attending physician” means a physician and surgeon who (a) is a doctor of medicine or osteopathy and (b) is identified by the patient, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual’s medical care, or (c) is a covering physician acting on behalf of the attending physician.

Bereavement Services.

“Bereavement Services” means those services available to the surviving family members for a period of at least one year after the death of the patient, including an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to and following the death of the patient.

Counselor.

“Counselor” means a person who has education and training consistent with his or her professional role to assist the patient and family with dietary, bereavement or spiritual issues.

Department.

“Department” means the State Department of Health Services.

Dietary Counseling.

“Dietary Counseling” means interventions and education provided by a registered nurse or registered dietitian regarding appropriate nutritional intake as a patient’s disease progresses.

Director.

“Director” means the Director of the State Department of Health Services.

Facility-based Service.

“Facility-based Service” means service provided in a licensed or certified facility where specific levels of care are provided to meet the needs of the patient/family.

Family.

“Family” means anyone the patient so identifies.

Home Health Aide.

“Home Health Aide” has the same meaning as set forth in subdivision (c) of Section 1727.

Home Health Aide Services.

“Home Health Aide Services” means those services described in subdivision (d) of Section 1727 that provide for the personal care of the terminally ill patient and the performance of related tasks in the patient’s home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient.

Homemaker.

“Homemaker” means a home health aide, volunteer or other individual who assists the patient/family with light chores.

Homemaker Services.

“Homemaker Services” means those non-medical services provided to assist with personal care needs and light chores.

Hospice.

“Hospice” means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide supportive care to the primary caregiver and the family of the patient, and meets all of the following criteria.

- A. Considers the patient and the patient’s family, in addition to the patient, as the unit of care.
- B. Utilizes an interdisciplinary team to assess the physical, medical, psychological, social and spiritual needs of the patient and the patient’s family.
- C. Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care that emphasizes supportive services, including, but not limited to, home care, pain control, and limited inpatient services. Limited inpatient services are intended to ensure both continuity of care and appropriateness of services for those patients who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
- D. Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.
- E. Provides for bereavement services following death to assist the family in coping with social and emotional needs associated with the death of the patient.
- F. Actively utilizes volunteers in the delivery of hospice services.
- G. To the extent appropriate, based on the medical needs of the patient, provides services in the patient’s home or primary place of residence.

Hospice Physician.

“Hospice Physician” means a person licensed as a physician and surgeon by the California Medical Board or by the California Board of Osteopathic Examiners who serves as a member of the hospice interdisciplinary team.

Inpatient Care Arrangements.

“Inpatient Care Arrangements” means arranging for those short inpatient stays that may become necessary to manage acute symptoms or because of the temporary absence, or need for respite, of a capable primary caregiver. The hospice shall arrange for these stays, ensuring both continuity of care and the appropriateness of services.

Interdisciplinary Care.

“Interdisciplinary Care” means care provided by an interdisciplinary team designed to address the physical, social, emotional and spiritual needs of a patient.

Interdisciplinary Team.

“Interdisciplinary Team” means the hospice care team that includes, but is not limited to, the patient and patient’s family, a physician and surgeon, a registered nurse, a social worker, a volunteer and a spiritual caregiver. The team shall be coordinated by a registered nurse and shall be under medical direction. The team shall meet regularly to develop and maintain an appropriate plan of care.

License.

“License” means the basic document issued by the Department permitting the operation of a hospice program. This document constitutes the authority to accept patients and to perform the services included within the scope of these regulations and as specified on the license.

Licensee.

“Licensee” means the person, persons, firm, partnership, association, corporation, receiver, political subdivision of the State or other governmental agency to whom a license has been issued and shall include the officers, directors, partners and members thereof and other persons having or exercising responsibility or authority in the operation of the hospice.

Licensed Vocational Nurse.

“Licensed Vocational Nurse” means a person licensed as such by the California Board of Vocational Nurses and Psychiatric Technician Examiners.

Medical Direction.

“Medical Direction” means those services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the interdisciplinary team, a consultant to the patient’s attending physician and surgeon, as requested, with regard to pain and symptom management, and a liaison with physicians and surgeons in the community.

Medical Director.

“Medical Director” means a physician and surgeon licensed in the state of California who is responsible for the overall medical direction of the hospice program.

Multiple Locations.

“Multiple Locations” means a location or site from which a hospice makes available basic hospice services within the service area of the parent agency. A multiple location shares administration, supervision, policies and procedures, and services with the parent agency in a manner that renders it unnecessary for the site to independently meet the licensing requirements.

Nurse Practitioner.

“Nurse Practitioner” means a registered nurse with advanced academic and clinical training in a health care specialty area. Advanced Practice Nurses practice under the rules and regulations of the Nurse Practice Act of the state of California.

Palliative.

“Palliative” refers to medical treatment, interdisciplinary care, or consultation provided to the patient or family members, or both, that has as its primary purpose preventing or relieving suffering and enhancing the quality of life, as described in subdivision (b) of Section 1339.31, of a patient who has an end-stage medical condition.

Parent Agency.

“Parent Agency” means the part of the hospice that is licensed pursuant to this chapter and that develops and maintains administrative controls of multiple locations. All services provided by the multiple location and parent agency are the responsibility of the parent agency.

Patient.

“Patient” means a person receiving palliative treatment for and management of a terminal illness and its related conditions.

Plan of Care.

“Plan of Care” means a written plan developed by the attending physician and surgeon, the medical director or physician and surgeon designee, and the interdisciplinary team that addresses the needs of a patient and family admitted to the hospice program. The hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered.

Preliminary Services.

“Preliminary Services” means those services authorized pursuant to subdivision (d) of Section 1749.

Primary Caregiver.

“Primary Caregiver” means person(s) not employed by the hospice program but designated by the patient or patient representative as responsible for ensuring that the day-to-day needs of the patient are met.

Professional Management.

“Professional Management” means the program’s responsibility for developing, coordinating, authorizing, and overseeing implementation of the plan of care.

Registered Nurse.

“Registered Nurse” means a person licensed in the State of California by the Board of Registered Nursing.

Residence.

“Residence” means wherever the patient lives, including temporary or permanent stays in health or community care facilities.

Respite Services.

“Respite Services” means relieving the primary caregiver by providing an alternative caregiver for a short time when necessary on an occasional basis consistent with the plan of care.

Skilled Nursing Services.

“Skilled Nursing Services” means nursing services provided by or under the supervision of a registered nurse under a plan of care developed by the interdisciplinary team and the patient’s physician and surgeon to a patient and his/her family that pertain to the palliative, supportive services required by patients with a terminal illness. Skilled nursing services include, but are not limited to, patient assessment, evaluation and case management of the medical nursing needs of the patient, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the patient and his or her family, and the instruction of caregivers in providing personal care to the patient. Skilled nursing services shall provide for the continuity of services for the patient and his or her family. Skilled nursing services shall be available on a 24-hour on-call basis.

Social Service/Counseling Services.

“Social Service/Counseling Services” means those counseling and spiritual care services that assist the patient and his or her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

Social Worker.

“Social Worker” means a person who has a Master of Social Work degree from a school accredited by the Council on Social Work Education and clinical experience relevant to the psychosocial needs of patients and families.

Social Work Associate.

“Social Work Associate” means a person with a baccalaureate degree in social work from a school accredited by the Council on Social Work Education and clinical experience relevant to the casework needs of patients and families.

Spiritual Services.

“Spiritual Services” means those services that support patients’ and families’ spiritual values or sacred values associated with their belief system, which give comfort in coping with issues accompanying a terminal illness.

Terminal Disease.

“Terminal disease” or “terminal illness” means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

Volunteer.

“Volunteer” means a person trained to provide support and companionship to the patient and family and/or other services for the hospice program.

Volunteer Services.

“Volunteer Services” means those services provided by trained hospice volunteers who have agreed to provide services under the direction of a hospice staff member who has been designated by the hospice to provide direction to hospice volunteers. Hospice volunteers may be used to provide support and companionship to the patient and his or her family during the remaining days of the patient’s life and to the surviving family following the patient’s death.

Article 2. Services

Section 2.1 Services Provided

In order to be licensed as a hospice, the licensee shall satisfy the definition of a hospice contained in Chapter 8.5, Division 2 of the California Health and Safety Code, Section 1746 and also provide or make provision for, but not be limited to, the following basic services:

Skilled Nursing Services.
Counseling Services.
Medical Direction.
Volunteer Services.
Inpatient Care.
Home Health Aide Services/Homemaker Services.
Social Work Services.

Section 2.2 Physician

A. Medical Director

Medical Director services are provided in a manner consistent with the philosophy of hospice and palliative care and include, but are not limited to:

1. Assuring the provision of quality care that meets the medical needs of the patient and family.
2. Consulting and coordinating care with hospice physicians and attending physicians.
3. Participating in the development and implementation of the policies related to the care provided by the interdisciplinary team.

B. Attending physician

Attending physician services may include, but are not limited to:

1. Primary responsibility for the overall medical care of the patient.
2. Palliation and medical management of the terminal illness in accordance with the plan of care.

C. Hospice Physician

1. The hospice physician is responsible for meeting the general medical needs of the patient to the extent that the needs are not met by the attending physician.
2. If the patient does not have an attending physician, there shall be a mechanism in place for the assignment of a physician to serve as the attending physician.

Section 2.3 Nursing

A. Skilled Nursing

1. Skilled Nursing Services shall be provided consistent with the hospice plan of care and the Nurse Practice Act.
2. The definition of skilled nursing shall not include interviews to determine the patient's and family's needs or referrals to licensed care or community resources.

B. Licensed Vocational Nursing

1. Services provided by Licensed Vocational Nurses shall be consistent with the plan of care as directed by a registered nurse and consistent with the Nurse Practice Act.

Section 2.4 Home Health Aide/Homemaker

A. Home Health Aide

1. Home Health Aide services shall be provided by certified personnel in a manner consistent with the scope of their certification.
2. When a program provides, or arranges for, Home Health Aide services, the services shall be given in accordance with the plan of care and shall be supervised by a Registered Nurse in accordance with applicable laws and regulations.
3. Home Health Aide services include, but are not limited to:
 - a. The performance of simple procedures as an extension of therapy services.
 - b. Personal care.
 - c. Ambulation and exercise.
 - d. Household services essential to healthcare at home.
 - e. Assistance with medications that are ordinarily self-administered.
 - f. Reporting changes observed in the patient's conditions and needs.

B. Homemaker

1. A hospice may provide or arrange for Homemaker services. The services shall be provided according to the plan of care and supervised by a member of the interdisciplinary team.
2. Homemaker duties may include, but are not limited, to the following:
 - a. Caregiver relief.
 - b. Basic meal preparation and meal planning for regular diets.
 - c. Escort and/or transportation services.
 - d. Laundry.
 - e. Light housekeeping.
 - f. Maintaining a safe environment.
 - g. Shopping.

Section 2.5 Social Work

A. Social work services include but are not limited to:

1. Assisting the interdisciplinary team in understanding the significant social and emotional factors related to a terminal illness.
2. Providing psychosocial and emotional support to the patient/family.
3. Facilitating appropriate community resources and providing casework.

- B. A Social Worker is a person who has a Master of Social Work degree from a school accredited by the Council on Social Work Education and clinical experience relevant to the psychosocial needs of patients and families.
- C. A Social Work Associate is a person with a baccalaureate degree in social work from a school accredited by the Council on Social Work Education and clinical experience relevant to the casework needs of patients and families.
- D. All social work personnel caring for hospice patients and families shall have orientation and training appropriate to the care of the patient and his/her family.

Section 2.6 Counseling

- A. Counseling Services include, at a minimum, dietary, bereavement and spiritual services. Other counseling services may be offered as defined by an individual’s plan of care.
 - 1. Dietary Services
 - a. Provision of counseling services intended to address the nutritional needs of the patient in accordance with the plan of care.
 - b. Assistance to the interdisciplinary team in understanding the significant dietary factors related to a terminal illness.
 - 2. Spiritual Services.
 - a. The hospice must make reasonable efforts to arrange for visits of clergy and other individuals who can support the spiritual needs of the patient for patients who request such visits and must advise patients of this availability.
 - b. Spiritual services include, but are not limited to:
 - (1) The provision of spiritual counseling.
 - (2) Facilitating access to community spiritual resources.
 - (3) Assistance with memorial/funeral planning.
 - (4) Assistance to the interdisciplinary team in understanding the significant spiritual factors related to a terminal illness.
 - 3. Bereavement Services.
 - a. The hospice shall provide services to individuals identified through the bereavement care planning process. Bereavement services shall be provided under the supervision of an individual who has documented evidence of training and experience in dealing with grief and loss.
 - b. Bereavement services shall be delivered consistent with a written plan of care and be available for a period of at least one year following the death of the patient.

Section 2.7 Facility-based Services.

- A. The same set of services must be provided as are provided to patients/families living in their own homes. The program must ensure that care is safe, appropriate and consistent with the plan of care, and that caregivers are kept informed and involved in the patient’s care.
- B. Programs must document evidence of education to facility staff on hospice care and symptom management. The program is responsible for managing the plan of care and ensuring that an

appropriate standard of care is provided in the facility. Services shall continue without interruption if patient care settings change.

1. Inpatient
 - a. Inpatient care for pain control and symptom management must be provided in one of the following:
 - (1) A hospice that meets the Medicare Conditions of Participation for providing inpatient care directly.
 - (2) A hospital or skilled nursing facility that meets the standards specified in the Medicare Conditions of Participation, Section 418.100 (a) and (c), regarding 24-hour nursing service and patient areas. At any time when general inpatient care is provided at least one Registered Nurse must be on site.
2. Respite Care
 - a. Provision of respite services to relieve the caregiver may be provided or arranged for under contract in a licensed acute or skilled nursing facility.
3. Residential
 - a. Allows for the provision of temporary or permanent care in a licensed care facility other than the patient's home.

Section 2.8 Volunteer Services.

- A. Volunteer services are provided under the direction of a staff member responsible for planning, organizing and directing a comprehensive volunteer services program. Volunteer services must be sufficient to meet the needs of the patient and family.
- B. Volunteer services include, but are not limited to:
 1. The provision of support and companionship to the patient and his/her family.
 2. Caregiver relief.
 3. Light chores.
 4. Running errands.
 5. Visiting.
 6. Bereavement services.
 7. Other practical activities of daily living.

Article 3. Plan of Care

Each patient must have a written plan of care that specifies the care and services necessary to meet the patient's specific needs as identified in the comprehensive assessment.

Section 3.1 Assessments

Comprehensive assessments are conducted and developed to identify the patient's need for care and the need for medical, nursing, social, emotional and spiritual care that includes the palliation and management of the terminal illness and related medical conditions.

- A. The program's representative makes an initial contact to determine the immediate care and support needs of the patient. The initial contact occurs as soon as possible after receipt of the referral for care.
- B. Following consent of the patient, the program must conduct a comprehensive assessment.
- C. A comprehensive assessment includes input from members of the interdisciplinary team. Information regarding the outcome of this assessment, which may be contained in one or more assessment documents, is located in the plan of care or elsewhere in the clinical record. The outcome of the comprehensive assessment forms the basis for the goals and interventions contained in the plan of care. The following information is evaluated as part of the comprehensive assessment document.
 - 1. The patient's physical condition, including functional ability and mental status.
 - 2. The patient's pain and other symptoms and the level of discomfort and symptom relief.
 - 3. A review of the patient's drug profile, including over-the-counter drugs.
 - 4. The patient's and family's social and emotional well being.
 - 5. The patient's spiritual orientation and needs.
 - 6. Imminence of death.
 - 1. Any other information necessary to develop an effective interdisciplinary plan of care.

Section 3.2 Content of the Plan

All services furnished to patients must follow a written plan of care established by the interdisciplinary team in collaboration with the attending physician.

- A. Each patient's written plan of care reflects planned interventions based on the problems identified in the comprehensive or continuing assessments. It ensures that care and services are appropriate to each patient's/family's specific needs.
- B. The plan of care includes but is not limited to:
 - 1. Interventions to facilitate the management of pain and symptoms.
 - 2. Frequency and mix of services necessary to meet the patient/family specific needs identified in the comprehensive assessment.
 - 3. Measurable outcomes that the program anticipates will occur as a result of implementing and coordinating the plan of care.
 - 4. Drugs and treatments necessary to meet the needs of the patient as identified in the assessment.
 - 5. Medical supplies and appliances necessary to meet the needs of the patient identified in the assessment.

6. Patient's/family's goals, understanding, agreement and involvement with the plan as they desire.
7. Anticipated discharge and bereavement care needs of the family.

Section 3.4 Review of the plan

- A. The plan must be reviewed and revised by the interdisciplinary group according to the program's policies in collaboration with the attending physician.

Section 3.5 Coordination of the plan

- A. The program must maintain a system of communication and integration of services, whether provided directly or under arrangement that ensures the identification of patient needs and the ongoing liaison of all disciplines providing care.
- B. The program identifies the level of coordination necessary to deliver safe and appropriate care to the patient at home or in the inpatient setting and involves the patient/family, as they desire, in coordination of care efforts.

Article 4. Interdisciplinary Team.

Section 4.1 Responsibilities

- A. The program shall establish an interdisciplinary team whose responsibility shall include but not be limited to:
 - 1. Establishment of a plan of care.
 - 2. Provision, and/or supervision and coordination of care services.
 - 3. Review and/or revision, on a regular basis, of the plan of care for each patient and family receiving care.
 - 4. Implementation of policies governing the day-to-day provision of care and services.
- B. The interdisciplinary team shall make use of consultants and community resources as necessary and appropriate.
- C. Any unusual change in the patient's physical, mental, spiritual or emotional status shall be reported to the primary caregiver(s), the attending physician and the interdisciplinary team.

Section 4.2 Documentation

- A. Documentation of coordination and continuity of care shall include but not be limited to:
 - 1. On-going communication with primary or attending physician.
 - 2. Coordination and communication among team members and others involved in the provision of care.
 - 3. Coordination and communication between facility-based and home care settings.
 - 4. Education of patient and family about needed care.
 - 5. Patient's response to interventions specified in the plan of care.

Section 4.3 Patient/Family Participation

- A. The interdisciplinary team shall enable the patient and family to be actively involved in hospice care including, but not limited to:
 - 1. Participating in designating a primary caregiver in the home or an alternate plan.
 - 2. Assisting the interdisciplinary team to identify and meet needs.
 - 3. Receiving instruction and participating in care and care decisions.

Article 5. Staffing

Section 5.1 Administration

- A. An administrator shall have supervisory or administrative experience in hospice or related health care fields or education in healthcare or administration that meet the requirements of the position.
- B. The administrator has overall responsibility for day-to-day operations, complying with applicable rules and regulations, and reporting to the governing body.
- C. The administrator or qualified alternate shall be available on the premises or by telecommunication during normal business hours.

Section 5.2 Medical Director

- A. A medical director shall have experience in hospice or palliative care or meet the minimum applicable training requirements in end of life care as determined by hospice policies and/or position description.
- B. The responsibilities of the medical director, consistent with the organizational plan and structure of the program, shall include but are not limited to:
 - 1. Reviewing necessary data from the referral source in order to validate the diagnosis and life-limiting prognosis established by the attending physician.
 - 2. Reviewing the clinical record and/or performing a medical examination to confirm the appropriateness of services.
 - 3. Assisting in developing and implementing the plan of care that is coordinated with the attending physician.
 - 4. Insuring the availability of physician services and providing a substitute in the absence of the attending physician.

Section 5.3 Director of Patient Care Services

- A. The Director of Patient Care Services or his/her designee shall be available on the premises or accessible by telecommunications during operating hours. The Director of Patient Care Services shall devote a sufficient number of hours to assure the quality and adequacy of services provided and supervision of staff.
- B. In the temporary absence (in excess of twenty [20] consecutive working days) of the Director of Patient Care Services, a Registered Nurse shall be designated in writing as responsible for fulfilling the duties of Director of Patient Care Services.
- C. Any vacancy in the Director of Patient Care Services position shall be filled within sixty (60) days of the vacancy and the Department notified of the replacement.

- D. The Director of Patient Care Services shall qualify for the position by fulfilling the requirements under one of the following categories:
1. A Registered Nurse with a baccalaureate or higher degree in nursing or another health-related field with three years of experience within the last five years in a hospice or home health agency, primary care clinic or health facility, at least one year of which was in a supervisory or administrative capacity.
 2. A Registered Nurse with four years experience within the last five years in a hospice, home health agency, primary care clinic or health facility, at least one year of which was in a supervisory or administrative capacity.

Section 5.4 Nursing

- A. A nurse supervisor shall have a current RN license, with at least two [2] years of hospice, home health, or community health experience in the last five [5] years.
- B. Registered Nurses shall have a minimum of (a) one [1] year of experience as a professional nurse within the last three [3] years; or (b) have a baccalaureate degree in nursing from a program accredited by the National League for Nursing and a current RN license.
- C. Licensed Vocational Nurses shall have a current LVN license, at least one [1] year experience as a Licensed Vocational Nurse, and shall work under the supervision of a Registered Nurse.
- D. Adequate licensed nursing staff will be available to provide 24 hours/day, 7 days/week on-call program coverage with visit capability.
- E. All nursing personnel caring for hospice patients and families shall have orientation and training appropriate to the care of the patient and his/her family.

Section 5.5 Home Health Aide/Homemaker Services.

- A. Qualifications of a Home Health Aide shall include:
1. Possession of a current certification to practice as a Home Health Aide in the state of California.
 2. Demonstrated experience as a Home Health Aide or completion of an appropriate orientation and training program.
 3. Demonstrated competency in performance of Home Health Aide functions.
- B. Qualifications of a Homemaker shall include:
1. The ability to demonstrate skills and knowledge in maintaining a safe home environment.
 2. Basic knowledge and skills of food preparation and household cleanliness.
 3. The ability to read, write and carry out directions.
 4. The Homemaker will have completed an appropriate orientation and training program.

Section 5.6 Social Work Services

- A. Social work services include but are not limited to:
1. Assisting the interdisciplinary team in understanding the significant social and emotional factors related to a terminal illness.
 2. Providing psychosocial and emotional support to the patient/family.
 3. Facilitating appropriate community resources and providing casework.

- B. All social work services personnel working with hospice patients and families shall have orientation and training appropriate to the needs of patients and family members.

Section 5.7 Spiritual Services.

- A. The program shall designate a specific person(s) to provide and/or oversee the spiritual care of the patient and/or caregiver(s) and to ensure that the patient's needs are met and rights are preserved.
- B. An initial spiritual assessment for all consenting patients and/or documentation supporting attempts to make such an assessment shall be completed within a reasonable period of time.
- C. The person(s) providing or overseeing the patients' and/or caregivers' spiritual care shall document visits, observations and interventions in the patient's clinical record including any contact with spiritual caregivers outside the interdisciplinary team.
- D. The designated person providing spiritual services shall have the following qualifications:
 - 1. Demonstrated experience and training to support the spiritual needs of the patient and family.
 - 2. Completion of an appropriate orientation and training program.

Section 5.8 Volunteers.

- A. Coordination
 - 1. Volunteer coordination should include, but not be limited to:
 - a. Recruiting, screening and training sufficient numbers of volunteers to meet the needs of the patients and families.
 - b. On-going support, supervision and evaluation of volunteers.
 - c. Coordinating the utilization of volunteers with other members of the interdisciplinary team.
 - d. Taking an active role in providing, reviewing and revising written volunteer policies and procedures.
 - e. Recording services of volunteers, including the type of service and the time worked.
 - 2. The person responsible for coordinating volunteers shall exhibit knowledge and understanding of hospice philosophy and have the ability to supervise and maintain a volunteer program.
- B. Training
 - 1. Volunteers shall be assigned duties they are trained and competent to perform. Care provided by volunteers must be supervised by a designated qualified and experienced staff member.
 - 2. The number, education, training and experience of the individuals providing volunteer services are to be consistent with the needs of the patients and families and within the scope of volunteer services. These services must be documented in the clinical record.
 - 3. Volunteers may also provide administrative support services to the program.
 - 4. There shall be a specialized volunteer orientation and training program that is sufficient to meet the needs of the patients and families This program shall include, but not be limited to:

- a. History, philosophy and structure of the hospice concept.
- b. Volunteers' roles and responsibilities.
- c. Volunteer program policies.

C. Personnel Files

- 1. There shall be personnel file(s) for each volunteer that include, but are not limited to:
 - a. Application.
 - b. Documentation of orientation and on-going volunteer training.
 - c. Health record to confirm TB screening.
 - d. Hepatitis B vaccinations will be offered to all volunteers whose jobs involve the risk of directly contacting blood or other potentially infectious materials consistent with OSHA standards.
 - e. Signed confidentiality statement.
 - f. Annual review.
 - g. Activity records that reflect the services and hours provided.

Article 6. Administration

Section 6.1 Governing Body.

- A. Each hospice shall have a governing body.
- B. The governing body shall:
 - 1. Adopt bylaws, a charter, articles of incorporation, an official statement of objectives or the hospice's governing policies that shall state explicitly that the program provides services directly or through arrangements with other qualified providers, and which shall state that the program does not refuse service to or employment to or in any other way discriminate against any person on the basis of race or color, age, religion, sex, pregnancy, childbirth and national origin.
 - 2. Assume full legal authority and responsibility for the operation of the program.
 - 3. Oversee the management and fiscal affairs of the program.
 - 4. Appoint a qualified administrator.
 - 5. At least annually, conduct an organized, effective and documented evaluation of overall agency functioning.

Section 6.2 Policies.

- A. Administrative Policies
 - 1. Written administrative policies shall be developed and shall be reviewed as necessary and, if indicated, revised. These policies shall be made available to patients/families or their agents upon request.
 - 2. These policies shall include, but not be limited to:
 - a. A policy that patients shall be accepted for care and be cared for without discrimination on the basis of age, sex, sexual orientation, mental or physical handicap, race, color, religion, ancestry or national origin.
 - b. A policy on charges for care or services.
 - a. A policy on causes for termination of services.
 - b. A policy that patients shall be accepted for treatment on the basis of a reasonable expectation that the patient's needs can be met by the program. Such reasonable expectations shall be based on an assessment of at least the following factors:
 - (1) A physician certifying a prognosis of a terminal illness with a prognosis of one year or less, if the disease follows its natural course.
 - (3) A plan to meet medical and non-medical emergencies.
 - (4) Physical facilities adequate for proper care and a safe environment for patients and program staff.
 - e. A policy for discharge of patients. Criteria for discharge may include:
 - (1) Death of the patient.
 - (2) The patient's condition has changed so he/she is no longer considered eligible for services.
 - (3) The patient and family or attending physician requests discharge.
 - (4) The patient/family is unwilling to comply with the plan of care, and consistently acts in a way that compromises standards of care.
 - (5) Issues of staff safety cannot be resolved.
 - (6) The patient moves from the geographic area served by the program.
 - (7) The patient and family elects to receive care from another provider.

- (8) Subject to applicable contracts, state and federal law, payment sources are exhausted, and the program is fiscally unable to provide free or part-cost care.
- (9) The program is closing.
- f. Patient care policies and procedures that govern record keeping and all services provided shall be established and followed.
- g. Policies on appropriate methods and procedures for the dispensing, administering and disposal of drugs and biologicals in accordance with accepted professional principles and appropriate Federal, State, and local laws.
- h. Policies for program evaluation.
- i. Policies on protecting patients from exposure to infectious diseases.
- j. Personnel policies shall include qualifications, responsibilities and conditions of employment. Policies shall be available to all personnel. Policies shall include, but are not limited to:
 - (1) Hours of work, wage scales, vacation and sick leave.
 - (2) Orientation and continuing in-service training.
 - (3) A plan for an annual evaluation of employee performance.
 - (4) Specific job descriptions for each category of personnel including qualifications, duties and activities.
 - (5) Requirement for all employees and volunteers with direct patient contact to have a background check as required by law prior to assignment to duties.
- k. A written policy assuring compliance with the Patient Self-Determination Act.
- l. A written policy and plan that addresses patient care during a disaster.

B. Contractual Services

- 1. When program services are not provided directly by employees there shall be a written agreement defining the nature and scope of services provided.
- 2. The agreement shall address, but not be limited to:
 - a. Services to be provided.
 - b. Rights and responsibilities of the program or individual providing services and of the contracting organization in the implementation, coordination, supervision and evaluation of the care or services.
 - c. Roles and responsibilities of the program and the contracted individual or organization in the following:
 - (1) Patient/family admission process.
 - (2) Patient/family assessment.
 - (3) Development, review, revision and management of the plan of care.
 - (4) Interdisciplinary team conferences.
 - (5) Scheduling visits or hours.
 - (6) Discharge planning.
 - (7) Bereavement follow-up.
 - d. Submission of documentation of services provided.
 - e. Responsibility of the contracted individual or organization to adhere to applicable policies, including personnel qualifications.
 - f. Procedure for charges and reimbursement.
 - g. Term of the agreement and the conditions for its renewal or termination.
 - h. Education requirements.

Section 6.3 Record-keeping Requirements

A. Employee Health Examinations and Health Records

1. All persons providing physician, nursing or home health aide services shall have a health examination by a physician, nurse practitioner or physician's assistant six months prior to employment or within 14 days of the date of employment. Each examination shall include confirmation by the person performing the examination that the employee is physically and medically qualified to perform the duties to be assigned, and that employee has no health condition that would create a hazard to patients.
2. The initial health examination shall include a tuberculosis screening. Tuberculosis screening shall occur annually thereafter.
3. Hepatitis B vaccinations will be offered to all employees whose jobs involve the risk of directly contacting blood or other potentially infectious materials consistent with OSHA standards.
4. Employees' health records shall be stored, protected against loss, destruction or unauthorized use.

B. Patients' Medical Records

1. Admission Records

- a. A program shall maintain for each patient a clinical record that shall include the following:
 - (1) An admission record that contains the following elements:
 - (a) Name.
 - (b) Current address.
 - (c) Date of birth.
 - (d) Sex.
 - (e) Race/ethnicity.
 - (f) Occupation or former occupation, if applicable.
 - (g) Date of admission and source of referral.
 - (h) Date of discharge or transfer from referring facility, if applicable.
 - (i) Name, address and telephone number of person or agency responsible for patient, and person to be notified in case of emergency/death.
 - (j) Name, address and telephone number of attending physician.
 - (2) Diagnosis and conditions with notation of those relevant to plan of care.
 - (3) Assessments.
 - (4) Plan of care.
 - (5) Allergies and known reactions to drugs and food. This information shall be given such prominence in the record that it cannot be missed by any hospice or contract personnel who have reason to provide food or medication to the patient.
 - (6) Medications and treatment orders, diet orders, orders for therapeutic and other program services.
 - (7) Side effects of medications and treatments requiring special precautions must be indicated.
 - (8) Medical supplies and appliances or special devices needed.
 - (9) Clinical notes dictated or written on the day of service by personnel rendering such service. Clinical notes shall include:

- (a) A concise and accurate record of care and treatment administered.
- (b) A record of pertinent observations of the patient including psychosocial, physical manifestations and specific observations to be brought to the immediate attention of the physician. Observations shall be recorded with sufficient frequency to indicate the progress in achieving goals of the plan of care and changes in status that occur in the patient.
- (c) Evidence of coordination of services through the interdisciplinary team.
- (d) Name, dosage, route, frequency and time of administration of medications and treatments. Site of injection shall be recorded. Documentation of teaching or instructions to patients and caregiver(s) and documentation of results of instruction.
- (e) Changes in level of care.
- (10) Laboratory and x-ray reports, if applicable.
- (11) Treatment consent forms.
- (12) Advanced directive, if available.

2. Discharge

- a. Discharge notes and summary of all program services, if other than by death shall include:
 - (1) Summary of the patient's physical, mental, spiritual and emotional status at the time of discharge.
 - (2) Method of initiation of discharge, i.e., by physician, hospice, patient and/or family.
 - (3) Date and reason for termination of service.
 - (4) Extent to which treatment goals were obtained.
 - (5) Referrals made, if necessary.
 - (6) Documentation of notification of the termination of services to patient, family and physician.
 - (7) Transfer notes, if appropriate.
- b. Discharge notes and summary of all program services, if discharged by death shall include:
 - (1) Date and location of death.
 - (2) Extent to which treatment goals were obtained, including pain and symptom management.
 - (3) Degree of emotional support extended to family and significant others.
 - (4) Bereavement services plan.
 - (5) Disposition of Schedule II drugs.

3. Maintenance of Records

- a. Patients' clinical records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient.
- b. Records shall be permanent and be kept on all patients admitted or accepted for treatment. All clinical records of discharged patients shall be completed within 30 days after discharge date and such records shall be kept for a minimum of seven (7) years, except for minors whose records shall be kept at least until one (1) year after the minor has reached the age of 18, but in no case less than seven

- (7) years. All required records, either originals or faithful and accurate reproductions, shall be maintained in legible form and available upon the request of the attending physician, the hospice or any authorized officer, agent, or employee of either or any other person authorized by law to make such request.
- c. Information contained in the clinical records shall be confidential and disclosed only to authorized persons as necessary for licensing, reimbursement or accreditation purposes.
 - d. If a program ceases operation, the Department shall be notified immediately of the arrangements for the safe preservation of patients' clinical records, or transfer to the new agency.
 - e. The hospice shall have a policy and procedure for patients and families or authorized persons to obtain copies of patients' clinical records.
 - f. The Department shall be informed immediately, in writing, when patient clinical records are defaced or destroyed before termination of the required retention period.
 - g. If the ownership of the hospice changes, the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department written documentation of one of the following:
 - (1) The new licensee will have custody of the patients' clinical records, and these records will be available to the former licensee, the new licensee and other authorized persons;
 - (2) Other arrangements have been made by the current licensee for safe preservation and location of the patients' clinical records, and records are available to the new and former licensee and other authorized persons.
 - h. Patients' clinical records shall be stored so as to be protected against loss, destruction or unauthorized use.

Section 6.4 Reporting Requirements

A Reporting of Outbreaks

All cases of outbreak or undue prevalence of infections or parasitic disease or infestation shall be reported to the local health officer in accordance with applicable law.

B Unusual Occurrences

1. Occurrences that threaten the welfare, safety or health of patients or program personnel shall be reported to the Department. These occurrences include, but are not limited to:
 - a. Poisonings.
 - b. Death from unnatural causes.
 - c. Fires.
 - d. Patient injury as a result of medical or nursing malfeasance or nonfeasance.
 - e. Criminal misconduct by a program employee or agent committed upon a patient.
2. The report shall be made by the next Department workday either by telephone (and confirmed in writing) or in person to the Department. An incident report shall be maintained by the hospice for one (1) year.
3. The program shall report alleged misconduct listed above to the appropriate licensing board of the individual involved. The program shall furnish other pertinent information related to such occurrences as the Department may require.
4. Criminal misconduct shall be reported to the appropriate law enforcement agency.

Section 6.5 Quality Assessment and Performance Improvement

- A. Each program shall have an organized system for assessing and improving the quality of care and services. This system shall be designed to improve performance on a systematic and continuous basis. The system shall consist of planned and measurable mechanisms for data collection, analysis and a process for improvement within specified time frames.
- B. The organization shall implement performance improvement processes that routinely assess and improve all services provided directly and by written agreement.
- C. Each organization shall have a written plan reviewed and revised at least annually for improving the organization's performance. This plan shall include, but not be limited to, assessment and improvement of the quality and efficiency of governance; management; and clinical and support processes.
- D. The organization must have a process for assessing employee competence; measuring consumer satisfaction; and investigating, addressing and documenting complaints and grievances.
- E. The hospice administrator is responsible for performance improvement.
- F. Each hospice will conduct a review of quality improvement and performance improvement policies at least annually. This review will be by a group composed of at least the following:
 - 1. The administrator.
 - 2. The hospice medical director.
 - 3. The patient care coordinator or director of patient care services.
 - 4. A hospice social worker or counselor.
- G. All performance improvement activities will be documented on a quarterly basis and maintained on file.
- H. Utilization review shall include criteria for each discipline providing care. Criteria shall include:
 - 1. Appropriateness of the level of care to protect the health and safety of patients.
 - 2. Timeliness of care.
 - 3. Adequacy of care to meet patients' needs.
 - 4. Appropriateness of specific services provided.
 - 5. Whether standards of practice for patient care were observed.
- I. The program shall provide or make provision for at least quarterly in-service education programs to its employees and volunteers who have direct patient contact.

Section 6.6 Patient/Family Rights and Responsibilities

- A. Rights and Responsibilities
 - 1. Written policies regarding rights and responsibilities of patients shall be established and made available to the patient, guardian, next-of-kin, sponsoring agency or representative payee and the public. Such policies shall ensure that each patient receiving care shall have the following rights and responsibilities:
 - a. To be fully informed, as evidenced by the patient's or his/her appointed representative's, written acknowledgment prior to or at the time of admission of these rights and of all rules and regulations governing patient conduct.

- b. To be fully informed, prior to or at the time of admission, of services available in the hospice and of related charges, including any charges for services not covered under Titles XVIII or XIX of the Social Security Act.
 - c. To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his or her medical treatment, including pain and symptom management, and to refuse to participate in experimental research.
 - d. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
 - e. To be advised of what services are to be rendered and by what discipline, e.g., Registered Nurse, counselor, chaplain, etc.
 - f. To be advised, in advance, of any change in treatment.
 - g. To be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
 - h. To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
 - i. To not be subjected to verbal or physical abuse of any kind and to be informed that corporal punishment is prohibited.
 - j. To be informed by the licensee of the provisions of the law regarding complaints and procedures for registering complaints confidentially, including, but not limited to, the address and telephone number of the local district office of the Department.
 - k. To be informed of the provisions of law pertaining to advanced directives, including withdrawal or withholding of treatment and/or life support.
 - l. To be assured that the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
2. Patient/family responsibilities:
- a. To remain under a doctor's care while receiving hospice services.
 - b. To inform the program of any advance directives or any changes in advance directives and provide the program with a copy.
 - c. To cooperate with the primary doctor, program staff and other caregivers.
 - d. To advise the program of any problems or dissatisfaction with patient care.
 - e. To notify the program of address or telephone number changes or when unable to keep appointments.
 - f. To provide a safe home environment in which care can be given. In the event that conduct occurs such that the patient's or staff's welfare or safety is threatened, service may be terminated.
 - g. Obtain medications, supplies and equipment ordered by the patient's physician if they cannot be obtained or supplied by the program.
 - h. Treat personnel with respect and consideration.
 - i. Sign the required consents and releases for insurance billing and provide insurance and financial records as requested.
 - j. Accept the consequences for any refusal of treatment or choice of non-compliance.

3. The program shall describe in writing patient and family responsibilities and the mechanism to file a grievance and obtain a receipt that this information has been received by the patient/family.

B. Retaliation or Discrimination

1. No program or employee of a program shall discriminate or retaliate in any manner against any patient or family or any employee on the basis or for the reason that the patient or family or the employee has presented a grievance or complaint, or has initiated or cooperated in any investigation or proceeding of any governmental entity relating to care, services or conditions of the program.