Rulemaking Hearing Rules

Department of Health - 1200
Board for Licensing Health Care Facilities

Chapter 1200-08-01
Standards for Hospitals

Chapter 1200-08-02
Standards for Prescribed Child Care Centers

Chapter 1200-08-06
Standards for Nursing Homes

Chapter 1200-08-10
Standards for Ambulatory Surgical Treatment Centers

Chapter 1200-08-11
Standards for Homes for the Aged

Chapter 1200-08-15
Standards for Residential Hospices

Chapter 1200-08-17
Alcohol and other Drugs of Abuse Residential Rehabilitation Treatment Facilities

Chapter 1200-08-22
Alcohol and other Drugs of Abuse Halfway House Treatment Facilities

Chapter 1200-08-23
Alcohol and other Drugs of Abuse Residential Detoxification Treatment Facilities

Chapter 1200-08-24
Standards for Birthing Centers

Chapter 1200-08-25
Standards for Assisted-Care Living Facilities

1200-08-26
Standards for Homecare Organizations Providing Home Health Services

1200-08-27
Standards for Homecare Organizations Providing Hospice Services

1200-08-28
Standards for HIV Supportive Facilities

Chapter 1200-08-32
Standards for End Stage Renal Dialysis Clinics

Chapter 1200-08-34
Standards for Home Care Organizations Providing Professional Support Services

Amendments

Chapters 1200-08-1, 1200-08-2, 1200-08-6, 1200-08-10, 1200-08-11, 1200-08-15, 1200-08-17, 1200-08-22, 1200-08-23, 1200-08-24, 1200-08-25, 1200-08-26, 1200-08-27, 1200-08-28, 1200-08-32, and 1200-08-34 are amended by adding the following forms as Appendix I to each of these chapters:

Appendix I

(1) Physician Orders for Scope of Treatment (POST) Form

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COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST) This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.	Patient's Last Name First Name/Middle Initial Date of Birth

Section A — Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.

☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitate (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B — Check One Box Only

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.

☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.

Other Instructions:_____

Section C — Check One Box Only

ANTIBIOTICS – Treatment for new medical conditions:

☐ No Antibiotics

☐ Antibiotics

Other Instructions:_____

Section D — Check One Box Only in Each Column

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.

☐ No IV fluids (provide other measures to assure comfort)	☐ No feeding tube
☐ IV fluids for a defined trial period	☐ Feeding tube for a defined trial period
☐ IV fluids long-term if indicated	☐ Feeding tube long-term

Other Instructions:_____

Section E — Must be Completed

Discussed with:	The Basis for These Orders Is: (Must be completed)
☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other:_____(Specify)	☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other)_____

Physician Name (Print)	Physician Phone Number	Office Use Only
Physician Signature (Mandatory)	Date	

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HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative			
Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences. (If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)			
Signature	Name (print)	Relationship (write "self" if patient)	
Contact Information			
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

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DO NOT ALTER THIS FORM!

(2) Advance Care Plan Form

This space left blank intentionally.

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.

☐ Yes ☐ No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	Life Support/Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ Yes ☐ No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE:_____
(Patient)

Witnesses:

1, I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. _____ Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. _____ Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF_____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

The rulemaking hearing rules set out herein were properly filed in the Department of State on the 16th day of February, 2007 and will become effective on the 2nd day of May, 2007. (FS 02-22-07, DBID 2367 through 2382)