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Sequence Number: 08-20-12
Rule ID(s): 5289-5303
File Date: 8/28/12
Effective Date: 11/26/12

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

Agency/Board/Commission:	Department of Health
Division:	Bureau of Health Licensure and Regulation Division of Health Care Facilities
Contact Person:	Diona E. Layden, Assistant General Counsel
Address:	Plaza One, Suite 210, 220 Athens Way, Nashville, Tennessee 37243
Zip:	37243
Phone:	(615) 741-1611
Email:	Diona.Layden@tn.gov

Revision Type (check all that apply):
X Amendment
x New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-08-01	Standards for Hospitals
Rule Number	**Rule Title**
1200-08-01-.15	Appendix I

Chapter Number	**Chapter Title**
1200-08-02	Standards for Prescribed Child Care Centers
Rule Number	**Rule Title**
1200-08-02-.14	Appendix

Chapter Number	**Chapter Title**
1200-08-06	Standards for Nursing Homes
Rule Number	**Rule Title**
1200-08-06-.16	Appendix I

Chapter Number	**Chapter Title**
1200-08-10	Standards for Ambulatory Surgical Treatment Centers
Rule Number	**Rule Title**
1200-08-10-.15	Appendix I

Chapter Number	**Chapter Title**
1200-08-11	Standards for Homes for the Aged

Rule Number	Rule Title
1200-08-11-.14	Appendix I

Chapter Number	Chapter Title
1200-08-15	Standards for Residential Hospices
Rule Number	**Rule Title**
1200-08-15-.15	Appendix I

Chapter Number	Chapter Title
1200-08-24	Standards for Birthing Centers
Rule Number	**Rule Title**
1200-08-24-.14	Appendix I

Chapter Number	Chapter Title
1200-08-25	Standards for Assisted-Care Living Facilities
Rule Number	**Rule Title**
1200-08-25-.17	Appendix

Chapter Number	Chapter Title
1200-08-26	Standards for Home Care Organizations Providing Home Health Services
Rule Number	**Rule Title**
1200-08-26-.15	Appendix I

Chapter Number	Chapter Title
1200-08-27	Standards for Home Care Organizations Providing Hospice Services
Rule Number	**Rule Title**
1200-08-27-.15	Appendix I

Chapter Number	Chapter Title
1200-08-28	Standards for HIV Supportive Living Facilities
Rule Number	**Rule Title**
1200-08-28-.15	Appendix I

Chapter Number	Chapter Title
1200-08-32	Standards for End Stage Renal Dialysis Clinics
Rule Number	**Rule Title**
1200-08-32-.15	Appendix I

Chapter Number	Chapter Title
1200-08-34	Standards for Home Care Organizations Providing Professional Support Services
Rule Number	**Rule Title**
1200-08-34-.15	Appendix I

Chapter Number	Chapter Title
1200-08-36	Standards for Adult Care Homes – Level 2
Rule Number	**Rule Title**
1200-08-36-.18	Appendix I

Chapter Number	Chapter Title

1200-08-35	Standards for Outpatient Diagnostic Centers
Rule Number	**Rule Title**
1200-08-35-.15	Appendix I

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Amendments

Rules 1200-08-01-.15 Appendix I, 1200-08-02-.14 Appendix, 1200-08-6-.16 Appendix I, 1200-08-10-.15 Appendix I, 1200-08-11-.14 Appendix I, 1200-08-15-.15 Appendix I, 1200-08-24-.14 Appendix I, 1200-08-25-.17 Appendix, 1200-08-26-.15 Appendix I, 1200-08-27-.15 Appendix I, 1200-08-28-.15 Appendix I, 1200-08-32-.15 Appendix I, 1200-08-34-.15 Appendix I, 1200-08-36-.18 Appendix I are amended by deleting the rules in their entirety and substituting the following forms, so that as amended, the new rules shall read as follows:

Appendix I

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

(This space intentionally left blank)

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & nutrition must be offered if medically feasible.

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

☐ **No feeding tube**
☐ **Feeding tube for a defined trial period**
☐ **Feeding tube long-term**

Other Instructions: _____

Section E *Must be Completed*

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____(Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self' if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes	☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes	☐ No	**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.
☐ Yes	☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes	☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

_____

_____

_____

_____

(Attach additional pages if necessary)

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

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

_____

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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

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.

New Rule

Chapter 1200-08-35
Standards for Outpatient Diagnostic Centers

Chapter 1200-08-35 is amended by adding new rule 1200-08-35-.15 Appendix I to read as follows:

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

(This space intentionally left blank)

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & nutrition must be offered if medically feasible.

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

*Other Instructions:*_____

Section E *Must be Completed*

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____(Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	**Physician Signature** (Mandatory)	Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

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

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(Tennessee)

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Name: _____ Phone #: _____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes	☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes	☐ No	**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.
☐ Yes	☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes	☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

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☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

_____

_____

_____

_____

(Attach additional pages if necessary)

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

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

_____

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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

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.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Larry Arnold, MD				X	
Sylvia Burton	X				
Paula Collier	X				
Betsy Cummins	X				
Alex Gaddy	X				
Robert Gordon				X	
Jennifer Gordon-Maloney, DDS				X	
Luke Gregory				X	
Janice Hill	X				
Roy King, MD	X				
Jeff Lawrence, MD	X				
Carissa Lynch	X				
Annette Marler	X				
John Marshall	X				
Jim Shulman	X				
James Weatherington	X				

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Board for Licensing Health Care Facilities on 05/02/2012, and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *03/09/12*

Rulemaking Hearing(s) Conducted on: (add more dates). *05/02/12*

Date: June 21, 2012

Signature: DEL

Name of Officer: Diona E. Layden

Title of Officer: Assistant General Counsel
Department of Health

THEODORA P WILKINS STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY

Subscribed and sworn to before me on: 6/21/12

Notary Public Signature: Theodora P. Wilkins

My commission expires on: 11/3/15

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Robert E. Cooper, Jr.
Attorney General and Reporter

8-23-12

Date

Department of State Use Only

Filed with the Department of State on: 8/28/12

Effective on: 11/26/12

Tre Hargett by Nora Hart, POA

Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Chris Puri spoke representing the Tennessee Health Care Association and stated the association supported the changes in the forms. Mr. Puri further stated that nursing homes, especially skilled nursing facilities certified by Medicare and Medicaid have tension in the survey process regarding advance directive forms. It was requested that the Board make a statement during the rulemaking stating the intent is to embrace the use of universal advance directives and increase the use of advance directive forms and ensure it is clear there may be inadvertent use of prior forms and this will not result in facility non-compliance.

The Board chose not to make a formal statement during the rulemaking.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

Regulatory Flexibility Analysis

(1) The proposed revisions to the forms do not overlap, duplicate, or conflict with other federal, state, or local government rules.

(2) The proposed revisions to the forms exhibit clarity, conciseness, and lack of ambiguity.

(3) The proposed revisions to the forms give consideration to compliance and reporting requirements for small businesses.

(4) There are no schedules or deadlines associated with the proposed revisions to the forms.

(5) The proposed revisions to the forms give consideration to compliance and reporting requirements for small businesses.

(6) The performance standards required in the proposed revisions to the forms are basic and do not necessitate the establishment of design or operational standards.

(7) There are no unnecessary entry barriers or other effects in the proposed revisions to the forms that would stifle entrepreneurial activity or curb innovation.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

1. **Types of small businesses that will be directly affected by the proposed rules:**

   Assisted-Care Living Facilities; Ambulatory Surgical Treatment Centers; Hospitals; Home Care Organizations Providing Home Health Services; Nursing Homes; HIV Supportive Living Centers; Homes for the Aged; Home Care Organizations Providing Professional Support Services; End Stage Renal Dialysis Clinics; Home Care Organizations Providing Hospice Services; Prescribed Child Care Centers; Residential Hospices; Birthing Centers; and Adult Care Homes.

2. **Types of small businesses that will bear the cost of the proposed rules:**

   The proposed revisions to the forms should not result in a cost to small businesses.

3. **Types of small businesses that will directly benefit from the proposed rules:**

   Unknown.

4. **Description of how small business will be adversely impacted by the proposed rules:**

   Small businesses should not be adversely impacted by the proposed revisions to the rules.

5. **Alternatives to the proposed rule that will accomplish the same objectives but are less burdensome, and why they are not being proposed:**

   The proposed revisions to the forms should not cause a burden to any small business.

6. **Comparison with Federal and State Counterparts:**

   Unknown.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

These rule amendments and new rule are not expected to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The Physician Orders for Scope of Treatment (POST) form, a universal do not resuscitate order, and the Advance Care Plan form, an advance directive, are being amended. The forms are attached as an appendix to the rules for the various facility/entity types. With respect to the POST form, the form has been reformatted so that the signature lines are now on the first page of the form. With respect to the Advance Care Plan form, clarifying language has been added to the form to make the form more user-friendly and to clearly and accurately record the individual's healthcare wishes.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The applicable law is contained in T.C.A. § 68-11-209 (Rules and regulations governing operation – Adoption by board); T.C.A. § 68-11-224(i)(1) (Withholding of resuscitative services – Regulations); and T.C.A. § 68-11-1805 (Model forms – Rules and regulations).

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons, organizations, corporations, and entities affected by these forms will be those who execute end of life directives and/or who assist individuals execute end of life directives. No one has urged rejection of the amendments to the forms.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

Tenn. Op. Atty. Gen. No. 05-093, 2005 WL 1839873 (Tenn.A.G.) – Authority Under the Tennessee Health Care Decisions Act

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The amendments to the forms should result in neither a positive nor a negative fiscal impact.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

I, as well as Vincent Davis, Director of the Division of Health Care Facilities, possess substantial knowledge and understanding of the rule.

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

I, as well as Vincent Davis, Director of the Division of Health Care Facilities, will explain the rules at a scheduled meeting of the Government Operation Committee.

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Diona E. Layden, Assistant General Counsel, Tennessee Department of Health, 220 Athens Way, Suite 210, Nashville, TN 37243, (615) 741-1611, Diona.Layden@tn.gov ; Vincent Davis, Director, Health Care Facilities,

227 French Landing Drive, Suite 501, Nashville, TN 37243, (615) 741-7221, Vincent.Davis@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

I will provide any additional information requested by the Government Operations Committee.

(Rule 1200-08-01-.14, continued)

deferral of elective admission patients and also for the early transfer or discharge of some current patients if it appears that the number of casualties will exceed available staffed beds.

3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to staff who would be assigned non-routine duties during these types of emergencies. Familiarization information shall be included in employee orientation sessions and more detailed instruction must be included in continuing education programs. Records of orientation and education must be maintained for at least three (3) years.

4. At least one drill shall be conducted each year for the purpose of educating staff, resource determination, and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

5. As soon as possible, actual community emergency situations that result in the treatment of more than twenty (20) patients, or fifteen percent (15%) of the licensed bed capacity, whichever is less, must be documented. Actual situations that had education and training value may be substituted for a drill. This includes documented actual plan activation during community emergencies, even if no patients are received.

(c) Emergency Planning with Local Government Authorities.

1. All hospitals shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

2. Each hospital must rehearse both the Physical Facility and Community Emergency plan as required in these regulations, even if the local Emergency Management Agency is unable to participate.

3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000.*

1200-08-01-.15 APPENDIX I

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

~~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~~

(Rule 1200-08-01-.15, continued)

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: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: _____ (Specify) The Basis for These Orders is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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

(Rule 1200-08-01-.15, continued)

~~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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

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

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED	
Physician Orders for Scope of Treatment (POST)	Patient's Last Name

(Rule 1200-08-01-.15, continued)

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.	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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & 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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(Rule 1200-08-01-.15, continued)

(2) Advance Care Plan Form

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 these 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 Signature of witness number 2
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.

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.

(Rule 1200-08-01-.15, continued)

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that

(Rule 1200-08-01-.15, continued)

medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2 Page 1 of 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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

(Rule 1200-08-01-.15, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

Inventory Results:

_____ indicated - medical confirmation of noninfectious status required

_____ not indicated - no further action necessary

Signature:_____

Date Completed:_____

Medical Confirmation:

_____ confirmation of noninfectious status received

Signature:_____

Date Received:_____

APPENDIX I

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

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	ANTIBIOTICS – Treatment for new medical conditions: ☐ No Antibiotics

(Rule 1200-08-02-Appendix I, continued)

Check One Box Only	☐ 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: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify) The Basis for These Orders Is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO PERSONNEL AUTHORIZED BY PATIENT

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.

(Rule 1200-08-02-Appendix I, continued)

~~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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

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

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)	Patient's Last Name
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.	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 Resuscitation (DNR/ no CPR) (Allow Natural Death)
	When not in cardiopulmonary arrest, follow orders in B, C, and D.

(Rule 1200-08-02-Appendix I, continued)

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 & NUTRITION. Oral fluids & 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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical Indications
☐ (Other) _____

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~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: _____~~

(Rule 1200-08-02-Appendix I, continued)

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)

(Rule 1200-08-02-Appendix I, continued)

~~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.~~

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

1200-08-06-.16 APPENDIX I

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

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: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify) The Basis for These Orders Is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMISSION TO DISCLOSE TO OTHER HEALTH CARE PROFESSIONALS AS NEEDED

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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & 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	☐ Patient's preferences
☐ Health care agent	☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Court-appointed guardian	☐ Medical indications
☐ Health care surrogate	☐ (Other) _____
☐ Parent of minor	
☐ Other: _____ (Specify)	

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

(Rule 1200-08-06-.16, continued)

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(2) Advance Care Plan Form

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

(Rule 1200-08-06-.16, continued)

	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

(Rule 1200-08-06-.16, continued)

- ~~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.~~

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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

(Rule 1200-08-06-.16, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(Rule 1200-08-10-.14, continued)

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed November 22, 1996; effective August 27, 1997. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003.*

1200-08-10-.15 APPENDIX I

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

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	Discussed with: ☐ Patient/Resident ☐ Health care agent The Basis for These Orders Is: (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown)

(Rule 1200-08-10-.15 continued)

Must be Completed	☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: _____ (Specify)	☐ Medical indications ☐ (Other) _____
	Physician Name (Print)	Physician Phone Number / Office Use Only
	Physician Signature (Mandatory)	Date

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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:

(Rule 1200-08-10-.15 continued)

~~(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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)** 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 & NUTRITION.** Oral fluids & 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:* _____

(Rule 1200-08-10-.15 continued)

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

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

(Rule 1200-08-10-.15 continued)

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~ADVANCE CARE PLAN~~

(Rule 1200-08-10-.15 continued)

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.: _____

(Rule 1200-08-10-.15 continued)

(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.

(2) Advance Care Plan Form

(Rule 1200-08-10-.15 continued)

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

(Rule 1200-08-10-.15 continued)

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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 _____

(Rule 1200-08-10-.15 continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(Rule 1200-08-10-.15 continued)

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.

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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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(Rule 1200-08-11-.13, continued)

1. Staff duties;
2. Equipment failures;
3. Evacuation procedures; and
4. Emergency food service.

(f) Earthquake Disaster Procedures Plan:

1. Staff duties;
2. Evacuation procedures;
3. Safety procedures; and
4. Emergency services.

(2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.

(3) For facilities which elect to have an emergency generator, the generator shall be designed to meet the facility's HVAC and essential needs and shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with local resources.

(a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.

(b) The emergency generator shall be operated at the existing connected load and not on dual power, and a monthly log shall be maintained by the facility. The facility shall have trained staff familiar with the generator's operation.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed July 27, 2000; effective October 10, 2000.*

1200-08-11-.14 APPENDIX I

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

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

(Rule 1200-08-11-.14, continued)

A Check One Box Only	☐ 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: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: _____ (Specify) The Basis for These Orders Is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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

(Rule 1200-08-11-.14, continued)

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.

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- 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

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

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)	Patient's Last Name

(Rule 1200-08-11-.14, continued)

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.	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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & 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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~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 these 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.

(2) Advance Care Plan Form

(Rule 1200-08-11-.14, continued)

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

(Rule 1200-08-11-.14, continued)

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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 _____

(Rule 1200-08-11-.14, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(Rule 1200-08-15-.14, continued)

6. The residential hospice shall develop and periodically review with all employees a pre-arranged plan for the orderly evacuation of all patients and/or residents in case of a fire, internal disaster or other emergency. The plan of evacuation shall be posted throughout the facility. Fire drills shall be held at least quarterly for each work shift for residential hospice personnel in each separate patient/resident-occupied residential hospice building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years.

(b) Emergency Planning with Local Government Authorities.

1. All residential hospices shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

2. Each residential hospice must rehearse both the Physical Facility and Community Emergency plan as required in these regulations, even if the local Emergency Management Agency is unable to participate.

3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed August 18, 1995; effective November 1, 1995. Amendment filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed April 27, 2000; effective July 11, 2000. Amendment filed November 22, 2005; effective February 5, 2006.*

1200-08-15-.15 APPENDIX I

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

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

(Rule 1200-08-15-.15, continued)

	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: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: _____ (Specify) The Basis for These Orders is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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.

(Rule 1200-08-15-.15, continued)

~~- 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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

~~DO NOT ALTER THIS FORM!~~

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

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)	Patient's Last Name
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.	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 Resuscitation (DNR/ no CPR) (Allow Natural Death)
	When not in cardiopulmonary arrest, follow orders in B, C, and D.

(Rule 1200-08-15-.15, continued)

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

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~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.~~

(Rule 1200-08-15-.15, continued)

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):

(Rule 1200-08-15-.15, continued)

~~☐ 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.~~

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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.

(Rule 1200-08-15-.15, continued)

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:

_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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.
☐ ☐	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV

(Rule 1200-08-15-.15, continued)

Yes	No	fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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:

(Rule 1200-08-15-.15, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(Rule 1200-08-24-.12, continued)

12, 1998. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed January 3, 2006; effective March 19, 2006. Amendment filed February 7, 2007; effective April 23, 2007.

1200-08-24-.13 DISASTER PREPAREDNESS.

(1) Physical Facility and Community Emergency Plans.

(a) Every birthing center shall have a current internal emergency plan, or plans, that provides for fires, bomb threats, severe weather, utility service failures, plus any local high risk situations such as floods, earthquakes, toxic fumes and chemical spills.

(b) The plan(s) must include provisions for the relocation of persons within the building and/or either partial or full building evacuation. Plans that provide for the relocation of patients to other healthcare facilities must have written agreements for emergency transfers. Their agreements may be mutual, i.e., providing for transfer either way.

(c) Copies of the plan(s), either complete or outlines, shall be available to all staff. Provisions that have security implications may be omitted from the outline versions. Familiarization information shall be included in employee orientation sessions and more detailed instructions must be included in continuing education programs. Records of orientation and education programs must be maintained for at least three (3) years.

(d) Drills of the fire safety plan shall be conducted at least once a year on each major work shift, for a minimum of three times a year for each facility. A combined drill of the other internal emergency plans shall be conducted at least once a year. The risk focus may vary by drill. Both types of drills are for the purposes of educating staff, resource determination, testing personal safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

(e) As soon as possible, real situations that result in a response by local authorities must be documented. This includes a critique of the activation of the plan. Actual documented situations that provided educational and training value may be substituted for a drill.

(2) Emergency Planning with Local Government Authorities.

(a) All birthing centers shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

(b) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed March 31, 1998; effective June 12, 1998.*

1200-08-24-.14 APPENDIX I

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

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

(Rule 1200-08-24-.14, continued)

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: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: _____ (Specify) The Basis for These Orders Is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

SIGNATURES OF PERSONS DISCUSSING CARE WITH HEALTH CARE PROFESSIONAL(S) ABOVE
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.

(Rule 1200-08-24-.14, continued)

(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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & 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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)

(Rule 1200-08-24-.14, continued)

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(Rule 1200-08-24-.14, continued)

(2) Advance Care Plan Form

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

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.
☐ ☐	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach

(Rule 1200-08-24-.14, continued)

Yes No	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.

(Rule 1200-08-24-.14, continued)
(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ ☐ Yes No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ ☐ Yes No	**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.
☐ ☐ Yes No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ ☐ Yes No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that

(Rule 1200-08-24-.14, continued)

medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ ☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2 Page 1 of 2

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

_____

_____

_____

(Attach additional pages if necessary)

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

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

_____

_____

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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 _____

(Rule 1200-08-24-.14, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

1200-08-25-.17 APPENDIX.

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

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	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian	The Basis for These Orders Is: (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown)

(Rule 1200-08-25-.17, continued)

Completed	☐ Health care surrogate ☐ Parent of minor ☐ Other:_____(Specify)	☐ Medical indications ☐ (Other)_____	
	Physician Name (Print)	Physician Phone Number	Office Use Only
	Physician Signature (Mandatory)	Date	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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

(Rule 1200-08-25-.17, continued)

~~(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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

~~DO NOT ALTER THIS FORM!~~

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & 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:

(Rule 1200-08-25-.17, continued)

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

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~ADVANCE CARE PLAN~~

(Rule 1200-08-25-.17, continued)

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.

(2) Advance Care Plan Form

(Rule 1200-08-25-.17, continued)

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

(Rule 1200-08-25-.17, continued)

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2 Page 1 of 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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 _____

(Rule 1200-08-25-.17, continued)

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

Authority: *T.C.A. §§ 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

1200-08-26-.14 DISASTER PREPAREDNESS.

(1) All agencies shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The agency shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

(2) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000.*

1200-08-26-.15 APPENDIX I

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

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

(Rule 1200-08-26-.15, continued)

Check One Box Only in Each Column	☐ No IV fluids (provide other measures to assure comfort) ☐ IV fluids for a defined trial period ☐ IV fluids long-term if indicated	☐ No feeding tube ☐ Feeding tube for a defined trial period ☐ Feeding tube long-term
	Other instructions:	
Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify)	The Basis for These Orders Is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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".

(Rule 1200-08-26-.15, continued)

~~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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

~~DO NOT ALTER THIS FORM!~~

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)** 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:* _____

(Rule 1200-08-26-.15, continued)

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

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

(Rule 1200-08-26-.15, continued)

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.

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~~(2) Advance Care Plan Form~~

~~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.~~

(Rule 1200-08-26-.15, continued)

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 these 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)

(Rule 1200-08-26-.15, continued)

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

(Rule 1200-08-26-.15, continued)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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.

(Rule 1200-08-26-.15, continued)

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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

(Rule 1200-08-26-.15, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

1200-08-27-.14 DISASTER PREPAREDNESS.

(1) All agencies shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The agency shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

(2) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000.*

1200-08-27-.15 APPENDIX I

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

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	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

(Rule 1200-08-27-.15, continued)

Box Only in Each Column	☐ IV fluids for a defined trial period ☐ IV fluids long-term if indicated	☐ Feeding tube for a defined trial period ☐ Feeding tube long-term
	Other Instructions:	
Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify)	The Basis for These Orders is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

[illegible]

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

(Rule 1200-08-27-.15, continued)

~~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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

~~DO NOT ALTER THIS FORM!~~

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)** 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:*

(Rule 1200-08-27-.15, continued)

Section D *Check One Box Only in Each Column*	**MEDICALLY ADMINISTERED FLUIDS & NUTRITION.** Oral fluids & 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:** ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify)	**The Basis for These Orders Is:** (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other)	
Physician Name (Print)	**Physician Signature** (Mandatory) Date		**Physician Phone Number**
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative **Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.**			
Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

(Rule 1200-08-27-.15, continued)

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~ADVANCE CARE PLAN~~

(Rule 1200-08-27-.15, continued)

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.: _____

(Rule 1200-08-27-.15, continued)

(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.

(2) Advance Care Plan Form

(Rule 1200-08-27-.15, continued)

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that

(Rule 1200-08-27-.15, continued)

medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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:

(Rule 1200-08-27-.15, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(III) Fighting the fire

(IV) Evacuation procedures

(V) Staff functions by department and job assignment

(VI) Fire drill schedules (fire drills shall be held at least quarterly on each work shift)

(ii) External disaster procedures plan (for tornado, flood, earthquakes) shall include:

(I) Staff duties by department and job assignment

(II) Evacuation procedures

(iii) Bomb Threat Procedures Plan:

(I) Staff duties by department and job assignment

(II) Search team, searching the premises

6. The HIV supportive living facility shall develop and periodically Review with all employees a pre-arranged plan for the orderly evacuation of all residents in case of a fire, internal disaster or other emergency. The plan of evacuation shall be posted throughout the facility. Fire drills shall be held at least quarterly for each work shift for HIV supportive living facility personnel in each separate resident occupied HIV supportive living facility building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years.

(b) Emergency Planning with Local Government Authorities.

1. All HIV supportive living facilities shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

2. Each HIV supportive living facility must rehearse both the Physical Facility and Community Emergency plan as required in these regulations, even if the local Emergency Management Agency is unable to participate.

3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 27, 2000; effective October 10, 2000. Amendment filed December 15, 2005; effective February 28, 2006.*

1200-08-28-.15 APPENDIX I

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

(Rule 1200-08-28-.15, continued)

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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐
Other: _____ (Specify)

The Basis for These Orders Is: (Must be completed)
☐ 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	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(Rule 1200-08-28-.15, continued)

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, 2006

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(Rule 1200-08-28-.15, continued)

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & 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	☐ Patient's preferences
☐ Health care agent	☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Court-appointed guardian	☐ Medical indications
☐ Health care surrogate	☐ (Other) _____
☐ Parent of minor	
☐ Other: (Specify)	

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

(Rule 1200-08-28-.15, continued)

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(Rule 1200-08-28-.15, continued)

(2) Advance Care Plan Form

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

(Rule 1200-08-28-.15, continued)

	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 Signature of witness number 2
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.

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.

(Rule 1200-08-28-.15, continued)
(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that

(Rule 1200-08-28-.15, continued)

medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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

(Rule 1200-08-28-.15, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(Rule 1200-08-32-.14, continued)

2. Evacuation procedures;

3. Safety procedures; and

4. Emergency services.

All facilities shall participate in the Tennessee Emergency Management local/county emergency plan on an annual basis. Participation includes but is not limited to filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation shall be maintained and shall be made available to survey staff as proof of participation.

(2) In the event of natural disaster or electrical power failure, no new dialysis procedures shall be begun, and dialysis procedures in progress shall be brought to conclusion as soon as possible.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed April 22, 2003; effective July 6, 2003.*

1200-08-32-.15 APPENDIX I

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

~~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~~

(Rule 1200-08-32-.15, continued)

	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: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify) The Basis for These Orders Is: (Must be completed) ☐ 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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

(Rule 1200-08-32-.15, continued)

~~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~~

~~COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED~~

~~DO NOT ALTER THIS FORM!~~

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)** 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:* _____

(Rule 1200-08-32-.15, continued)

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

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

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

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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~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

~~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 these treatment decisions myself.~~

(Rule 1200-08-32-.15, continued)

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

(Rule 1200-08-32-.15, continued)

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: Phone #: Relation:
Address:

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

(Rule 1200-08-32-.15, continued)

Please sign on page 2 Page 1 of 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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:

(Rule 1200-08-32-.15, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

1200-08-34-.15 APPENDIX I

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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)	Patient's Last Name
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.	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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐
Other: _____ (Specify)

The Basis for These Orders is: (Must be completed)
☐ 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	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(Rule 1200-08-34-.15, continued)

PRIVACY RULE: DISCLOSURE OF POST TO OTHER PEOPLE AND 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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(Rule 1200-08-34-.15, continued)

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)** 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 & NUTRITION.** Oral fluids & 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:** ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: _____ (Specify) **The Basis for These Orders Is:** (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other) _____

Physician Name (Print)	Physician Signature (Mandatory) Date	Physician Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

(Rule 1200-08-34-.15, continued)

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

(Rule 1200-08-34-.15, continued)

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

~~(2) Advance Care Plan Form~~

~~ADVANCE CARE PLAN~~

(Rule 1200-08-34-.15, continued)

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

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 these 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.: _____

(Rule 1200-08-34-.15, continued)

(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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Rule 1200-08-34-.15, continued)

(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

(Rule 1200-08-34-.15, continued)

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2 Page 1 of 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. 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 or alternate. 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 _____

(Rule 1200-08-34-.15, continued)

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

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.*
Administrative History: *Original rule filed February 16, 2007; effective May 2, 2007.*

(Rule 1200-08-36-.17, continued)

(f) Earthquake Disaster Procedures Plan shall include:

1. Staff duties;

2. Evacuation procedures;

3. Safety procedures; and

4. Emergency services.

(2) An ACH shall comply with the following:

(a) Maintain a detailed log with staff signatures designating training each employee receives regarding disaster preparedness.

(b) Train all employees annually as required in the plans listed above and keep each employee informed with respect to the employee's duties under the plans.

(c) Exercise each of the plans listed above annually.

(3) An ACH shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes:

(a) Filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency; and

(b) Maintaining documentation of participation that shall be made available to survey staff as proof of participation.

(4) An ACH shall have a functioning emergency back-up generator adequate to meet the ACH's HVAC and essential needs until regular service is restored. The ACH shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with the local resources.

(a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.

(b) The emergency generator shall be operated at the existing connected load and not on dual power. The ACH shall maintain a monthly log and have trained staff familiar with the generator's operation.

Authority: *T.C.A. §§ 68-11-209, 68-11-224, and 68-11-1801* ***Administrative History:*** *Emergency rule filed November 2, 2010; effective through May 1, 2011.*

1200-08-36-.18 APPENDIX I.

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

(Rule 1200-08-36-.18, continued)

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 Resuscitation (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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____ (Specify)

The Basis for These Orders Is: (Must be completed)
☐ 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	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(Rule 1200-08-36-.18, continued)

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

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(Rule 1200-08-36-.18, continued)

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

A COPY OF THIS 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 Resuscitation (DNR/ no CPR) (Allow Natural Death)**

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 & NUTRITION. Oral fluids & 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:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any

time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(2) Advance Care Plan Form

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.

(Rule 1200-08-36-.18, continued)

☐ 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

(Rule 1200-08-36-.18, continued)

~~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.~~

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

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. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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 the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address:
_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any

(Rule 1200-08-36-.18, continued)

	other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

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

(Attach additional pages if necessary)

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

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

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must 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 or alternate. I witnessed the patient's signature on this form. _____
Signature of witness number 1

(Rule 1200-08-36-.18, continued)

2. I am a competent adult who is not named as the agent or alternate. 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

Authority: *T.C.A. §§ 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Emergency rule filed November 2, 2010; effective through May 1, 2011.*