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CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance With Act 434 of 1967 As Amended.

Valetta M. Buck
SIGNATURE

Director, Division of Health Facility Services
TITLE

October 12, 1990
DATE

007.05.90--002

RULES AND REGULATIONS FOR HOSPICE IN ARKANSAS

ARKANSAS DEPARTMENT OF HEALTH 1983

(Pursuant to Act 283 of 1983)

PREFACE

These rules and regulations have been prepared for the purpose of establishing a criterion for minimum standards for the certification, operation and maintenance of hospices in Arkansas that is consistent with current trends in patient care practices. By necessity they are of a regulatory nature but are considered to be practical minimal design and operational standards for these facilities. These standards are not static and are subject to periodic revisions in the future as new knowledge and changes in patient care trends become apparent. However, it is expected that facilities will exceed these minimum requirements and that they will not be dependent upon future revisions in these standards as a necessary prerequisite for improved services. Hospices have a strong moral responsibility for providing optimum patient care and treatment for the terminally ill and their families.

AUTHORITY

The following Rules and Regulations for Hospices in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in Act 283 of 1983.

PURPOSE

To establish rules, regulations and minimum standards for hospice programs operating in the State of Arkansas in accordance with Act 283 of 1983. These rules will ensure high quality professional care for terminally ill patients and their families by providing for the safe, humane and appropriate palliative care of all admitted to a hospice program regardless of setting and shall apply to both new and existing agencies.

DEFINITIONS

1. State Health Officer means the secretary for the State Board of Health.
2. department means the State Board of Health.
3. Director means the chief administrative office in the Division of Health Facility Services.
4. division means the Division of Health Facility Services.
5. administrator means the person responsible for the management of a hospice.
6. hospice or hospice care means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family, employing an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement, with such care being available twenty-four (24) hours a day, seven (7) days a week and provided on the basis of need regardless of ability to pay.

7. unit of care means the patient and those closely linked with the patient who may or may not be involved in the health and supportive care of a terminally ill patient.

8. autonomous means a separate and distinct entity which functions under its own administration and bylaws either within or independently of a parent organization.

9. attending physician means a physician who (a) is a doctor of medicine or osteopathy; and (b) is identified by the individual, at the time he/she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

10. bereavement counseling means counseling services provided to the individual's family after the individual's death.

11. employee means an employee of the hospice or, if the hospice is a subdivision of an agency or an organization, an employee of the agency or organization who is assigned and works substantially full-time for the hospice unit. "Employee" also refers to a volunteer under the jurisdiction of the hospice.

12. free standing hospice means a hospice that is not part of any other type of participating provider.

13. hospice means a public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals.

14. Social Worker means a person who has at least a Bachelor's Degree from a school accredited or approved by the Council on Social Work Education.

15. terminally ill means that the individual has a medical prognosis that his/her life expectancy is six (6) months or less.

16. representative means a person who is, because of the individual's mental or physical incapacity, authorized in accordance with State law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.
17. consent form means that initial election for hospice care must be informed consent signed by the patient or representative and must be maintained in the hospice patient medical record.

INSPECTION

Any authorized representative of the department shall have the right to enter a hospice at any time in order to make whatever inspection is deemed necessary in accordance with the minimum standards and regulations prescribed herein.

REQUIREMENTS FOR CERTIFICATION

1. No public or private agency or person shall establish, conduct, or maintain a hospice or hold itself out to the public as a hospice without first obtaining certification, or provisional certification from the department. Hospice organizations that were in operation prior to enactment of Act 283 of 1983 shall make application to the department within sixty (60) days after these regulations are approved and filed.
2. Certification to operate a hospice issued by the department will be based upon the results of an operational and physical plant survey conducted by the department to determine compliance with the Rules and Regulations of Hospice. Certification for the operation of a hospice program shall, unless sooner revoked, be for a period of one (1) year.

3. Temporary State Certification: Temporary state certification for one (1) year or less may be granted to a hospice provider, at the discretion of the Director of Health Facility Services, provided the following minimum standards are met:

   a. Hospice care must be available twenty-four (24) hours a day, seven (7) days a week.

   b. There must be a Medical Director (Physician) and a full-time Registered Professional Nurse.

   c. Palliative care must be provided.

   d. Care must be available both in the home and in an inpatient setting.

   e. Complete medical records must be maintained.

   f. The patient and family are considered the unit of care.

   g. Bereavement services are available.

   h. Counseling is provided.

   i. Volunteers are trained and utilized by the hospice.

   j. There is an active plan developed to bring the hospice into compliance with state standards.

Temporary state certification may be revoked if appropriate progress is not made at any time as determined by the Director.

REVOCATION OF STATE CERTIFICATION OF HOSPICE CARE

The department is empowered to deny, suspend or revoke certification on any of the following grounds:

1. Violation of any of the rules and regulations promulgated as developed under the authority of Act 283 of 1983.

2. Permitting, aiding or abetting the commission of any unlawful act in connection with the operation of a hospice.
3. Revocation shall be effective for a minimum of ninety (90) days before the department will accept reapplication.
4. Right of Appeal shall be through the Arkansas Board of Health.

APPLICATION FOR STATE CERTIFICATION

An applicant shall file applications under oath with the department upon forms prescribed by the department. The application shall be signed by the owner, if an individual or partnership, or in the case of a corporation, by two (2) of its officers, or in the case of a governmental unit by the head of the governmental unit having jurisdiction over it.

The application shall set forth the full name and address of the hospice for which state certification is sought and such additional information as the department may require.

A certificate of need from the appropriate agency shall be submitted with the application papers.

CHANGE OF OWNERSHIP

If change of ownership is contemplated, the new owner shall submit, or cause to be submitted, an application for and receive certification to continue operation of the hospice.

GOVERNING BODY

There shall be a governing body established by written bylaws of the hospice with autonomous authority for conduct of the hospice program and which shall satisfy the following:

1. Members shall reside or work in the geographical area or areas in which the hospice is certified to operate.
2. There must be a schedule of not less than quarterly meetings during each calendar year.

INFECTION CONTROL

Each hospice shall develop an infection control program which shall have as its purpose the protection of patient, family and personnel from hospice or community associated infection in patients admitted to the hospice, outpatient and home-care program.

GENERAL PROVISION

Implementation of rules, regulations and standards for hospice care in Arkansas shall be in general agreement with guidelines of the National Hospice Organization, the Arkansas State Hospice Association and the Health Care Finance Administration. Hospice providers not seeking certification for participation in Medicare reimbursement shall meet the Conditions of Participation for Hospice Care as set forth by the Department of Health and Human Services, Health Care Finance Administration, with certain exceptions to subparts A, B, and C of 42CFR. References to eligibility, election of benefits and reimbursement have been deleted.

(EDITOR'S NOTE: The following is edited for readability, i.e., to delete the exceptions to Medicare Conditions of Participation. The original version is available in the Division of Health Facility Services, Arkansas Department of Health. Edited July, 1987)

CERTIFICATION OF TERMINAL ILLNESS

(a) Obtaining certification. The hospice must obtain the certification that an individual is terminally ill. The hospice obtains, no later than two (2) calendar days after hospice care is initiated, written certification statements, signed by --

(i) The medical director of the hospice or the physician member of the hospice interdisciplinary group; and

(ii) The individual's attending physician if the individual has an attending physician.

(b) Certification statement. The certification must include --

(1) The statement that the individual's medical prognosis is that his or her life expectancy is six (6) months or less; and

(2) The signature(s) of the physician(s) required to certify the terminal illness.

(c) Maintaining a record. The hospice maintains the certification statements.

ELECTION OF HOSPICE CARE

(a) Duration of election. An election to receive hospice care will be considered to continue as long as the individual lives.

(1) Remains in the care of a hospice: and

(2) Does not revoke the election for hospice care.

(b) Effective date of election. (1) An individual or representative may designate an effective date for the election period that beings with the first day of hospice care or any subsequent day of hospice care.

(c) Waiver of other benefits. An individual can elect hospice care from only one (1) hospice provider at any given time.

ELEMENTS OF THE ELECTION STATEMENT

The election statement must include the following:

(a) Identification of the particular hospice that will provide care to the individual.

(b) The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

(c) The effective date of the election.

(d) The signature of the individual or representative.

REVOKING THE ELECTION OF HOSPICE CARE

(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period.

(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

(1) A signed statement that the individual or representative revokes the individual's election for hospice care.

(2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

CHANGE OF THE DESIGNATED HOSPICE

(a) An individual or representative may change, once as long as he lives, the designation of the particular hospice from which hospice care will be received.

(b) The change of the designated hospice is not considered a revocation of hospice care.

(c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

(1) The name of the hospice from which the individual has received care and the names of the hospice from which he or she plans to receive care.

(2) The date the change is to be effective.

ADMINISTRATION: GENERAL PROVISIONS

(a) Compliance. A hospice must maintain compliance with all the following sections, through "Short Term Inpatient Care". A freestanding hospice that provides inpatient services directly must also maintain compliance with the Section titled, "Free Standing Hospices Providing Inpatient Care Directly".

(b) Required services. A hospice must be primarily engaged in providing the care and services described in this document including bereavement counseling, and must:

(1) Make nursing services, physician services, and drugs and biologicals routinely available on a twenty-four (24) hour basis;

(2) Make all services available on a twenty-four (24) hours basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions; and

(3) Provide these services in a manner consistent with accepted standards of practice.

(c) Disclosure of information. The hospice must meet the disclosure of information requirements.

GOVERNING BODY

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

The governing body must designate an individual who is responsible for the day to day management of the hospice program.

The governing body must also ensure that all services provided are consistent with accepted standards of practice.

MEDICAL DIRECTOR

The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

PROFESSIONAL MANAGEMENT

A hospice may arrange for another individual or entity to furnish services to the hospice's patients. If services are provided under arrangement (i.e., under contract), the hospice must meet the following standards:

(a) Continuity of care. The hospice program assures the continuity of patient/family care in home outpatient, and inpatient settings.

(b) Written agreement. The hospice has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following:

(1) Identification of the services to be provided.

(2) A stipulation that services may be provided only with the express authorization of the hospice.

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

(4) The delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment, and the interdisciplinary group care conferences.

(5) Requirements for documenting that services are furnished in accordance with the agreement.

(6) The qualifications of the personnel providing the services.

(c) Professional management responsibility. The hospice retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications of this part, and in accordance with the patient's plan of care and the other requirements of this part.

(d) Inpatient care. The hospice must have a written agreement approved with area inpatient facilities which states, that the hospice may continue to follow any hospice patient admitted to their facility, and supplement any inpatient care as indicated and approved by the attending physician during the patients inpatient stay and that medical record information will be furnished by each agency on hospice.

PLAN OF CARE

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

(a) Establishment of plan. The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(b) Review of plan. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

(c) Content of plan. The plan must include assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

CONTINUATION OF CARE

A hospice may not discontinue or diminish care because of inability to pay for that care.

INFORMED CONSENT

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or representative.

INSERVICE TRAINING

A hospice must provide an ongoing program for the training of its employees.

QUALITY ASSURANCE

A hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care and care provided under arrangements. The findings are used by the hospice to correct identified problems and to revise hospice policies if necessary. Those responsible for the quality assurance program must --

(a) Implement and report on activities and mechanisms for monitoring the quality of patient care;

(b) Identify and resolve problems; and

(c) Make suggestions for improving patient care.

INTERDISCIPLINARY GROUP

The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice.

(a) Composition of group. The hospice must have an interdisciplinary group or groups that include at least the following individuals who are employees of the hospice:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) A social worker.

(4) A pastoral or other counselor.

(b) Role of group. The interdisciplinary group is responsible for --

(1) Participation in the establishment of the plan of care;

(2) Provision of supervision of hospice care and services;

(3) Periodic review and updating of the plan of care for each individual receiving hospice care; and

(4) Establishment of policies governing the day-to-day provision of hospice care and services.

(c) If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described in paragraph (b) (4) of this section.

(d) Coordinator. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

VOLUNTEERS

The hospice in accordance with the numerical standards, specified in paragraph (e) of this section, uses volunteers , in defined roles, under the supervision of a designated hospice employee.

(a) Training. The hospice must provide appropriate orientation and training that is consistent with acceptable standards of hospice practice.

(b) Role. Volunteers must be used in administrative or direct patient care roles.

(c) Recruiting and retaining. The hospice must document active and ongoing efforts to recruit and retain volunteers.

(e) Level of activity. A hospice must document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 percent of the total patient care hours of all

paid hospice employees and contract staff. The hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services, and the time worked, must be recorded.

(f) Availability of clergy. The hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request such visits and must advise patients of this opportunity.

LICENSURE

The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.

(a) Licensure of program. If State or local law provides for licensing of hospices, the hospice must be licensed.

(b) Licensure of employees. Employees who provide services must be licensed, certified or registered in accordance with applicable Federal or State laws.

CENTRAL CLINICAL RECORDS

In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

(a) Content. Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services. The record should include all

services whether furnished directly or under arrangements made by the hospice. Each individual's record contains --

(1) The initial and subsequent assessments;

(2) The plan of care;

(3) Identification data;

(4) Consent and authorization and election forms;

(5) Pertinent medical history; and

(6) Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

(b) Protection of information. The hospice must safeguard the clinical record against loss, destruction and unauthorized use.

CORE SERVICES

A hospice must ensure that substantially all the core services (i.e., Nursing, Medical Social Services, Physician Services and Counseling) described in the following sections are routinely provided directly by hospice employees. A hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial, and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet the requirements specified for Nursing, Medical Social Services, Physician Services, and Counseling..

NURSING SERVICES

The hospice must provide nursing care and services by or under the supervision of a registered nurse.

(a) Nursing services must be directed and staffed to assure that the nursing needs of patients are met.

(b) Patient care responsibilties of nursing personnel must be specified.

(c) Services must be provided in accordance with recognized standards of practice.

MEDICAL SOCIAL SERVICES

Medical social services must be provided by a qualified social worker, under the direction of a physician.

PHYSICIAN SERVICES

In addition to palliation and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.

COUNSELING SERVICES

Counseling services must be available to both the individual and the family. Counseling includes bereavement counseling, provided after the patient's death as well as dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice.

(a) Bereavement counseling. There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs,

as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient).

(b) Dietary counseling. Dietary counseling, when required, must be provided by a qualified individual.

(c) Spiritual counseling. Spiritual counseling must include notice to patients as to the availability of clergy.

(d) Additional counseling. Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

OTHER SERVICES

A hospice must ensure that the following services are provided directly by hospice employees or under arrangements (i.e., contracts) made by the hospice as specified under the "Professional Management" section.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY

Physical therapy services, and speech language pathology services must be available and when provided, offered in a manner consistent with acceptable standards of practice. Occupational therapy must be provided if needed and available in the service area.

HOME HEALTH AIDE AND HOMEMAKER SERVICES

Home health aide and homemaker services must be available and adequate in frequency to meet the needs of the patients. A home health aide is a person who meets the training, attitude and skill requirements specified in the following section.

HOME HEALTH AIDE SERVICES

Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. Aides are carefully trained in methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, procedures for maintaining clean, healthful; and pleasant environment, changes in patient's condition that should be reported, work of agency and the health team, ethics, confidentiality, and recordkeeping. They are closely supervised to assure their competence in providing care.

(a) Assignment and duties of the home health aide. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. Duties include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs; and completing appropriate records.

(b) Supervision. The registered nurse or appropriate professional staff member, if other services are provided, makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

MEDICAL SUPPLIES

Medical supplies and appliances including drugs and biologicals, must be provided as needed for the palliation and management of the terminal illness and related conditions.

(a) Administration. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(b) Controlled drugs in the patient's home. The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient.

(c) Administration of pharmaceuticals. Pharmaceuticals are administered only by tne following individuals:

(1) A licensed nurse or physician.

(2) The patient if his or her attending physician has approved.

SHORT-TERM INPATIENT CARE

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in licensed facilities, as stated below:

(a) Inpatient care for symptom control. Inpatient care for pain control and symptom management must be provided in one of the following:

(1) A hospice that meets the requirements for providing inpatient care directly as specified in the section, "Free Standing Hospices Providing Inpatient Care Directly".

(2) A hospital or a Skilled Nursing Facility (SNF) that also meets the requirements specified for nursing service and patient areas. (See paragraphs (a) twenty-four (24) hour nursing services, and (f) patient

areas, under "Freestanding Hospices Providing Inpatient Care Directly".)

(b) Inpatient care for respite purposes. Inpatient care for respite purposes must be provided by one of the following:

(1) A provider specified in paragraph (a) of this section.

(2) An Intermediate Care Facility (ICF) that also meets the requirements specified under "Free Standing Hospices Providing Inpatient Care Directly" paragraphs (a) and (f) regarding twenty-four (24) hour nursing service and patient areas.

FREE STANDING HOSPICE PROVIDING INPATIENT CARE DIRECTLY

A freestanding hospice that provides inpatient care directly must comply with all of the following standards.

(a) Twenty-four (24) hour nursing services.

(1) The facility provides twenty-four (24) hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient plan of care. Each patient receives treatments, medications, and diet as prescribed, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) Each shift must include a registered nurse who provides direct patient care;

(b) Disaster preparedness. The hospice has an acceptable written plan, periodically rehearsed with staff, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.

(c) Health and safety laws. The hospice must meet all Federal, State, and local laws, regulations, and codes pertaining to health and safety, such as provisions regulating --

(1) Construction, maintenance, and equipment for the hospice;

(2) Sanitation;

(3) Communicable and reportable diseases; and

(4) Post mortem procedures.

(d) Fire protection. The hospice must meet the health care occupancy provisions of the 1981 edition of the Life Safety Code of the National Fire Protection Association.

(f) Patient areas --

(1) The hospice must design and equip areas for the comfort and privacy of each patient and family members.

(2) The hospice must have --

(i) Physical space for private patient/family visiting;

(ii) Accommodation for family members to remain with the patient throughout the night;

(iii) Accommodations for family privacy after a patient's death;

(iv) Decor which is homelike in design and function.

(3) Patients must be permitted to receive visitors at any hour, including small children.

(g) Patient rooms and toilet facilities. Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients.

(1) Each patient's room must --

(i) Be equipped with or conveniently located near toilet and bathing facilities;

(ii) Be at or above grade level;

(iii) Contain a suitable bed for each patient and other appropriate furniture;

(iv) Have closet space that provides security and privacy for clothing and personal belongings;

(v) Contain no more than four beds;

(vi) Measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multipatient room; and

(vii) Be equipped with a device for calling the staff member on duty.

(h) Bathroom facilities. The hospice must --

(1) Provide an adequate supply of hot water at all times for patient use; and

(2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.

(i) Linen. The hospice has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(j) Isolation areas. The hospice must make provision for isolating patients with infectious diseases.

(k) Meal service, menu planning, and supervision. The hospice must --

(1) Serve at least three (3) meals or their equivalent each day at regular times, with not more than fourteen (14) hours between a substantial evening meal and breakfast;

(2) Procure, store, prepare, distribute, and serve all food under sanitary conditions;

(3) Have a staff member trained or experienced in food management or nutrition who is responsible for --

(i) Planning menus that meet the nutritional needs of each patient, following the orders of the patient's physician and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences (Recommended Dietary Allowances (9th ed., 1981) is available from the Printing and Publications Office, National Academy of Sciences, Washington, DC 20416); and

(ii) Supervising the meal preparation and service to ensure that the menu plan is followed; and

(4) If the hospice has patients who require medically prescribed special diets, have the menus for those patients planned by a professionally qualified dietitian and supervise the preparation and serving of meals to ensure that the patient accepts the special diet.

(l) Pharmaceutical hospice service. The hospice provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for drugs and biologicals for patients, insofar as they are covered under the program and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws.

(1) Licensed pharmacist: The hospice must --

(i) Employ a licensed pharmacist; or

(ii) Have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and recordkeeping of drugs and biologicals.

(2) Orders for medications.

(i) A physician must order all medications for the patient.

(ii) If the medication order is verbal --

(a) The physician must give it only to a licensed nurse, pharmacist, or another physician; and

(b) The individual receiving the order must record and sign it immediately and have the prescribing physician sign it in a manner consistent with good medical practice.

(3) Administering medication. Medications are administered only by one of the following individuals:

(i) A licensed nurse or physician.

(ii) The patient if his or her attending physician has approved.

(4) Control and accountability. The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility. Drugs are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled.

(5) Labeling of drugs and biologicals. The labeling of drugs and biologicals is based on currently accepted professional principles, and in-

cludes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.

(6) Storage. In accordance with State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention & Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. An emergency medication kit approved by the pharmaceutical services committee is kept readily available.

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

CONSTRUCTION REGULATIONS AND CODES

Free standing hospice shall meet the applicable construction requirements of the Rules and Regulations for Hospitals and Related Institutions in Arkansas. Act 414 of 1961 as amended.

SEVERABILITY

If any provision of these Rules and Regulations for Hospice in Arkansas or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the Rules which can

be given effect without the invalid provision or application and to this end the provisions of these Rules are declared to be severable.

REPEAL

All Regulations and parts of Regulations in conflict herewith are hereby repealed.

CERTIFICATION

This will certify that the foregoing Rules and Regulations for Hospice in Arkansas were adopted by the Arkansas State Board of Health at a regular session of the Board held in Little Rock on the 24th day of January, 1985.

Ben N. Saltzman, M.D.
Secretary
Arkansas State Board of Health

The foregoing Rules and Regulations for Hospice in Arkansas having been filed in my office are hereby adopted on this 15th day of February, 1985.

Bill Clinton
Governor

CERTIFICATION

This will certify that Amendments 1, 2 and 3 of the Rules and Regulations for Hospice in Arkansas were adopted by the Arkansas State Board of Health at a regular session of the Board held in Little Rock on the 26th day of July, 1990.

M. Joycelyn Elders, M.D.
Secretary
Arkansas State Board of Health

The foregoing Amendments 1, 2 and 3 of the Rules and Regulations for Hospice in Arkansas having been filed in my office are hereby adopted on this day of September 20, 1990.

Bill Clinton
Governor

RULES AND REGULATIONS FOR HOSPICE IN ARKANSAS
ACT 283 OF 1983

Amendment No. 1

Under DEFINITIONS, Item 15. Terminally Ill to read:

15. Terminally Ill means that the individual is in the last phases of an incurable illness and has a limited prognosis.

Amendment No. 2

Under CERTIFICATION OF TERMINAL ILLNESS, Item (b) Certification Statement to read:

(b) Certification Statement. The certification statement must include --
(1) The statement that the individual has a medical prognosis with a limited life expectancy and for Medicare has a prognosis which is in compliance with the Medicare Hospice Regulations.

Amendment No. 3

Under CERTIFICATION OF TERMINAL ILLNESS, Item (a) Obtaining Statement to read:

(a) Obtaining Statement. If the written certification is not obtained within two (2) calendar days following the initiation of hospice care, a verbal certification may be made within two (2) days following the initiation of hospice care, with a written certification not later than eight (8) days after care is initiated.

007.05.90--002

BILL CLINTON
GOVERNOR

Arkansas DEPARTMENT OF HEALTH

4815 WEST MARKHAM STREET • LITTLE ROCK, ARKANSAS 72205
TELEPHONE AC 501 661-2000

M. JOYCELYN ELDERS, M.D.
DIRECTOR

October 12, 1990

W. J. "Bill" McCuen
Secretary of State
State Capitol
Little Rock, AR 72201-1094

Dear Mr. Secretary:

We have enclosed four (4) certified copies of Amendments 1, 2 & 3 of the Rules and Regulations for Hospice in Arkansas.

Please let me know if you have any questions.

Sincerely,

Valetta M. Buck

Valetta M. Buck
Director
Division of Health Facility Services

CWG/djt

Attachments