Chapter 400, Part IV
Hospices

400.6005 Legislative findings and intent.—The Legislature finds that terminally ill individuals and their families, who are no longer pursuing curative medical treatment, should have the opportunity to select a support system that permits the patient to exercise maximum independence and dignity during the final days of life. The Legislature finds that hospice care provides a cost-effective and less intrusive form of medical care while meeting the social, psychological, and spiritual needs of terminally ill patients and their families. The intent of this part is to provide for the development, establishment, and enforcement of basic standards to ensure the safe and adequate care of persons receiving hospice services.

History.—s. 1, ch. 93-179.

400.601 Definitions.—As used in this part, the term:

(1) "Agency" means the Agency for Health Care Administration.
(2) "Department" means the Department of Elderly Affairs.
(3) "Hospice" means a centrally administered corporation or a limited liability company that provides a continuum of palliative and supportive care for the terminally ill patient and his or her family.
(4) "Hospice care team" means an interdisciplinary team of qualified professionals and volunteers who, in consultation with the patient, the patient's family, and the patient's primary or attending physician, collectively assess, coordinate, and provide the appropriate palliative and supportive care to hospice patients and their families.
(5) "Hospice residential unit" means a homelike living facility, other than a facility licensed under other parts of this chapter, under chapter 395, or under chapter 429, that is operated by a hospice for the benefit of its patients and is considered by a patient who lives there to be his or her primary residence.
(6) "Hospice services" means items and services furnished to a patient and family by a hospice, or by others under arrangements with such a program, in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility.
(7) "Palliative care" means services or interventions which are not curative but are provided for the reduction or abatement of pain and human suffering.
(8) "Patient" means the terminally ill individual receiving hospice services.
(9) "Plan of care" means a written assessment by the hospice of each patient's and family's needs and preferences, and the services to be provided by the hospice to meet those needs.

(10) "Terminally ill" means that the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.

History.—s. 1, ch. 79-186; s. 1, ch. 80-64; s. 256, ch. 81-259; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 2, 14, ch. 93-179; s. 788, ch. 95-148; s. 57, ch. 95-418; s. 1, ch. 2006-155; s. 65, ch. 2006-197; s. 14, ch. 2012-160.

400.602 Licensure required; prohibited acts; exemptions; display, transferability of license.—

(1)

(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and to entities licensed by or applying for such licensure from the agency pursuant to this part. A license issued by the agency is required in order to operate a hospice in this state. Any person or legal entity that is not licensed as a hospice under this part may not use the word "hospice" in its name, or offer or advertise hospice services or hospice-like services in such a way as to mislead a person to believe that the offeror is a hospice licensed under this part.

(b) It is unlawful for any person or legal entity offering, describing, or advertising hospice services or hospice-like services or otherwise holding itself out as a hospice to do so without stating the year of initial licensure as a hospice in the state or the year of initial licensure of the hospice entity or affiliate based in the state that owns the hospice. At a minimum, the year of initial licensure must be stated directly beneath the name of the licensed entity in a type no less than 25 percent of the size of the type used for the name or other indication of hospice services or hospice-like services and must be prominently stated at least one time on any document, item, or other medium offering, describing, or advertising hospice services or hospice-like services. This requirement excludes any materials relating to the care and treatment of an existing hospice patient.

(2) Services provided by a hospital, nursing home, or other health care facility, health care provider, or caregiver, or under the Community Care for the Elderly Act, do not constitute a hospice unless the facility, provider, or caregiver establishes a separate and distinct administrative program to provide home, residential, and homelike inpatient hospice services.

(3)

(a) A separately licensed hospice may not use a name which is substantially the same as the name of another hospice licensed under this part.

(b) A licensed hospice which intends to change its name or address must notify the agency at least 60 days before making the change.

History.—s. 3, ch. 79-186; s. 2, ch. 80-64; s. 2, ch. 81-271; s. 2, ch. 81-318; ss. 66, 79, 83, ch. 83-181; s. 10, ch. 89-527; ss. 3, 14, ch. 93-179; s. 58, ch. 95-418; s. 11, ch. 97-270; s. 2, ch. 2006-155; s. 84, ch. 2007-230.

400.6045 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.—

(1) A hospice licensed under this part must provide the following staff training:

(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or dementia-related disorders.

(b) In addition to the information provided under paragraph (a), employees who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.

(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the patient's independence in activities of daily living, and instruction in skills for working with families and caregivers.

(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.

(e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.
(f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.
(g) The Department of Elderly Affairs or its designee must approve the required 1-hour and 3-hour training provided to employees or direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.
(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different hospice or to a home health agency, assisted living facility, nursing home, or adult day care center.
(i) An employee who is hired on or after July 1, 2003, must complete the required training by July 1, 2004, or by the deadline specified in this section, whichever is later.

(2) A hospice licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The hospice must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the hospice and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the hospice's records as part of the license renewal procedure.

History.—s. 5, ch. 93-105; s. 4, ch. 2003-271.

400.605 Administration; forms; fees; rules; inspections; fines.—

(1) The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. The department, in consultation with the agency, shall by rule establish minimum standards and procedures for a hospice pursuant to this part. The rules must include:
(a) The qualifications of professional and ancillary personnel to ensure the provision of appropriate and adequate hospice care.
(b) Standards and procedures for the administrative management of a hospice.
(c) Standards for hospice services that ensure the provision of quality patient care.
(d) Components of a patient plan of care.
(e) Procedures relating to the implementation of advanced directives and do-not-resuscitate orders.
(f) Procedures for maintaining and ensuring confidentiality of patient records.
(g) Standards for hospice care provided in freestanding inpatient facilities that are not otherwise licensed medical facilities and in residential care facilities such as nursing homes, assisted living facilities, adult family-care homes, and hospice residential units and facilities.
(h) Components of a comprehensive emergency management plan, developed in consultation with the Department of Health, the Department of Elderly Affairs, and the Division of Emergency Management.
(i) Standards and procedures relating to the establishment and activities of a quality assurance and utilization review committee.
(j) Components and procedures relating to the collection of patient demographic data and other information on the provision of hospice care in this state.

(2) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. The amount of the fee shall be established by rule and may not exceed $1,200 per biennium.

(3) In accordance with s. 408.811, the agency shall conduct annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The

agency shall conduct such inspections and investigations as are necessary in order to determine the state of compliance with the provisions of this part, part II of chapter 408, and applicable rules.

(4) In accordance with part II of chapter 408, the agency may impose an administrative fine for any violation of the provisions of this part, part II of chapter 408, or applicable rules.

History.—s. 2, ch. 79-186; s. 2, ch. 81-318; ss. 69, 79, 83, ch. 83-181; s. 13, ch. 91-282; ss. 4, 14, ch. 93-179; s. 59, ch. 95-418; s. 1, ch. 99-139; s. 15, ch. 2000-140; s. 2, ch. 2005-191; s. 85, ch. 2007-230; s. 278, ch. 2011-142.

400.60501 Outcome measures; adoption of national initiatives; annual report.—

(1) No later than December 31, 2007, the Department of Elderly Affairs, in conjunction with the Agency for Health Care Administration, shall develop outcome measures to determine the quality and effectiveness of hospice care for hospices licensed in the state. At a minimum, these outcome measures shall include a requirement that 50 percent of patients who report severe pain on a 0-to-10 scale must report a reduction to 5 or less by the end of the 4th day of care on the hospice program.

(2) For hospices licensed in the state, the Department of Elderly Affairs, in conjunction with the Agency for Health Care Administration, shall:

(a) Consider and adopt national initiatives, such as those developed by the National Hospice and Palliative Care Organization, to set benchmarks for measuring the quality of hospice care provided in the state.

(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.

History.—s. 7, ch. 2006-155.

400.6051 Construction and renovation; requirements.—

(1) The requirements for the construction and the renovation of a hospice residential or inpatient facility or unit must comply with the provisions of chapter 553 which pertain to building construction standards, including plumbing, electrical code, glass, manufactured buildings, accessibility for persons with disabilities, and the state minimum building codes. The Agency for Health Care Administration shall provide technical assistance to the Florida Building Commission in updating the construction standards of the Florida Building Code which govern hospice facilities.

(2) Upon request by the prospective licensee of an inpatient hospice facility, the agency may provide an informal review of a facility prior to construction in order to assist the facility in complying with agency rules and this part.

(3) The agency may charge a fee that is commensurate with the cost of providing consultation under this section and that is not refundable.

History.—s. 3, ch. 2005-191; s. 1, ch. 2007-238.

400.606 License; application; renewal; conditional license or permit; certificate of need.—

(1) In addition to the requirements of part II of chapter 408, the initial application and change of ownership application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:

(a) The estimated average number of terminally ill persons to be served monthly.

(b) The geographic area in which hospice services will be available.

(c) A listing of services which are or will be provided, either directly by the applicant or through contractual arrangements with existing providers.

(d) Provisions for the implementation of hospice home care within 3 months after licensure.

(e) Provisions for the implementation of hospice homelike inpatient care within 12 months after licensure.

(f) The number and disciplines of professional staff to be employed.

(g) The name and qualifications of any existing or potential contractee.

(h) A plan for attracting and training volunteers.

If the applicant is an existing licensed health care provider, the application must be accompanied by a copy of the most recent profit-loss statement and, if applicable, the most recent licensure inspection report.

(2) In addition to the requirements of part II of chapter 408, the application for license renewal shall be accompanied by an update of the plan for delivery of hospice care only if information contained in the plan submitted pursuant to subsection (1) is no longer applicable.
(3) The agency shall not issue a license to a hospice that fails to receive a certificate of need under the provisions of part I of chapter 408. A licensed hospice is a health care facility as that term is used in s. 408.039(5) and is entitled to initiate or intervene in an administrative hearing.
(4) A freestanding hospice facility that is engaged in providing inpatient and related services and that is not otherwise licensed as a health care facility shall obtain a certificate of need. However, a freestanding hospice facility that has six or fewer beds is not required to comply with institutional standards such as, but not limited to, standards requiring sprinkler systems, emergency electrical systems, or special lavatory devices.
(5) The agency may deny a license to an applicant that fails to meet any condition for the provision of hospice care or services imposed by the agency on a certificate of need by final agency action, unless the applicant can demonstrate that good cause exists for the applicant's failure to meet such condition.

History.—s. 6, ch. 79-186; s. 5, ch. 81-271; s. 2, ch. 81-318; ss. 70, 79, 83, ch. 83-181; s. 47, ch. 87-92; ss. 5, 14, ch. 93-179; s. 60, ch. 95-418; s. 54, ch. 98-171; s. 3, ch. 2006-155; s. 86, ch. 2007-230; s. 15, ch. 2012-160.

400.6065 Background screening.—The agency shall require level 2 background screening for personnel as required in s. 408.809(1)(e) pursuant to chapter 435 and s. 408.809.

History.—ss. 55, 71, ch. 98-171; s. 22, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 17, ch. 2004-267; s. 87, ch. 2007-230; s. 9, ch. 2010-114.

400.607 Denial, suspension, revocation of license; emergency actions; imposition of administrative fine; grounds.—

(1) The agency may deny, revoke, and suspend a license, impose an action under s. 408.814, and impose an administrative fine, which may not exceed $5,000 per violation, for the violation of any provision of this part, part II of chapter 408, or applicable rules.
(2) Any of the following actions by a licensed hospice or any of its employees shall be grounds for action by the agency against a hospice:
    (a) A violation of the provisions of this part, part II of chapter 408, or applicable rules.
    (b) An intentional or negligent act materially affecting the health or safety of a patient.
(3) If, 3 months after the date of obtaining a license, or at any time thereafter, a hospice does not have in operation the home-care component of hospice care, the agency shall immediately revoke the license of such hospice.
(4) If, 12 months after the date of obtaining a license pursuant to s. 400.606, or at any time thereafter, a hospice does not have in operation the inpatient components of hospice care, the agency shall immediately revoke the license of such hospice.
(5) The remedies set forth in this section are independent of and cumulative to other remedies provided by law.

History.—s. 7, ch. 79-186; s. 2, ch. 81-318; ss. 71, 79, 83, ch. 83-181; ss. 6, 14, ch. 93-179; s. 56, ch. 98-171; s. 50, ch. 2004-267; s. 88, ch. 2007-230.

400.6085 Contractual services.—A hospice may contract out for some elements of its services. However, the core services, as set forth in s. 400.609(1), with the exception of physician services, shall be provided directly by the hospice. Any contract entered into between a hospice and a health care facility or service provider must specify that the hospice retains the responsibility for planning, coordinating, and prescribing hospice care and services for the hospice patient and family. A hospice that contracts for any hospice service is prohibited from charging fees for services provided directly by the hospice care team that duplicate contractual services provided to the patient and family.

(1) A contract for hospice services, including inpatient services, must:
    (a) Identify the nature and scope of services to be provided.
    (b) Require that direct patient care shall be maintained, supervised, and coordinated by the hospice care team.
    (c) Limit the services to be provided to only those expressly authorized by the hospice in writing.
    (d) Delineate the roles of hospice staff and contract staff in the admission process and patient assessment.
    (e) Identify methods for ensuring continuity of hospice care.
    (f) Plan for joint quality assurance.

(g) Specify the written documentation, including patient records, required of contract staff.
(h) Specify qualifications of persons providing the contract services.
(i) Specify the effective dates for the contract.

(2) With respect to contractual arrangements for inpatient hospice care:
(a) Licensed beds designated for inpatient hospice care through contract between an existing health care facility and a hospice shall not be required to be delicensed from one type of health care in order to enter into a contract with a hospice, nor shall the physical plant of any facility licensed pursuant to chapter 395 or part II of this chapter be required to be altered, except that a homelike atmosphere may be required.
(b) Hospices contracting for inpatient care beds shall not be required to obtain an additional certificate of need for the number of such designated beds. Such beds shall remain licensed to the health care facility and be subject to the appropriate inspections.
(c) Staffing standards for inpatient hospice care provided through a contract may not exceed the staffing standards required under the license held by the contractee.
(d) Under no circumstances may a hospice place a patient requiring inpatient care in a health care facility that is under a moratorium, has had its license revoked, or has a conditional license, accreditation, or rating. However, a hospice may continue to provide care or initiate care for a terminally ill person already residing in such a facility.

History.—s. 7, ch. 93-179; s. 219, ch. 99-13; s. 2, ch. 99-139.

400.609 Hospice services.—Each hospice shall provide a continuum of hospice services which afford the patient and the family of the patient a range of service delivery which can be tailored to specific needs and preferences of the patient and family at any point in time throughout the length of care for the terminally ill patient and during the bereavement period. These services must be available 24 hours a day, 7 days a week, and must include:

(1) SERVICES.—
(a) The hospice care team shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. Physician services may be provided by the hospice directly or through contract. A hospice may also 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.
(b) Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, home health aide services, infusion therapy, provision of medical supplies and durable medical equipment, day care, homemaker and chore services, and funeral services.

(2) HOSPICE HOME CARE.—Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.

(3) HOSPICE RESIDENTIAL CARE.—Hospice care and services, to the extent practicable and compatible with the needs and preferences of the patient, may be provided by the hospice care team to a patient living in an assisted living facility, adult family-care home, nursing home, hospice residential unit or facility, or other nondomestic place of permanent or temporary residence. A resident or patient living in an assisted living facility, adult family-care home, nursing home, or other facility subject to state licensing who has been admitted to a hospice program shall be considered a hospice patient, and the hospice program shall be responsible for coordinating and ensuring the delivery of hospice care and services to such person pursuant to the standards and requirements of this part and rules adopted under this part.

(4) HOSPICE INPATIENT CARE.—The inpatient component of care is a short-term adjunct to hospice home care and hospice residential care and shall be used only for pain control, symptom management, or respite care. The total number of inpatient days for all hospice patients in any 12-month period may not exceed 20 percent of the total number of hospice days for all the hospice patients of the licensed hospice. Hospice inpatient care shall be under the direct administration of the hospice, whether the inpatient facility is a freestanding hospice facility or part of a facility licensed pursuant to chapter 395 or part II of this chapter. The facility or rooms within a facility

used for the hospice inpatient component of care shall be arranged, administered, and managed in such a manner as to provide privacy, dignity, comfort, warmth, and safety for the terminally ill patient and the family. Every possible accommodation must be made to create as homelike an atmosphere as practicable. To facilitate overnight family visitation within the facility, rooms must be limited to no more than double occupancy; and, whenever possible, both occupants must be hospice patients. There must be a continuum of care and a continuity of caregivers between the hospice home program and the inpatient aspect of care to the extent practicable and compatible with the preferences of the patient and his or her family. Fees charged for hospice inpatient care, whether provided directly by the hospice or through contract, must be made available upon request to the Agency for Health Care Administration. The hours for daily operation and the location of the place where the services are provided must be determined, to the extent practicable, by the accessibility of such services to the patients and families served by the hospice.

(5) BEREAVEMENT COUNSELING.—The hospice bereavement program must be a comprehensive program, under professional supervision, that provides a continuum of formal and informal supportive services to the family for a minimum of 1 year after the patient's death. This subsection does not constitute an additional exemption from chapter 490 or chapter 491.

History.—s. 9, ch. 79-186; s. 7, ch. 81-271; s. 2, ch. 81-318; ss. 73, 79, 83, ch. 83-181; s. 5, ch. 91-48; s. 67, ch. 91-221; s. 97, ch. 92-33; ss. 8, 14, ch. 93-179; s. 789, ch. 95-148; s. 21, ch. 95-210; s. 3, ch. 99-139.

400.6095 Patient admission; assessment; plan of care; discharge; death.—

(1) Each hospice shall make its services available to all terminally ill persons and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances. A hospice shall not impose any value or belief system on its patients or their families and shall respect the values and belief systems of its patients and their families.

(2) Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician licensed pursuant to chapter 458 or chapter 459 and shall be dependent on the expressed request and informed consent of the patient.

(3) At the time of admission, the hospice shall inquire whether advance directives have been executed pursuant to chapter 765, and if not, provide information to the patient concerning the provisions of that chapter. The hospice shall also provide the patient with information concerning patient rights and responsibilities pursuant to s. 381.026.

(4) The admission process shall include a professional assessment of the physical, social, psychological, spiritual, and financial needs of the patient. This assessment shall serve as the basis for the development of a plan of care.

(5) Each hospice, in collaboration with the patient and the patient's primary or attending physician, shall prepare and maintain a plan of care for each patient, and the care provided to a patient must be in accordance with the plan of care. The plan of care shall be made a part of the patient's medical record and shall include, at a minimum:
   (a) Identification of the primary caregiver, or an alternative plan of care in the absence of a primary caregiver, to ensure that the patient's needs will be met.
   (b) The patient's diagnosis, prognosis, and preferences for care.
   (c) Assessment of patient and family needs, identification of the services required to meet those needs, and plans for providing those services through the hospice care team, volunteers, contractual providers, and community resources.
   (d) Plans for instructing the patient and family in patient care.
   (e) Identification of the nurse designated to coordinate the overall plan of care for each patient and family.
   (f) A description of how needed care and services will be provided in the event of an emergency.

(6) The hospice shall provide an ongoing assessment of the patient and family needs, update the plan of care to meet changing needs, coordinate the care provided with the patient's primary or attending physician, and document the services provided.

(7) In the event a hospice patient chooses to be discharged or transferred to another hospice, the hospice shall arrange for continuing care and services and complete a comprehensive discharge summary for the receiving provider.

(8) The hospice care team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Hospice staff shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation

pursuant to such an order and applicable rules. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

(9) The death of a person enrolled as a hospice patient shall be considered an attended death for the purposes of s. 406.11(1)(a)5. However, a hospice shall report the death to the medical examiner if any unusual or unexpected circumstances are present.

History.—s. 9, ch. 93-179; s. 6, ch. 99-331; s. 16, ch. 2000-140; s. 4, ch. 2000-295; s. 89, ch. 2007-230.

400.610 Administration and management of a hospice.—

(1) A hospice shall have a clearly defined organized governing body, consisting of a minimum of seven persons who are representative of the general population of the community served. The governing body shall have autonomous authority and responsibility for the operation of the hospice and shall meet at least quarterly. The governing body shall:

(a) Adopt an annual plan for the operation of the hospice, which shall include a plan for providing for uncompensated care and philanthropic community activities.

(b) 1. Prepare and maintain a comprehensive emergency management plan that provides for continuing hospice services in the event of an emergency that is consistent with local special needs plans. The plan shall include provisions for ensuring continuing care to hospice patients who go to special needs shelters. The plan shall include the means by which the hospice provider will continue to provide staff to provide the same type and quantity of services to their patients who evacuate to special needs shelters which were being provided to those patients prior to evacuation. The plan is subject to review and approval by the county health department, except as provided in subparagraph 2. During its review, the county health department shall contact state and local health and medical stakeholders when necessary. The county health department shall complete its review to ensure that the plan complies with criteria in rules of the Department of Elderly Affairs within 90 days after receipt of the plan and shall either approve the plan or advise the hospice of necessary revisions. Hospice providers may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the provider to reach its clients. A hospice shall demonstrate a good faith effort to comply with the requirements of this paragraph by documenting attempts of staff to follow procedures as outlined in the hospice's comprehensive emergency management plan and to provide continuing care for those hospice clients who have been identified as needing alternative caregiver services in the event of an emergency.

2. For any hospice that operates in more than one county, the Department of Health during its review shall contact state and local health and medical stakeholders when necessary. The Department of Health shall complete its review to ensure that the plan complies with criteria in rules of the Department of Elderly Affairs within 90 days after receipt of the plan and shall approve the plan or advise the hospice of necessary revisions. The Department of Health shall make every effort to avoid imposing differing requirements on a hospice that operates in more than one county as a result of differing or conflicting comprehensive plan requirements of the counties in which the hospice operates.

(c) Adopt an annual budget.

(d) Appoint a director who shall be responsible for the day-to-day management and operation of the hospice and who shall serve as the liaison between the governing body and the hospice staff.

(e) Undertake such additional activities as necessary to ensure that the hospice is complying with the requirements for hospice services as set forth in this part.

(2) Each hospice shall develop and implement a comprehensive quality assurance and utilization review plan to be used for ongoing internal evaluation of the appropriateness and effectiveness of the hospice services provided. Each hospice shall take the corrective actions identified by the review and report a summary of these actions to the governing body at least annually.

(3) Each hospice shall ensure that adequate policies, procedures, and systems are developed and implemented to provide effective delivery of services.

History.—s. 10, ch. 79-186; s. 2, ch. 81-318; ss. 74, 79, 83, ch. 83-181; ss. 10, 14, ch. 93-179; s. 17, ch. 2000-140; s. 24, ch. 2006-71.

400.6105 Staffing and personnel.—

(1) Each hospice shall have a medical director licensed pursuant to chapter 458 or chapter 459 who shall have responsibility for directing the medical care and treatment of hospice patients.
(2) Each hospice shall employ a full-time registered nurse licensed pursuant to part I of chapter 464 who shall coordinate the implementation of the plan of care for each patient.
(3) A hospice shall employ a hospice care team or teams who shall participate in the establishment and ongoing review of the patient's plan of care, and be responsible for and supervise the delivery of hospice care and services to the patient. The team shall, at a minimum, consist of a physician licensed pursuant to chapter 458 or chapter 459, a nurse licensed pursuant to part I of chapter 464, a social worker, and a pastoral or other counselor. The composition of the team may vary for each patient and, over time, for the same patient to ensure that all the patient's needs and preferences are met.
(4) A hospice must maintain a trained volunteer staff for the purpose of providing both administrative support and direct patient care. A hospice must use trained volunteers who work in defined roles and under the supervision of a designated hospice employee for an amount of time that equals at least 5 percent of the total patient care or administrative hours provided by all paid hospice employees and contract staff in the aggregate. The hospice shall document and report the use of volunteers, including maintaining a record of the number of volunteers, the number of hours worked by each volunteer, and the tasks performed by each volunteer.
(5) A hospice may contract with other persons or legal entities to provide additional services beyond those provided by the hospice care team or, to supplement the number of persons on the hospice care team, to ensure that the needs of patients and their families are met. Persons hired on contract shall have the same qualifications as are required of hospice personnel.
(6) Each hospice shall provide ongoing training and support programs for hospice staff and volunteers.

History.—s. 11, ch. 93-179; s. 106, ch. 2000-318; s. 4, ch. 2006-155.

400.611 Interdisciplinary records of care; confidentiality.—

(1) An up-to-date, interdisciplinary record of care being given and patient and family status shall be kept. Records shall contain pertinent past and current medical, nursing, social, and other therapeutic information and such other information that is necessary for the safe and adequate care of the patient. Notations regarding all aspects of care for the patient and family shall be made in the record. When services are terminated, the record shall show the date and reason for termination.
(2) Patient records shall be retained for a period of 5 years after termination of hospice services, unless otherwise provided by law. In the case of a patient who is a minor, the 5-year period shall begin on the date the patient reaches or would have reached the age of majority.
(3) Patient records of care are confidential. A hospice may not release a record or any portion thereof, unless:
    (a) A patient or legal guardian has given express written informed consent;
    (b) A court of competent jurisdiction has so ordered; or
    (c) A state or federal agency, acting under its statutory authority, requires submission of aggregate statistical data. Any information obtained from patient records by a state agency pursuant to its statutory authority is confidential and exempt from the provisions of s. 119.07(1).

History.—s. 11, ch. 79-186; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 12, 14, ch. 93-179; s. 232, ch. 96-406.