

**RULES
OF
THE TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES**

**CHAPTER 1200-08-24
STANDARDS FOR BIRTHING CENTERS**

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1200-08-24-.01 DEFINITIONS.

- (1) Adult. An individual who has capacity and is at least 18 years of age.
- (2) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.
- (3) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.
- (4) Birthing Center. Any institution, facility, place or building devoted exclusively or primarily to the provision of routine delivery services and postpartum care for mothers and their newborn infants.
- (5) Board. The Tennessee Board for Licensing Health Care Facilities.
- (6) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a patient to make health care decisions while having the capacity to do so. A patient shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a patient shall have the burden of proving lack of capacity.
- (7) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary functions in a patient, whether by mechanical devices, chest compression, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilators or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a patient where cardiac or respiratory arrest has occurred or is believed to be imminent.
- (8) Certified Nurse Midwife (CNM). A registered nurse currently licensed as such by the Tennessee Board of Nursing and certified by the American College of Nurse-Midwives and qualified to deliver midwifery services.

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- (9) Certified Professional Midwife (CPM). A North American Registry of Midwives (NARM) certified midwife, who must have midwifery skills and experience evaluated and pass written and skills examinations.
- (10) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.
- (11) Competent. A patient who has capacity.
- (12) Corrective Action Plan/Report. A report filed with the department by the facility after reporting an unusual event. The report must consist of the following:
 - (a) the action(s) implemented to prevent the reoccurrence of the unusual event,
 - (b) the time frames for the action(s) to be implemented,
 - (c) the person(s) designated to implement and monitor the action(s), and
 - (d) the strategies for the measurements of effectiveness to be established.
- (13) Department. The Tennessee Department of Health.
- (14) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.
- (15) Do Not Resuscitate (DNR) Order. An order entered by the patient's treating physician in the patient's medical record which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.
- (16) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.
- (17) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.
- (18) Guardian. A judicially appointed guardian or conservator having authority to make a health care decision for an individual.
- (19) Hazardous Waste. Materials whose handling, use, storage, and disposal are governed by local, state, or federal regulations.
- (20) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).
- (21) Health Care Decision. Consent, refusal of consent or withdrawal of consent to health care.
- (22) Health Care Decision-maker. In the case of a patient who lacks capacity, the patient's health care decision-maker is one of the following: the patient's health care agent as specified in an advance directive, the patient's court-appointed guardian or conservator with health care decision-making authority, the patient's surrogate as determined pursuant to Rule 1200-08-

(Rule 1200-08-24-.01, continued)

24-.12 or T.C.A. §33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

- (23) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.
- (24) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.
- (25) Hospital. Any institution, place, building or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the use, in connection with services of a physician or dentist, of one (1) or more nonrelated persons who may be suffering from deformity, injury or disease or from any other condition for which nursing, medical or surgical services would be appropriate for care, diagnosis or treatment.
- (26) Incompetent. A patient who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.
- (27) Individual instruction. An individual's direction concerning a health care decision for the individual.
- (28) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.
- (29) Licensee. The person or body to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.
- (30) Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.
- (31) Medical Record. Medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations, and other written electronics, or graphic data prepared, kept, made or maintained in a facility that pertains to confinement or services rendered to patients admitted or receiving care.
- (32) Medically Inappropriate Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the patient or other medical or surgical treatments to achieve the expressed goals of the informed patient. In the case of the incompetent patient, the patient's representative expresses the goals of the patient.
- (33) Member of the Professional Medical Community. A professional employed by the birthing center and on the premises at the time of a voluntary delivery.
- (34) NFPA. The National Fire Protection Association.
- (35) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.

(Rule 1200-08-24-.01, continued)

- (36) Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.
- (37) Personally Informing. A communication by any effective means from the patient directly to a health care provider.
- (38) Physician. An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.
- (39) Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.
- (40) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.
- (41) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs. Such availability shall include, but not be limited to, availability by telephone.
- (42) Routine Delivery Services. Services provided by a physician or a certified professional midwife practicing when these rules become final or a certified nurse midwife related to the normal, uncomplicated prenatal course as determined by adequate prenatal care and prospects for a normal uncomplicated birth as defined by reasonable and generally accepted criteria of maternal and fetal health, promoting a family-centered approach to care and viewing pregnancy and delivery as a normal physiological process requiring limited technological and pharmacological support.
- (43) Shall or Must. Compliance is mandatory.
- (44) Stabilize. To provide such medical treatment of the emergency medical condition as may be necessary to assure, within reasonable medical probability, that the condition will not materially deteriorate due to the transfer as determined by a physician or other qualified medical personnel when a physician is not readily available.
- (45) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.
- (46) Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board or equivalent body.
- (47) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.
- (48) Surrogate. An individual, other than a patient's agent or guardian, authorized to make a health care decision for the patient.
- (49) Transfer. The movement of a patient to a hospital at the direction of a physician or other qualified medical personnel when a physician is not readily available but does not include such movement of a patient who leaves the facility against medical advice.
- (50) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the patient.

(Rule 1200-08-24-.01, continued)

- (51) **Universal Do Not Resuscitate Order.** A written order that applies regardless of the treatment setting and that is signed by the patient's physician which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The Physician Order for Scope of Treatment (POST) form promulgated by the Board for Licensing Health Care Facilities as a mandatory form shall serve as the Universal DNR according to these rules.
- (52) **Unusual Event.** The abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition.
- (53) **Unusual Event Report.** A report form designated by the department to be used for reporting an unusual event.
- (54) **Voluntary Delivery.** The action of a mother in leaving an unharmed infant aged seventy-two (72) hours or younger on the premises of a birthing center with any birthing center employee or member of the professional medical community without expressing any intention to return for such infant, and failing to visit or seek contact with such infant for a period of thirty (30) days thereafter.

Authority: T.C.A. §§4-5-202, 4-5-204, 39-11-106, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-255 and 68-11-1802. **Administrative History:** Original rule filed March 31, 1998; effective June 12, 1998. Amendment filed September 17, 2002; effective December 1, 2002. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed January 3, 2006; effective March 19, 2006. Amendment filed February 7, 2007; effective April 23, 2007.

1200-08-24-.02 LICENSING PROCEDURES.

- (1) No person, partnership, association, corporation, or any state, county or local government unit, or any division, department, board or agency thereof shall establish, conduct, operate, or maintain in the State of Tennessee any birthing center without having a license. A license shall be issued to the person or persons named and for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the facility.
- (2) In order to make application for a license:
 - (a) The applicant shall submit an application on a form prepared by the department.
 - (b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.
 - (c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Patients shall not be admitted to the birthing center until a license has been issued. Applicants shall not hold themselves out to the public as being a birthing center until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules and regulations.
 - (d) The applicant must prove the ability to meet the financial needs of the facility.
 - (e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a

(Rule 1200-08-24-.02, continued)

license or has had a license disciplined or has attempted to avoid inspection and review process.

- (f) The applicant shall allow the birthing center to be inspected by a Department surveyor. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action to the Board that must be accepted by the Board. Once the deficiencies have been corrected, then the Board shall consider the application for licensure.
- (3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.
- (a) For the purposes of licensing, the licensee of a birthing center has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the facilities operation is transferred.
 - (b) A change of ownership occurs whenever there is a change in the legal structure by which the birthing center is owned and operated.
 - (c) Transactions constituting a change of ownership include, but are not limited to, the following:
 - 1. Transfer of the facility's legal title;
 - 2. Lease of the facility's operations;
 - 3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;
 - 4. One partnership is replaced by another through the removal, addition or substitution of a partner;
 - 5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;
 - 6. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;
 - 7. The consolidation of a corporate facility owner with one or more corporations; or,
 - 8. Transfers between levels of government.
 - (d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:
 - 1. Changes in the membership of a corporate board of directors or board of trustees;
 - 2. Two (2) or more corporations merge and the originally-licensed corporation survives;
 - 3. Changes in the membership of a non-profit corporation;
 - 4. Transfers between departments of the same level of government; or,

(Rule 1200-08-24-.02, continued)

5. Corporate stock transfers or sales, even when a controlling interest.
 - (e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.
 - (f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the exact same legal form as the former owner.
- (4) Renewal.
 - (a) In order to renew a license, each birthing center shall submit to periodic inspections by Department surveyors for compliance with these rules. If deficiencies are noted, the licensee shall submit an acceptable plan of corrective action and shall remedy the deficiencies. In addition, each licensee shall submit a renewal form approved by the board and applicable renewal fee prior to the expiration date of the license.
 - (b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars (\$100) per month for each month or fraction of a month that renewal is late.
 - (c) In the event that a licensee fails to renew its license within the sixty (60) day grace period following the license expiration date, then the licensee shall reapply for a license by submitting the following to the Board office:
 1. a completed application for licensure;
 2. the license fee provided in rule 1200-08-24-.02(2)(b); and
 3. any other information required by the Health Services and Development Agency.
 - (d) Upon reapplication, the licensee shall submit to an inspection of the facility by Department of Health surveyors.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, § 68-11-209(a)(1), 68-11-210, 68-11-216, Chapter 846 of the Public Acts of 2008, §1, T.C.A. §68-11-206(a)(5) [effective January 1, 2009]. **Administrative History:** Original rule filed March 31, 1998; effective June 12, 1998. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed January 19, 2007; effective April 4, 2007. Public necessity rules filed April 29, 2009; effective through October 11, 2009. Emergency rules filed October 9, 2009; effective through April 7, 2010.

1200-08-24-.03 DISCIPLINARY PROCEDURES.

- (1) The board may suspend or revoke a license for:
 - (a) Violation of federal or state statutes;
 - (b) Violation of the rules as set forth in this chapter;
 - (c) Permitting, aiding or abetting the commission, of any illegal act in the birthing center;

(Rule 1200-08-24-.03, continued)

- (d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the patients of the facility; and
 - (e) Failure to renew license.
- (2) The board may consider all factors which it deems relevant, including but not limited to the following, when determining sanctions:
- (a) The degree of sanctions necessary to ensure immediate and continued compliance;
 - (b) The character and degree of impact of the violation on the health, safety and welfare of the patient in the facility;
 - (c) The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and,
 - (d) Any prior violations by the facility of statutes, regulations or orders of the board.
- (3) Inappropriate transfers are prohibited and violation of the transfer provisions shall be deemed sufficient grounds to suspend or revoke a birthing center's license.
- (4) When a birthing center is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of the receipt of the statement of deficiencies the facility must return a plan of correction indicating the following:
- (a) How the deficiency will be corrected;
 - (b) The date upon which each deficiency will be corrected;
 - (c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and
 - (d) How the corrective action will be monitored to ensure that the deficient practice does not recur.
- (5) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the birthing center's license to possible disciplinary action.
- (6) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Administrative Procedures Act, *T.C.A. §§ 4-5-101, et seq.*
- (7) **Reconsideration and Stays.** The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, and 68-11-209. Administrative History: Original rule filed March 31, 1998; effective June 12, 1998. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-08-24-.04 ADMINISTRATION.

- (1) Birthing centers must have a governing body which is legally responsible for:

(Rule 1200-08-24-.04, continued)

- (a) The overall operation and maintenance of the facility;
 - (b) The provision of personnel, facilities, equipment, supplies, and services to mothers and families;
 - (c) Adopting administrative policies regarding patient care;
 - (d) Appointing an administrator or director responsible for implementing the adopted policies;
 - (e) Establishing and maintaining a written organizational plan;
 - (f) Appointing a clinical staff and assuring its competence; and
 - (g) Documenting all of the above.
- (2) When licensure is applicable for a particular job, a copy of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Adequate medical screenings to exclude communicable disease shall be required of each employee.
 - (3) Whenever the rules and regulations of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. A birthing center which violates a required policy also violates the rule and regulation establishing the requirement.
 - (4) Policies and procedures shall be consistent with professionally recognized standards of practice.
 - (5) The facility shall develop policies and procedures for testing a patient's blood for the presence of the hepatitis B virus and the HIV virus in the event that an employee of the facility, a student studying at the facility; or other health care provider rendering services at the facility is exposed to a patient's blood or other body fluid. The testing shall be performed at no charge to the patient, and the test results shall be confidential.
 - (6) The facility and its employees shall adopt and utilize standard precautions of the Centers for Disease Control (CDC) for preventing transmission of infections, HIV, and communicable diseases.
 - (7) All birthing centers shall adopt appropriate policies regarding the testing of patients and staff for human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome.
 - (8) Each birthing center utilizing students shall establish policies and procedures for their supervision.
 - (9) Each birthing center shall establish policies for permitting visitors.
 - (10) No birthing center shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Adult Protective Services, or the Comptroller of the State Treasury. A birthing center shall neither retaliate nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(Rule 1200-08-24-.04, continued)

- (11) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:
 - (a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;
 - (b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and
 - (c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-222, and 71-6-121. **Administrative History:** Original rule filed March 31, 1998; effective June 12, 1998. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed July 18, 2007; effective October 1, 2007.

1200-08-24-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

- (1) Prior to admission for services, the birthing center shall inform the patient of:
 - (a) The qualifications of the birthing center staff;
 - (b) The risks related to out-of-hospital childbirth;
 - (c) The benefits of out-of-hospital childbirth; and
 - (d) The possibility of referral or transfer if complications arise during pregnancy or labor.
- (2) The birthing center clinical staff shall obtain the patient's written consent for birthing center services.
- (3) The signed consent form shall be included with the patient's individual clinical record.
- (4) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
- (5) Birthing center patients are limited to those women who are initially determined to be at low risk and who are evaluated regularly throughout pregnancy to assure that they remain at low risk.
- (6) Each birthing center shall establish a written risk assessment system which shall be a part of the policy and procedure manual. The individual risk assessment shall be included in the patient's clinical record.

(Rule 1200-08-24-.05, continued)

- (7) Written policies, procedures and practice guidelines for management of emergencies and discharge must be developed and implemented.
- (8) Each birthing center shall have a written agreement with a hospital(s), which is licensed to provide obstetrical services, for emergency care. Each physician practicing or consulting in the birthing center shall have admitting privileges at a designated back-up hospital.
- (9) The birthing center shall have written practice guidelines which shall include at a minimum:
 - (a) The name, address, telephone numbers and contact persons of the licensed transport service, the hospital licensed to provide emergency obstetrical and neonatal services and other hospitals in the vicinity;
 - (b) The criteria to determine risk status which require medical consultation or transfer to a hospital will be outlined in the clinical practice guidelines; and,
 - (c) The criteria and practice guidelines for transfer shall be readily accessible to clinical staff at all times.
- (10) The names and telephone numbers of the ambulance service, neonatal transport service, and hospital shall be clearly posted at each telephone in the birthing center.
- (11) Infant Abandonment.
 - (a) Any birthing center shall receive possession of any newborn infant left on birthing center premises with any birthing center employee or member of the professional medical community, if the infant:
 1. Was born within the preceding seventy-two (72) hour period, as determined within a reasonable degree of medical certainty;
 2. Is left in an unharmed condition; and
 3. Is voluntarily left by a person who purported to be the child's mother and who did not express an intention of returning for the infant.
 - (b) The birthing center, any birthing center employee and any member of the professional medical community at such birthing center shall inquire whenever possible about the medical history of the mother or newborn and whenever possible shall seek the identity of the mother, infant, or the father of the infant. The birthing center shall also inform the mother that she is not required to respond, but that such information will facilitate the adoption of the child. Any information obtained concerning the identity of the mother, infant or other parent shall be kept confidential and may only be disclosed to the Department of Children's Services. The birthing center may provide the parent contact information regarding relevant social service agencies, shall provide the mother the name, address and phone number of the department contact person, and shall encourage the mother to involve the Department of Children's Services in the relinquishment of the infant. If practicable, the birthing center shall also provide the mother with both orally delivered and written information concerning the requirements of these rules relating to recovery of the child and abandonment of the child.
 - (c) The birthing center, any birthing center employee and any member of the professional medical community at such birthing center shall perform any act necessary to protect the physical health or safety of the child.

(Rule 1200-08-24-.05, continued)

- (d) As soon as reasonably possible, and no later than twenty-four (24) hours after receiving a newborn infant, the birthing center shall contact the Department of Children's Services, but shall not do so before the mother leaves the birthing center premises. Upon receipt of notification, the department shall immediately assume care, custody and control of the infant.
- (e) Notwithstanding any provision of law to the contrary, any birthing center, any birthing center employee and any member of the professional medical community shall be immune from any criminal or civil liability for damages as a result of any actions taken pursuant to the requirements of these rules, and no lawsuit shall be predicated thereon; provided, however, that nothing in these rules shall be construed to abrogate any existing standard of care for medical treatment or to preclude a cause of action based upon violation of such existing standard of care for medical treatment.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-255.
Administrative History: Original rule filed March 31, 1998; effective June 12, 1998. Amendment filed September 17, 2002; effective December 1, 2002.

1200-08-24-.06 BASIC BIRTHING CENTER FUNCTIONS.

- (1) Quality Assurance. The birthing center governing body must ensure that there is an established program for evaluating the quality of direct care services to childbearing families, and the environment in which the services are provided. with an organizational plan to identify and resolve problems.
- (2) Staff.
 - (a) The governing body must ensure that there are adequate numbers of qualified and, where required, licensed personnel to provide services needed by mothers and families and to provide for safe maintenance of the birthing center.
 - (b) The governing body must appoint a medical director who:
 - 1. Is a qualified specialist in obstetrics/gynecology or family practice;
 - 2. Approves all policies, procedures and practice guidelines for the medical management of care;
 - 3. Approves standardized criteria for admission screening and monitoring the risk status of each mother during pregnancy, labor, birth and postpartum; and
 - 4. Is available for consultation and referral in obstetrics or pediatrics or has made arrangements with a qualified physician for these services.
- (3) Equipment.
 - (a) A readily accessible emergency cart or tray for the mother, equipped to carry out the written emergency procedures of the center and securely placed with a written log of routine maintenance for readiness.
 - (b) A readily accessible emergency cart or tray for the newborn, equipped to carry out the written emergency procedures of the center and securely placed with a written log of routine maintenance for readiness.
 - (c) Properly maintained equipment for routine care of women and neonates including but not limited to:

(Rule 1200-08-24-.06, continued)

1. A heat source for infant examination or resuscitation;
 2. Transfer incubator or isolette or demonstrated capability of ready access to transfer incubator;
 3. Sterilizer or demonstration of sterilizing capability;
 4. Blood pressure equipment, thermometers, fetoscope/doptone;
 5. Intravenous equipment;
 6. Oxygen equipment for mother and newborn; and,
 7. Instruments for episiotomy and repair.
- (4) Prenatal Care. The physician, certified professional midwife and nurse-midwife shall ensure that patients have adequate education and prenatal care by generally accepted definitions. Records of this care should be available in the center at the time of admission. When, in the course of prenatal care, risk factors are identified which preclude childbirth at the center, the woman shall be referred for care in a hospital setting and her prenatal records made available to the attending clinicians.
- (5) Surgical Services. Surgical procedures shall be limited to those normally accomplished during uncomplicated childbirth, such as episiotomy and repair, and must not include operative obstetrics or cesarean section.
- (6) If intervention beyond what is allowed in the practice guidelines is required at any time during the course of pregnancy and/or labor, the woman and her newborn must be managed at a more intensive level of care.
- (7) Laboratory Services. The birthing center shall have the capacity to perform on site routinely necessary tests such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity.
- (8) Intrapartum Care. Labor shall not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor. Drugs for induction or augmentation of labor, vacuum extractors, forceps, continuous electronic fetal monitoring and ultrasound imaging are not appropriate during normal labor. A nurse midwife, certified professional midwife or physician must be in attendance or available to attend during all stages of the delivery.
- (9) Analgesia and Anesthesia. General and conduction anesthesia shall not be administered at birthing centers. Local anesthesia for pudendal block may be performed. Systemic analgesia may be administered, but pain control should depend primarily on close emotional support and adequate preparation for the birth experience.
- (10) Postpartum Care. Mothers and infants must be discharged in accordance with standards set by the clinical staff and specified in the policy and procedures manual, including laboratory tests required by state laws. A program for prompt follow-up care and postpartum evaluation after discharge shall be ensured and outlined in the manual of policies and procedures. This program should include assessment of infant health including physical examination, laboratory screening tests at the appropriate times, maternal postpartum status, instruction in child care including immunization, referral to sources of pediatric care, provision of family planning services, and assessment of mother-child relationship including breast feeding.

(Rule 1200-08-24-.06, continued)

- (11) Food Services. The birthing center must provide mothers and families with nutritious liquids and snacks as required. Food may be prepared by the family, catered, or prepared in the birthing center's kitchen. Meals that are prepared and served by the birthing center will be subject to local regulations for food preparation and service.
- (12) The physical environment of the facility shall be maintained in a safe, clean and sanitary manner.
 - (a) Any condition on the birthing center site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.
 - (b) Cats, dogs or other animals shall not be allowed in any part of the facility except for specially trained animals for the handicapped. The facility shall designate in its policies and procedures those areas where animals will be excluded. The areas designated shall be determined based upon an assessment of the facility performed by medically trained personnel.

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 March 31, 1998; effective June 12, 1998. Amendment filed January 3, 2006; effective March 19, 2006.

1200-08-24-.07 BUILDING STANDARDS.

- (1) The birthing center must be constructed, arranged, and maintained to ensure the safety of the patient.
- (2) The condition of the physical plant and the overall birthing center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
- (3) No birthing center shall hereafter be constructed, nor shall major alterations be made to existing birthing centers, or change in birthing center type be made without the prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new birthing center is licensed or before any alteration or expansion of a licensed birthing center can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.
- (4) After the application and licensure fees have been submitted, the building construction plans must be submitted to the department. All new facilities shall conform to the current addition of the Standard Building Code, the National Fire Protection Code (NFPA), the National Electrical Code, the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities (if applicable), and the U.S. Public Health Service Food Code as adopted by the Board for Licensing Health Care Facilities. When referring to height, area or construction type, the Standard Building Code shall prevail. All new and existing facilities are subject to the requirements of the Americans with Disabilities Act (A.D.A.). Where there are conflicts between requirements in the above listed codes and regulations and provisions of this chapter, the most restrictive shall apply.
- (5) The codes in effect at the time of submittal of plans and specifications, as defined by these regulations shall be the codes to be used throughout the project.

(Rule 1200-08-24-.07, continued)

- (6) Review of plans and specifications shall be acknowledged in writing with copies sent to the architect and the owner, manager or other executive of the institution. The distribution of such review may be modified at the discretion of the department.
- (7) All construction shall be executed in accordance with the approved plans and specifications.
- (8) All new construction and renovations to birthing centers, other than minor alterations not affecting fire and life safety or functional issues, shall be performed in accordance with the specific requirements of these regulations governing new construction in birthing centers, including the submission of phased construction plans and the final drawings and the specifications to each.
- (9) In the event submitted materials do not appear to satisfactorily comply with 1200-08-24-.07 (4) the department shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.
- (10) Notice of satisfactory review from the department constitutes compliance with this requirement if construction begins within one hundred eighty (180) days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes or rules of any responsible agency.
- (11) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. The working drawings and specifications shall be complete and adequate for contract purposes.
- (12) Prior to final inspection, a CD Rom disc, in TIF or DMG format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.
- (13) Detailed plans shall be drawn to a scale of at least one-eighth inch equals one foot ($1/8" = 1'$), and shall show the general arrangement of the building, the intended purpose and the fixed equipment in each room, with such additional information as the department may require. These plans shall be prepared by an architect or engineer licensed to practice in the State of Tennessee. The plans shall contain a certificate signed by the architect or engineer that to the best of his or her knowledge or belief the plans conform to all applicable codes.
 - (a) Two (2) sets of plans shall be forwarded to the appropriate section of the department for review. After receipt of approval of phased construction plans, the owner may proceed with site grading and foundation work prior to receipt of approval of final plans and specifications with the understanding that such work is at the owner's risk and without assurance that final approval of final plans and specifications shall be granted. Final plans and specifications shall be submitted for review and approval. Final approval must be received before proceeding beyond foundation work.
 - (b) Review of plans does not eliminate responsibility of owner and/or architect to comply with all rules and regulations.
- (14) Specifications shall supplement all drawings. They shall describe the characteristics of all materials, products and devices, unless fully described and indicated on the drawings. Specification copies should be bound in an 8½ x 11 inch folder.
- (15) Drawings and specifications shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical and Sprinkler.

(Rule 1200-08-24-.07, continued)

(16) Architectural drawings shall include:

- (a) Plot plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;
- (b) Floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture;
- (c) Separate life safety plans showing the compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units. All fire and smoke walls must be identified;
- (d) The elevation of each facade;
- (e) The typical sections throughout the building;
- (f) The schedule of finishes;
- (g) The schedule of doors and windows;
- (h) Roof plans;
- (i) Details and dimensions of elevator shaft(s), car platform(s), doors, pit(s), equipment in the machine room, and the rates of car travel must be indicated for elevators; and
- (j) Code analysis.

(17) Structural drawings shall include:

- (a) Plans of foundations, floors, roofs and intermediate levels which show a complete design with sizes, sections and the relative location of the various members;
- (b) Schedules of beams, girders and columns; and
- (c) Design live load values for wind, roof, floor, stairs, guard, handrails, and seismic.

(18) Mechanical drawings shall include:

- (a) Specifications which show the complete heating, ventilating, fire protection, medical gas systems and air conditioning systems;
- (b) Water supply, sewerage and HVAC piping systems;
- (c) Pressure relationships shall be shown on all floor plans;
- (d) Heating, ventilating, HVAC piping, medical gas systems and air conditioning systems with all related piping and auxiliaries to provide a satisfactory installation;
- (e) Water supply, sewage and drainage with all lines, risers, catch basins, manholes and cleanouts clearly indicated as to location, size, capacities, etc., and location and dimensions of septic tank and disposal field; and,
- (f) Color coding to show clearly supply, return and exhaust systems.

(19) Electrical drawings shall include:

(Rule 1200-08-24-.07, continued)

- (a) A certification that all electrical work and equipment is in compliance with all applicable local codes and laws, and that all materials are currently listed by recognized testing laboratories;
 - (b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, and transformers when located within the building;
 - (c) The electrical system, which shall comply with applicable codes, and shall include:
 - 1. The fire alarm system; and
 - 2. The emergency power system including automatic services as defined by the codes.
 - (d) Color coding to show all items on emergency power.
- (20) Sprinkler drawings shall include:
- (a) Shop drawings, hydraulic calculations, and manufacturer cut sheets;
 - (b) Site plan showing elevation of fire hydrant to building, test hydrant, and flow data (Data from within a 12 month period); and
 - (c) Show "Point of Service" where water is used exclusively for fire protection purposes.
- (21) No system of water supply, plumbing, sewage, garbage or refuse disposal shall be installed nor shall any existing system be materially altered or extended until complete plans and specifications for the installation, alteration or extension have been submitted to the department and show that all applicable codes have been met and necessary approval has been obtained.
- (a) Before the facility is used, the water supply system shall be approved by the Tennessee Department of Environment and Conservation.
 - (b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.
 - (c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F.
- (22) The following alarms are required and shall be monitored twenty-four (24) hours per day:
- (a) Fire alarms; and
 - (b) Generators (if applicable)
- (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.

(Rule 1200-08-24-.07, continued)

- (24) With the submission of plans the facility shall specify the evacuation capabilities of the patients as defined in the National Fire Protection Code (NFPA). This declaration will determine the design and construction requirements of the facility.

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 March 31, 1998; effective June 12, 1998. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed January 3, 2006; effective March 19, 2006.

1200-08-24-.08 LIFE SAFETY.

- (1) Any birthing center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.
- (2) The birthing center shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.

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 March 31, 1998; effective June 12, 1998. Amendment filed January 3, 2006; effective March 19, 2006.

1200-08-24-.09 INFECTIOUS AND HAZARDOUS WASTE.

- (1) Each birthing center must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous waste, including a specific policy and procedure on containment and repackaging of spilled waste. These policies and procedures must comply with the standards of this section and all other applicable state and federal regulations.
- (2) The following waste shall be considered to be infectious waste:
- (a) Waste contaminated by patients who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control "Guidelines for Isolation, Precautions in Hospitals";
 - (b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, culture dishes and devices used to transfer, inoculate, and mix cultures;
 - (c) Waste human blood and blood products such as serum, plasma, and other blood components;
 - (d) Pathological waste, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

(Rule 1200-08-24-.09, continued)

- (e) All discarded sharps (e.g., hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in patient care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories;
 - (f) Contaminated carcasses, body parts, and bedding of animals that were exposed to pathogens in research, in the production of biologicals, or in the in vivo testing of pharmaceuticals; and,
 - (g) Other waste determined to be infectious by the facility in its written policy.
- (3) Infectious and hazardous waste must be segregated from other waste at the point of generation (i.e., the point at which the material becomes a waste) within the facility.
- (4) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how it will be handled and transported, and how the waste will be treated and disposed of.
- (a) Contaminated sharps must be directly placed in leakproof, rigid and puncture-resistant containers which must then be tightly sealed.
 - (b) Whether disposable or reusable, all containers, bags, and boxes used for containment and disposal of infectious waste must be conspicuously identified. Packages containing infectious waste which pose additional hazards (e.g., chemical, radiological) must also be conspicuously identified to clearly indicate those additional hazards.
 - (c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.
 - (d) Opaque packaging must be used for pathological waste.
- (5) After packaging, waste must be handled and transported by methods ensuring containment and preservation of the integrity of the packaging, including the use of secondary containment where necessary.
- (a) Waste must not be compacted or ground (i.e., in a mechanical grinder) prior to treatment, except that pathological waste may be ground prior to disposal.
 - (b) Plastic bags of infectious waste must be transported by hand.
- (6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.
- (a) Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents and does not create a nuisance.
 - (b) Pathological waste must be promptly treated, disposed of, or placed in refrigerated storage.

(Rule 1200-08-24-.09, continued)

- (7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the facility must ensure that proper actions are immediately taken to:
 - (a) Isolate the area from the public and all except essential personnel;
 - (b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph (6) of this section;
 - (c) Sanitize all contaminated equipment and surfaces appropriately; and,
 - (d) Complete an incident report and maintain a copy on file.
- (8) Except as provided otherwise in this rule a facility must treat or dispose of infectious waste by one or more of the methods specified in this paragraph.
 - (a) A facility may treat infectious waste in an on-site sterilization or disinfection device, or in an incinerator or a steam sterilizer, which has been designed, constructed, operated and maintained so that infectious waste treated in such a device is rendered non-infectious and is, if applicable, authorized for that purpose pursuant to current rules of the Department of Environment and Conservation. A valid permit or other written evidence of having complied with the Tennessee Air Pollution Control Regulations shall be available for review, if required. Each sterilizing or disinfection cycle must contain appropriate indicators to assure that conditions were met for proper sterilization or disinfection of materials included in the cycle, and appropriate records kept. Proper operation of such devices must be verified at least monthly, and records of the monthly verifications shall be available for review. Waste that contains toxic chemicals that would be volatilized by steam must not be treated in steam sterilizers. Infectious waste that has been rendered to carbonized or mineralized ash shall be deemed non-infectious. Unless otherwise hazardous and subject to the hazardous waste management requirements of the current rules of the Department of Environment and Conservation, such ash shall be disposable as a (non-hazardous) solid waste under current rules of the Department of Environment and Conservation.
 - (b) A facility may discharge liquid or semi-liquid infectious waste to the collection sewerage system of a wastewater treatment facility which is subject to a permit pursuant to *T.C.A. §§ 69-3-101, et seq.*, provided that such discharge is in accordance with any applicable terms of that permit and/or any applicable municipal sewer use requirements.
 - (c) Any health care facility accepting waste from another state must promptly notify the Department of Environment and Conservation, county, and city public health agencies, and must strictly comply with all applicable local, state and federal regulations.
- (9) The facility may have waste transported off-site for storage, treatment, or disposal. Such arrangements must be detailed in a written contract, available for review. If such off-site location is located within Tennessee, the facility must ensure that it has all necessary State and local approvals, and such approvals shall be available for review. If the off-site location is within another state, the facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility's waste. Waste shipped off-site must be packaged in accordance with applicable federal and state requirements. Waste transported to a sanitary landfill in this state must meet the requirements of current rules of the Department of Environment and Conservation.
- (10) Human anatomical remains which are transferred to a mortician for cremation or burial shall be exempt from the requirements of this rule. Any other human limbs and recognizable organs must be incinerated or discharged (following grinding) to the sewer.

(Rule 1200-08-24-.09, continued)

- (11) All garbage, trash and other non-infectious waste shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily-cleanable material, and shall be kept on elevated platforms.

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-.10 RECORDS AND REPORTS.

- (1) A report of all births, deaths and stillbirths which have occurred in the birthing center shall be filed with the local registrar in the county where the institution is located. The report shall be filed on the third (3rd) working day of each month on a form furnished by the State Registrar. The report shall state whether or not the list is complete for all events which have occurred in the facility during the preceding calendar month, and if not complete, shall show the number of events not included in the report. If no birth, death, or stillbirth occurred in the facility, the words "No Report" shall be entered on the form and forwarded to the local registrar.
- (2) The Joint Annual Report, a calendar year statistical report, shall be filed with the department's Bureau of Information Resources no later than sixty (60) days following the twelve (12) months ending December 31.
- (3) The birthing center shall report each case of communicable disease to the local county health officer in the manner provided by existing regulations of the department. Repeated failure to report communicable diseases shall be cause for revocation of a facility license.
- (4) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient.
 - (a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:
 1. medication errors;
 2. aspiration in a non-intubated patient related to conscious/moderate sedation;
 3. intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;
 4. volume overload leading to pulmonary edema;
 5. blood transfusion reactions, use of wrong type of blood and/or delivery of blood to the wrong patient;
 6. perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness;

(Rule 1200-08-24-.10, continued)

7. burns of a second or third degree;
8. falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;
9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:
 - (i) procedure related injury requiring repair or removal of an organ;
 - (ii) hemorrhage;
 - (iii) displacement, migration or breakage of an implant, device, graft or drain;
 - (iv) post operative wound infection following clean or clean/contaminated case;
 - (v) any unexpected operation or reoperation related to the primary procedure;
 - (vi) hysterectomy in a pregnant woman;
 - (vii) ruptured uterus;
 - (viii) circumcision;
 - (ix) incorrect procedure or incorrect treatment that is invasive;
 - (x) wrong patient/wrong site surgical procedure;
 - (xi) unintentionally retained foreign body;
 - (xii) loss of limb or organ, or impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence;
 - (xiii) criminal acts;
 - (xiv) suicide or attempted suicide;
 - (xv) elopement from the facility;
 - (xvi) infant abduction, or infant discharged to the wrong family;
 - (xvii) adult abduction;
 - (xviii) rape;
 - (xix) patient altercation;
 - (xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;
 - (xxi) restraint related incidents; or
 - (xxii) poisoning occurring within the facility.

(Rule 1200-08-24-.10, continued)

- (b) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:
 - 1. strike by the staff at the facility;
 - 2. external disaster impacting the facility;
 - 3. disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and
 - 4. fires at the facility which disrupt the provision of patient care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.
- (c) For health services provided in a “home” setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.
- (d) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department. The department’s approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or causal factor(s) that underlie variation in performance leading to the unusual event by (a) determining the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.
- (e) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner’s representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.
- (f) The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.

(Rule 1200-08-24-.10, continued)

- (g) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.
 - (h) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in (a) and (b). If an event or specific incident fails to come within these examples, it shall be classified as “other” with the facility explaining the facts related to the event or incident.
 - (i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.
 - (j) The affected patient and/or the patient’s family, as may be appropriate, shall also be notified of the event or incident by the facility.
 - (k) During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of unusual events and incidents reported by facilities to the Department for the preceding calendar year.
 - (l) The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.
- (5) The birthing center shall report information contained in the medical records of patients who have cancer or precancerous or tumorous diseases as provided by existing regulations. These reports shall be sent to the Cancer Reporting System of the department on a quarterly schedule no later than six (6) months after the date of the diagnosis or treatment.
- (6) The birthing center shall retain legible copies of the records and reports specified in this paragraph for the thirty-six (36) month period following their issuance. Copies of these reports shall be maintained in a single file at a location convenient to the public and, during normal business hours, they shall be promptly produced for the inspection of any person who requests to view them. Each patient and each person assuming any financial responsibility for a patient must be fully informed, before or at the time of admission, of the availability of these reports to the public, of their location within the facility, and given an opportunity to inspect the file before entering into any monetary agreement with the facility.
- (a) Local fire safety inspections.
 - (b) Local building code inspections, if any.
 - (c) Fire marshal reports.

(Rule 1200-08-24-.10, continued)

- (d) Department licensure and fire safety inspections and surveys.
- (e) Department quality assurance surveys, including follow-up visits, and certification inspections, if any.
- (f) Federal Health Care Financing Administration surveys and inspections, if any.
- (g) Orders of the Commissioner or Board, if any.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213. **Administrative History:** Original rule filed March 31, 1998; effective June 12, 1998. Amendment filed April 11, 2003; effective June 25, 2003.

1200-08-24-.11 PATIENT RIGHTS.

- (1) Each patient has at least the following rights:
 - (a) To privacy in treatment and personal care;
 - (b) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department and the Tennessee Department of Human Services, Adult Protective Services;
 - (c) To refuse treatment. The patient must be informed of the consequences of that decision, the refusal and its reason must be reported to the physician and documented in the medical record;
 - (d) To refuse experimental treatment and drugs. The patient's or health care decision maker's written consent for participation in research must be obtained and retained in his or her medical record; and
 - (e) To have their records kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision maker. The birthing center must have policies to govern access and duplication of the patient's record.
- (2) Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.

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 March 31, 1998; effective June 12, 1998. Amendment filed January 3, 2006; effective March 19, 2006.

1200-08-24-.12 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

- (1) Pursuant to this Rule, each birthing center shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual patients. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.
- (2) An adult or emancipated minor may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the patient could

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

- have made while having capacity, or may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the patient could have made while having capacity.
- (3) The advance directive shall be in writing, signed by the patient, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the patient by blood, marriage, or adoption and would not be entitled to any portion of the estate of the patient upon the death of the patient. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.
 - (4) Unless otherwise specified in an advance directive, the authority of an agent becomes effective only upon a determination that the patient lacks capacity, and ceases to be effective upon a determination that the patient has recovered capacity.
 - (5) A facility shall use the mandatory advance directive form that meets the requirements of the Tennessee Health Care Decisions Act and has been developed and issued by the Board for Licensing Health Care Facilities.
 - (6) A determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.
 - (7) An agent shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the patient's best interest. In determining the patient's best interest, the agent shall consider the patient's personal values to the extent known.
 - (8) An advance directive may include the individual's nomination of a court-appointed guardian.
 - (9) A health care facility shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the patient's residence.
 - (10) No health care provider or institution shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.
 - (11) Any living will, durable power of attorney for health care, or other instrument signed by the individual, complying with the terms of Tennessee Code Annotated, Title 32, Chapter 11, and a durable power of attorney for health care complying with the terms of Tennessee Code Annotated, Title 34, Chapter 6, Part 2, shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.
 - (12) A patient having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.
 - (13) A patient having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

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

- (14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.
- (15) An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.
- (16) Surrogates.
 - (a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. The designation may be oral or written.
 - (b) A surrogate may make a health care decision for a patient who is an adult or emancipated minor if and only if:
 1. the patient has been determined by the designated physician to lack capacity, and
 2. no agent or guardian has been appointed, or
 3. the agent or guardian is not reasonably available.
 - (c) In the case of a patient who lacks capacity, the patient's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the patient is receiving health care.
 - (d) The patient's surrogate shall be an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, who is reasonably available, and who is willing to serve.
 - (e) Consideration may be, but need not be, given in order of descending preference for service as a surrogate to:
 1. the patient's spouse, unless legally separated;
 2. the patient's adult child;
 3. the patient's parent;
 4. the patient's adult sibling;
 5. any other adult relative of the patient; or
 6. any other adult who satisfies the requirements of 1200-08-24-.12(16)(d).
 - (f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the patient shall be eligible to serve as the patient's surrogate.
 - (g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:
 1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the patient or in accordance with the patient's best interests;

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

2. The proposed surrogate's regular contact with the patient prior to and during the incapacitating illness;
 3. The proposed surrogate's demonstrated care and concern;
 4. The proposed surrogate's availability to visit the patient during his or her illness; and
 5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.
- (h) If the patient lacks capacity and none of the individuals eligible to act as a surrogate under 1200-08-24-.12(16)(c) thru 1200-08-24-.12(16)(g) is reasonably available, the designated physician may make health care decisions for the patient after the designated physician either:
1. Consults with and obtains the recommendations of a facility's ethics mechanism or standing committee in the facility that evaluates health care issues; or
 2. Obtains concurrence from a second physician who is not directly involved in the patient's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.
- (i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.
- (j) A surrogate shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.
- (k) A surrogate who has not been designated by the patient may make all health care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the designated physician and a second independent physician certify in the patient's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to regain capacity to make medical decisions.
- (l) Except as provided in 1200-08-24-.12(16)(m):
1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; and
 2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the patient's treating health care provider.

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

- (m) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate if:
 - 1. the employee so designated is a relative of the patient by blood, marriage, or adoption; and
 - 2. the other requirements of this section are satisfied.
 - (n) A health care provider may require an individual claiming the right to act as surrogate for a patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.
- (17) Guardian.
- (a) A guardian shall comply with the patient's individual instructions and may not revoke the patient's advance directive absent a court order to the contrary.
 - (b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.
 - (c) A health care provider may require an individual claiming the right to act as guardian for a patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.
- (18) A designated physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record the determination in the patient's current clinical record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.
- (19) Except as provided in 1200-08-24-.12(20) thru 1200-08-24-.12(22), a health care provider or institution providing care to a patient shall:
- (a) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and
 - (b) comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.
- (20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.
- (21) A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is:
- (a) contrary to a policy of the institution which is based on reasons of conscience, and
 - (b) the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.
- (22) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

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

- (23) A health care provider or institution that declines to comply with an individual instruction or health care decision pursuant to 1200-08-24-.12(20) thru 1200-08-24-.12(22) shall:
- (a) promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient;
 - (b) provide continuing care to the patient until a transfer can be effected or until the determination has been made that transfer cannot be effected;
 - (c) unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision; and
 - (d) if a transfer cannot be effected, the health care provider or institution shall not be compelled to comply.
- (24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.
- (25) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:
- (a) complying with a health care decision of a person apparently having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;
 - (b) declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or
 - (c) complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.
- (26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.
- (27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for such identification made in good faith.
- (28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.
- (29) The withholding or withdrawal of medical care from a patient in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.
- (30) Universal Do Not Resuscitate Order (DNR).
- (a) The Physicians Order for Scope of Treatment (POST) form, a mandatory form meeting the provisions of the Health Care Decision Act and approved by the Board for Licensing Health Care Facilities, shall be used as the Universal Do Not Resuscitate Order by all facilities. A universal do not resuscitate order (DNR) may be used by a

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

physician for his/her patient with whom he/she has a physician/patient relationship, but only:

1. with the consent of the patient; or
 2. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or
 3. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available, the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.
- (b) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke a universal do not resuscitate order. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke a universal do not resuscitate order.
- (c) Universal do not resuscitate orders shall remain valid and in effect until revoked. Qualified emergency medical services personnel, and licensed health care practitioners in any facility, program or organization operated or licensed by the board for licensing health care facilities or by the department of mental health and developmental disabilities or operated, licensed, or owned by another state agency are authorized to follow universal do not resuscitate orders.
- (d) Nothing in these rules shall authorize the withholding of other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.
- (e) If a person with a universal do not resuscitate order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the universal do not resuscitate order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the universal do not resuscitate order accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the universal do not resuscitate order a part of the patient's record.
- (f) This section shall not prevent, prohibit, or limit a physician from issuing a written order, other than a universal do not resuscitate order, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices.
- (g) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to the then-current law, shall remain valid and shall be given effect as provided.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, 68-11-1801 through 68-11-1815. **Administrative History:** Original rule filed March 31, 1998; effective June 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.

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

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)

<p align="center">Physician Orders for Scope of Treatment (POST)</p> <p>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, <u>first</u> follow these orders, <u>then</u> contact physician.</p>		Patient's Last Name	
		First Name/Middle Initial	
		Date of Birth	
Section A Check One Box Only	<p>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing.</p> <p><input type="checkbox"/> Resuscitate (CPR) <input type="checkbox"/> Do Not Attempt Resuscitate (DNR/no CPR)</p> <p>When not in cardiopulmonary arrest, follow orders in B, C, and D.</p>		
Section B Check One Box Only	<p>MEDICAL INTERVENTIONS. Patient has pulse <u>and/or</u> is breathing.</p> <p><input type="checkbox"/> 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 <u>only</u> if comfort needs cannot be met in current location.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.</p> <p>Other Instructions: _____</p>		
Section C Check One Box Only	<p>ANTIBIOTICS – Treatment for new medical conditions:</p> <p><input type="checkbox"/> No Antibiotics</p> <p><input type="checkbox"/> Antibiotics</p> <p>Other Instructions: _____</p>		
Section D Check One Box Only in Each Column	<p>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.</p> <p><input type="checkbox"/> No IV fluids (provide other measures to assure comfort) <input type="checkbox"/> No feeding tube</p> <p><input type="checkbox"/> IV fluids for a defined trial period <input type="checkbox"/> Feeding tube for a defined trial period</p> <p><input type="checkbox"/> IV fluids long-term if indicated <input type="checkbox"/> Feeding tube long-term</p> <p>Other Instructions: _____</p>		
Section E Must be Completed	<p>Discussed with:</p> <p><input type="checkbox"/> Patient/Resident</p> <p><input type="checkbox"/> Health care agent</p> <p><input type="checkbox"/> Court-appointed guardian</p> <p><input type="checkbox"/> Health care surrogate</p> <p><input type="checkbox"/> Parent of minor</p> <p><input type="checkbox"/> Other: _____ (Specify)</p>		<p>The Basis for These Orders Is: (Must be completed)</p> <p><input type="checkbox"/> Patient's preferences</p> <p><input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown)</p> <p><input type="checkbox"/> Medical indications</p> <p><input type="checkbox"/> (Other) _____</p>
	Physician Name (Print)		Physician Phone Number
	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.	

(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			
<p><u>Completing POST</u></p> <p>Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.</p> <p>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.</p> <p>Photocopies/faxes of signed POST forms are legal and valid.</p> <p><u>Using POST</u></p> <p>Any incomplete section of POST implies full treatment for that section.</p> <p>No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".</p> <p>Oral fluids and nutrition <u>must</u> always be <u>offered</u> if medically feasible.</p> <p>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).</p> <p>IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".</p> <p>Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".</p> <p>A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.</p> <p><u>Reviewing POST</u></p> <p>This POST should be reviewed if:</p> <ol style="list-style-type: none"> (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. <p>Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.</p>			
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!

(2) Advance Care Plan Form

ADVANCE CARE PLAN

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

<input type="checkbox"/>	<input type="checkbox"/>	<u>CPR (Cardiopulmonary Resuscitation):</u> 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	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Life Support/Other Artificial Support:</u> 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	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Treatment of New Conditions:</u> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Tube feeding/IV fluids:</u> 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.
Yes	No	

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

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

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.