

National Hospice and Palliative Care
Organization



QUALITY GUIDELINES

FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

NHPCO

VISION

A WORLD WHERE INDIVIDUALS AND FAMILIES FACING SERIOUS ILLNESS, DEATH, AND GRIEF WILL EXPERIENCE THE BEST THAT HUMANKIND CAN OFFER.

MISSION

TO LEAD AND MOBILIZE SOCIAL CHANGE FOR IMPROVED CARE AT THE END OF LIFE.

In 2003, the National Hospice and Palliative Care Organization (NHPCO) significantly affirmed its commitment to end-of-life care in all settings by continuing the work begun by the Volunteers of America (VOA) and its Guiding Responsive Action in Corrections at End of life (GRACE) Project. NHPCO has collaborated with stakeholders working in, and committed to this field to gather information, develop curricula and identify correctional end-of-life programs throughout the country.

The development of the *Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings* is the culmination of the work that NHPCO has done in partnership with community hospice organizations and correctional institutions to make gentle death a reality within the corrections environment.

The following quality guidelines were developed by the National Hospice and Palliative Care Organization.

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Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings by the National Hospice and Palliative Care Organization (NHPCO).

QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

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QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

THE FOLLOWING ORGANIZATIONS ARE PARTNERING WITH THE NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION IN SUPPORT OF THE *QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS*.

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QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

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Dear Colleagues:

The health care needs of aging and terminally ill inmate patients are growing dramatically. Approximately 3,300 inmates die of natural causes each year. As the number of aging and ill incarcerated men and women increases, correctional facilities are seeking both a method and a model to care for these inmate patients in a humane and caring manner.

“Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings” has been developed to guide and support correctional facilities as they strive to create and sustain programs that serve inmate patients who are reaching the end of their lives.

As new programs are developed, these guidelines will serve as a model, a beacon and a reminder that the very foundation for quality care is dependent upon a deep and abiding understanding of the unique needs of those who are facing death in a correctional setting.

“Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings” had been created with the help of corrections experts from across the country and from those who work in correctional facilities. It is our hope that the Guidelines will enhance and improve quality of care for all inmate patients who are facing the end of their lives behind the walls.

Best Wishes,

A handwritten signature in black ink that reads "J. Donald Schumacher". The signature is written in a cursive style with a large, sweeping initial "J".

J. Donald Schumacher, PsyD

President & CEO

National Hospice & Palliative Care Organization

QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

INTRODUCTION AND THE TEN KEY COMPONENTS OF QUALITY CARE IN CORRECTIONAL SETTINGS

The NHPCO Quality Guidelines encompass ten key components of quality that offer hospice and end-of-life care-providers a clear framework for a 360-degree surveillance of their entire operation, focusing on both clinical and non-clinical areas. The overall goal of the initiative is to help hospice/end-of-life care providers in corrections to measurably show organizational excellence and demonstrate improvement efforts across all areas of hospice operations in correctional care facilities. In addition, the Quality Guideline Initiative will assist new programs to set policies and procedures to ensure quality care and will assist established programs in assessing their effectiveness.


The *Quality Guidelines for Hospice and End-of-Life care in Correctional Settings* has been organized around the following ten components:

Inmate Patient and Family-Centered Care: Providing care and services that are responsive to the needs of the inmate patient and their family of choice and exceeding the expectations of those we serve.

Ethical Behavior and Inmate Patient Rights: Upholding high standards of ethical conduct and advocating for the rights of inmate patients and their families.

Clinical Excellence and Safety: Ensuring clinical excellence and promoting safety through standards of practice.

Inclusion and Access: Promoting inclusiveness in the correctional community by ensuring that all people — regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age, disease or other characteristics — have access to hospice and end-of-life care programs and services.



Organizational Excellence and Accountability: Building a culture of quality and accountability within our organization that values collaboration and communication and ensures ethical business practices.


Workforce Excellence: Fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability and workforce excellence, through professional development, training and support to all staff and volunteers.

Quality Guidelines: Utilizing NHPCO’s “Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings” as guidelines for developing and implementing hospice in corrections in concert with American Correctional Association and National Commission on Correctional Health Care accreditation standards.

Compliance with Laws and Regulations: Ensuring compliance with applicable laws, regulations and professional standards of practice, implementing systems and processes that prevent fraud and abuse.

Stewardship and Accountability: Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight.

Performance Improvement: Collecting, analyzing and actively using Performance Improvement data to foster quality assessment and performance improvement in all areas of care and services.



INMATE PATIENT AND FAMILY-CENTERED CARE (PFC)

Principles: *The inmate patient is the unit of care. The inmate patient’s “family of choice” is also a focus of care. “Family of choice” is defined as biological family members, significant others from the community and/or inmates or individuals named as family by the inmate patient. The extent of involvement of the family of choice is determined by the inmate patient. The community hospice emphasis on family is in part because most of the care giving is provided by family. The “family” as traditionally defined, is more fluid in the correctional setting. Families of biology are frequently no longer in the picture, while intense and meaningful “family” relationships have developed with other inmates. Many inmate patients may not be interested in involving biological or family of choice to the degree encountered in the community. Patient-centered care means the inmate patient retains the ultimate choice as to the involvement level of others in concert with prison policy.*

If the inmate patient desires, the hospice interdisciplinary team, in collaboration with the inmate patient and family of choice, develops and maintains an inmate-patient-directed, individualized, safe and coordinated plan of palliative care.

Note: For the purpose of this document, “family” is used with the understanding that it means “family of choice.”

Availability of Services

Guideline:

PFC 1 Hospice/facility services are available 24 hours a day, seven days a week.

PFC 1.1 The hospice/facility ensures a timely response to inmate patient concerns and family contacts 24 hours a day, seven days a week. Contact with the family will follow hospice/facility guidelines for contacts with family and/or community significant others, e.g. spiritual advisor or minister.

PFC 1.2 Professional staff consultations provide assessment, instruction, support and, when indicated, appropriate interventions.

Practice Examples:

- Documentation of actions taken after normal business hours, contacts and visits are submitted in writing within forty-eight hours (48) hours.
- An assigned member of the interdisciplinary team develops written recommendations, parameters for interventions and updates for staff providing care to patients after normal business hours to ensure continuity of care. The updates include new or changed medications, changes in the inmate patient's condition and a summary of current issues, helpful approaches, special concerns and information on uncommon diagnoses.

Coordination of Care

Guideline:

PFC 2 Care is fully coordinated to ensure ongoing continuity for the inmate patient and for the family, when indicated.

PFC 2.1 The hospice/facility has criteria for the receiving of referrals and verification of eligibility that are used to make admission decisions.

PFC 2.2 Procedures are established and utilized for initial and ongoing assessment of inmate patients and the family by all disciplines.

PFC 2.3 The interdisciplinary team's services are adjusted as required by the inmate patient and family and are coordinated and delivered through the identified team member responsible for managing the care-plan revisions.

Practice Examples:

- The inmate patient/family/caregiver's needs are assessed utilizing available tools (e.g., NHPCO *A Pathway for Patients and Families Facing Terminal Illness*) throughout the course of care, and the plan of care is changed as appropriate.
- Interdisciplinary team meetings may include individuals, as stated in PFC 4.1, contracted service providers, community clergy, attending physicians, inmate volunteers and family, security/classification officers and mental-health professionals, as needed to address issues related to the coordination of care.

Guideline:

PFC 3 A qualified health-care professional coordinates the hospice interdisciplinary team of professionals and volunteers to ensure continuous assessment, planning and integration of the inmate's and family needs.

PFC 3.1 The health professional coordinates the care based on the inmate patient's and family's unique needs, the skills and specialties of the health professionals and the patient population served by the hospice.

Practice Example:

- The team coordinator is the focal point for current patient information. The team coordinator's other responsibilities may include attending team conferences and inmate patient and family/inmate volunteer conferences; updating and making recommendations for health-professional assignments, as needed; communicating with the physician and other team members; identifying and addressing ongoing spiritual and psychosocial needs; addressing pain and comfort measures; and supporting the timely retrieval of signed physician orders and other documentation.

Care Planning

Guideline:

PFC 4 A written plan of care is developed for each inmate patient prior to providing care and services. The written plan of care will take into account the special needs of the family and the services provided to the family, as the inmate patient so chooses.

PFC 4.1 Individuals involved in developing the plan of care may include:

- The inmate patient;
- The family, if desired by the inmate patient and in accordance with facility policy;
- The inmate patient's attending physician;
- A hospice physician, the facility medical director or other physicians as designated;
- Qualified nursing personnel, including a registered nurse, qualified LPN or aide;
- A qualified mental-health professional;
- A qualified chaplain and/or spiritual advisor;
- Inmate volunteers;
- A bereavement counselor;
- Security staff/classification officer; and
- Others, as appropriate.

PFC 4.2 The plan of care is based on the following data:

- Inmate patient goals for care;
- Goals of the family;
- Primary and secondary diagnosis and any comorbidity;
- Current medical findings, including clinical indicators and data to support the terminal prognosis; and

- Interdisciplinary team assessments of the inmate patient’s symptoms, coping and resource status or the family coping and resource status.

PFC 4.3 The plan of care includes:

- Desired goals or outcomes;
- Inmate patient’s and family problems/issues/needs and opportunities for growth;
- Interventions directed to achieve the desired goals or outcomes desired by the inmate patient and interdisciplinary team;
- Scope, frequency and type of services to be provided, including the interdisciplinary team interventions, pharmaceuticals and medical equipment to be provided; and
- Other agencies or organizations that may be involved in the care.

Practice Example:

- The admission visit is completed by the identified member of the interdisciplinary team. The plan of care is developed by the interdisciplinary team members with input from the inmate patient and family, if desired by the inmate patient. The hospice medical director, or the equivalent, is aware of and provides input into the plan of care.

Guideline:

PFC 5 The hospice facility designates an interdisciplinary team (IDT) that assesses, plans, provides and evaluates the inmate patient’s care and services with attention to the needs of the family, if desired by the inmate patient.

PFC 5.1 The interdisciplinary team may include:

- The inmate patient’s attending physician and/or other physicians or physician extender (i.e. PA, ARNP) with related experience and education;
- Qualified nursing professional, preferably registered nurses with education and experience in effective pain and symptom management and competency in physical and other assessments;

- Qualified LPN or aides with appropriate clinical and educational experience;
- Qualified mental health professionals with experience or education in bereavement issues and in psychosocial issues related to death and dying;
- Qualified chaplain/spiritual advisor;
- Security/classification officer; and
- Inmate hospice volunteers.

Practice Examples:

- Inmate hospice volunteers who provide patient support/care are advised of IDT meeting outcomes. Input from inmate volunteers is encouraged on an ongoing basis. A means is in place for transmitting inmate volunteer concerns and observations to the IDT. Inmate volunteers may be invited to IDT meetings when there is discussion of their assigned inmate patient, depending upon facility policies.
- Registered nurses who work in the infirmary may make recommendations or transmit information to the IDT even if they are not a member.

PFC 5.2 IDT meetings are scheduled in a timely manner that ensures active discussion of, and evaluation/revision of, inmate patient needs and goals as the inmate patient's status indicates. Meetings include IDT members as identified in PFC 5.1.

Practice Examples:

- IDT meetings will be regularly scheduled and will also be held in response to specific needs or changes. Regularly scheduled meetings should be held every two weeks, if possible, and never less than monthly. Attendance at the meeting by all members of the IDT is expected.
- The hospice/facility IDT makes every effort to counsel the inmate patient's family in resolving specific issues related to the dynamics of the relationship. Intervention may include referral to community counseling centers and other community sources of support as appropriate.

Guideline:

PFC 6 Procedures are in place to ensure, whenever possible, that an inmate patient's death is attended by a member of the IDT, including inmate volunteers. The family is present whenever possible. The hospice will have in place specific guidelines for facilitating family visits, These guidelines will recognize the need for privacy, expressions of caring, and grieving needs.

Practice Example:

- The hospice will follow the policies and procedures of its facility, department of corrections and state mandates for the pronouncement of death and notification procedures. A plan is in place for notification of family prior to and following the death. A plan is in place for notification of the IDT members, including inmate volunteers.

Guideline:

PFC 7 The hospice has a defined bereavement program that includes a specified time period for services following the death of an inmate patient.

Practice Examples:

- Qualified staff members with experience and education in bereavement care have contact with the inmate patient and family, if the inmate patient desires, prior to the inmate patient's death. The intervention may include referrals to a community hospice or bereavement program.
- Ancillary staff or volunteers, such as music therapists, may be utilized in facilitating the inmate patient's expression of feelings

ETHICAL BEHAVIOR AND INMATE PATIENT RIGHTS (EBIPR)

Principle: Upholding high standards of ethical conduct and advocating for the rights of inmate patients and their caregivers.

Rights: The hospice respects and honors the rights of each inmate patient it serves.

Ethics: The hospice assumes responsibility for ethical decision-making and behavior related to the provision of hospice care.

Guideline:

EBIPR 1 Hospice inmate patients have the right to be involved in all decisions regarding their care, treatment and services.

EBIPR 1.1 Inmate patients are given an explanation at the time of admission of the hospice program's focus on palliative care.

EBIPR 1.2 The inmate patient has the right to designate family to be informed and involved in decision-making. The inmate patient has the right to refuse involvement of family.

EBIPR 1.3 Informed consent for hospice care is obtained from the inmate patient or warden and documented in the clinical record.

EBIPR 1.4 The hospice verifies the inmate patient's advance-directive status and documents pertinent information in the clinical record.

EBIPR 1.5 The hospice assists the inmate patient in completing an advance directive if requested.

EBIPR 1.6 The inmate patient's wishes are respected and taken into consideration when planning for the inmate patient's care and are documented in the clinical record.

EBIPR 1.7 Decisions regarding care or services to be provided are communicated to the inmate patient and family and documented in the clinical record.

EBIPR 1.8 The hospice provides each inmate patient and family with a statement of rights and responsibilities (e.g., resources).

EBIPR 1.9 Advance-care planning is strongly encouraged and may be required for participation in specific hospice programs.

EBIPR 1.10 End-of-life programs and services are managed by a clearly defined organizational structure that identifies the roles, responsibilities and authority of every stakeholder and facilitates participation in decision-making by individuals closest to an issue or process.

Practice Examples:

- On admission and prior to rendering care, the hospice completes an advance-directive summary form and educates each inmate patient about his or her right to formulate an advance directive.
- Inmate patient/family satisfaction surveys include a question related to the hospice's consideration of the inmate patient's wishes (e.g., did the inmate patient receive any unwanted medical intervention?)
- The inmate patient's status and desires related to end-of-life decisions are evaluated and documented in each psychosocial assessment.
- When the hospice is not able to obtain a copy of the inmate patient's executed advance directive, a staff member documents the inmate patient's preferences regarding treatment choices, designation of a surrogate, etc. in the clinical record.

Guideline:

EBIPR 2 Hospice inmate patients and their families have the right to confidentiality.

EBIPR 2.1 The hospice has written policies and procedures regarding confidentiality and the protection of information from inappropriate, unnecessary and/or unlawful disclosure.

EBIPR 2.2 When data are collected and aggregated, individual inmate patient confidentiality is protected.

EBIPR 2.3 Staff members are educated about inmate patient confidentiality and the hospice's policies and procedures related to confidentiality.

EBIPR 2.4 During orientation or prior to having any contact with inmate patient, family or caregiver information, all staff members, including volunteers, agree in writing to maintain inmate patient confidentiality.

EBIPR 2.5 Information is collected and disseminated to appropriate individuals in a timely manner. A comprehensive, timely and accurate record of services provided in the facility is maintained.

EBIPR 2.6 Information is protected against loss, theft and destruction.

Practice Examples:

- Any inmate patient information is handled in a manner so that inmate patient names, diagnoses or clinical reports are not observable.
- Hospice inmate volunteers and caregivers know how to respond appropriately when asked by other concerned individuals about inmate patients they are visiting.
- Staff ensures that inmate patient, family and caregiver information is not left exposed in work areas.
- The hospice has defined procedures for the disposal of documents that contain inmate patient, family and caregiver information.

Guideline:

EBIPR 3 Inmate patients and families have the right to have their complaints heard and addressed.

EBIPR 3.1 The hospice has a complaint-resolution process in place and implements this process whenever a complaint is received.

EBIPR 3.2 The hospice informs inmate patients and families of the complaint-resolution process at the time of admission to the hospice program

EBIPR 3.3 Complaints are tracked and regularly reviewed to identify any patterns or trends.

EBIPR 3.4 Staff members are educated about the complaint-resolution process and accept responsibility for helping identify and address complaints.

EBIPR 3.5 A well-organized review and improvement process is implemented throughout the hospice program. This process is supported by the facility warden or superintendent.

EBIPR 3.6 The end-of-life quality improvement program is part of an institutional program for improving performance.

Practice Examples:

- A complaint log is maintained and includes the complaint, source of the complaint and documentation of efforts toward resolution.
- A written summary of the types of complaints received is developed periodically (e.g., quarterly), and problem areas are identified and addressed.
- The interdisciplinary team (IDT) reviews any inmate patient, family and caregiver complaint about care provided and takes remedial action as appropriate.
- There is a designated person in the hospice that is responsible for complaint follow-up, resolution and documentation.

Guideline:

EBIPR 4 The hospice acknowledges and respects each inmate patient's and family's rights and responsibilities.

EBIPR 4.1 The hospice provides a statement to each inmate patient, family and caregiver on admission of their rights and responsibilities and makes the document available to the community.

EBIPR 4.2 The hospice has written policies and procedures that address:

- The purpose and scope of hospice services;
- Informed consent by the inmate patient/family to hospice services;
- Surrogate consent according to state laws; and
- Staff education related to inmate patient and family rights and responsibilities.

EBIPR 4.3 There is evidence in the clinical record acknowledging that the inmate patient, family and caregiver received an explanation of their rights and responsibilities.

EBIPR 4.4 There is a process that facilitates annual review of the program's mission, purpose, vision, policies and procedures.

EBIPR 4.5 All persons involved with the program acknowledge and respect each inmate patient's and family's values and beliefs regarding end-of-life issues.

EBIPR 4.6 All persons involved with the program maintain professional boundaries and appropriate relationships with the inmate patient, family and hospice volunteers.

EBIPR 4.7 Inmate patients and their families are protected from abuse and exploitation.

Practice Examples:

- The clinical-record review-process verifies that each inmate patient, family and caregiver received an explanation of his/her rights and responsibilities.
- A statement of the hospice inmate patients' and families' rights is included in each hospice admission packet or booklet.

Guideline:

EBIPR 5 Each member of the IDT recognizes and demonstrates a fiduciary relationship, maintains professional boundaries, and understands that it is his/her personal responsibility to maintain appropriate relationships with the inmate patient and family.

EBIPR 5.1 The hospice provides orientation and training for staff and volunteers regarding inmate patient, family and caregiver boundaries and conflict of interest.

EBIPR 5.2 There are administrative policies that define the roles and responsibilities of all staff, contractors and volunteers.

EBIPR 5.3 An appropriate number of qualified health-care professionals, paraprofessionals and volunteers are available to meet the unique care needs of the program's patients.

EBIPR 5.4 All staff receives orientation, training, development opportunities and continuing education on end-of-life care, appropriate to their responsibilities. There is continuous education for staff, contractors and volunteers.

EBIPR 5.5 A relationship exists with community hospice programs that promotes shared training, education and consultation, if needed.

EBIPR 5.6 A competency assessment is in place for all staff and volunteers responsible for providing inmate patient care activities.

EBIPR 5.7 Staff and hospice volunteers reflect the diversity of the inmate patients served, whenever possible.

EBIPR 5.8 Adequate supervision and professional consultation by qualified personnel is continuously available to program staff and hospice volunteers.

EBIPR 5.9 Caring volunteers are provided who are specially trained in the care of the inmate patient and in other aspects of the program's operation and who are capable of assisting inmate patients without making value judgments.

EBIPR 5.10 Volunteers, whether they are inmates or from the community, receive specialized training related to care giving in a correctional setting.

EBIPR 5.11 Volunteers meet as a group monthly, or more frequently if necessary, to receive clinical supervision and support.

EBIPR 5.12 The program's leaders ensure compliance with professional, legal and regulatory requirements and guidelines.

Practice Examples:

- Hospice staff and volunteer personnel records include a signed conflict-of-interest statement that addresses both paid and unpaid staff.
- Hospice staff does not give inmate patient, family or caregiver information to the media for the purpose of promoting the hospice program, unless the inmate patient, family or caregiver has provided written consent.
- Hospice staff does not accept money or gifts from inmate patients or family. The facility may have a procedure/process for gifts to the program not to individuals.
- Hospice staff members do not give inmate patients or family their home telephone number, but rather, provide them with the appropriate telephone number to call with questions about their inmate patient.

Guideline:

EBIPR 6 The hospice has a mechanism in place to assist the IDT when ethical dilemmas arise in care of inmate patients and families of choice.

EBIPR 6.1 Procedures are established to identify, review and discuss ethical dilemmas that cannot be resolved by established professional-practice guidelines or hospice policies and procedures.

EBIPR 6.2 Hospice staff members are educated about ethics in hospice care and the hospice program's procedures for addressing ethical issues.

EBIPR 6.3 The IDT consults with a qualified, trained professional in the area of the medical ethics or has a medical ethics committee available for consultation whenever ethical dilemmas arise in the care of patients and families.

Practice Examples:

- An ethics committee is established and meets to review ethical considerations related to inmate patient care or end-of-life care issues (e.g., assisted suicide, pediatric care, withdrawal of life-sustaining care or life support, and caregiver safety).
- The hospice develops a Code of Ethics to guide ethical decision-making.
- The hospice staff completes a competency-based educational module on ethics and has a mechanism in place for continuing education regarding ethical issues.
- Hospice team members can readily identify common ethical issues or dilemmas in hospice care and how to address them appropriately.

Guideline:

EBIPR 7 Feelings of loss experienced by staff, volunteers, family and inmates following the death of a patient are addressed.

EBIPR 7.1 Written guidelines are established for hospice staff members in working with inmate patients and families and surviving family members as volunteers, in public relations or in other non-therapeutic activities.

EBIPR 7.2 Deaths that occur in the correctional facility are handled with the utmost respect and compassion toward the inmate patient and family.

EBIPR 7.3 Bereavement services are provided through a defined program to help inmate patients, families, volunteers, staff and other inmates cope with the losses that occur during the illness and after the eventual death of the inmate patient.

EBIPR 7.4 A plan of bereavement care for families and caregivers identifies bereavement problems and needs, interventions, goals and outcomes, and is developed and documented for families of choice and caregivers. Ongoing care for families in the community may include referrals to community agencies equipped to provide bereavement support and counseling.

EBIPR 7.5 Bereavement education and supportive services are offered to the larger correctional community.

EBIPR 7.6 A mechanism to evaluate bereavement services on a regular basis is maintained.

Practice Examples:

- Volunteer recruitment brochures clearly identify any qualifications pertaining to volunteering after a death in the family.
- Orientation and development for staff include information on the appropriate approaches to use with families when developing activities. New employee orientation includes training related to boundary setting with inmate patients and families.

CLINICAL EXCELLENCE AND SAFETY (CES)

Principles: *Ensuring clinical excellence and promoting safety through standards of practice.*

The desired outcomes of hospice intervention are safe and comfortable dying, self-determined life closure and effective grieving, all as determined by the patient and family/caregivers. The interdisciplinary team identifies, assists and respects the desires of the patient and family/caregivers in the facilitation of those outcomes through treatment, prevention and promotion of strategies based on continuous assessment.

The hospice provides for the safety of all staff and promotes the development and maintenance of a safe environment for patients and families served.

Guideline:

CES 1 The interdisciplinary team (IDT) treats and prevents symptoms of the patient's disease and/or comorbidity factors based on a comprehensive assessment.

CES 1.1 Information documenting the patient's terminal illness is obtained at the time of the referral for hospice care.

CES 1.2 Assessments include a description of the patient's symptoms and patient preference for treatment.

CES 1.3 Psychosocial and spiritual assessments identify issues that impact symptoms of the patient's disease.

Practice Examples:

- The hospice includes assessment of common co-morbid conditions as part of the initial nursing assessment.
- The care plan is based on the initial assessments and is updated according to reassessments.

Guideline:

CES 2 An initial pain assessment is completed on every patient admitted.

CES 2.1 Procedures and protocols for pain assessment and management are developed and implemented.

CES 2.3 Patients and families are educated about the importance of effective pain management, the pain assessment process and methods of pain management.

CES 2.4 Non-pharmacological interventions are considered for the treatment of pain.

CES 2.5 Common side effects of medications are anticipated, and preventive measures are implemented.

Practice Examples:

- Pain assessment is a distinct, easily identifiable part of initial assessment and other documentation tools.
- The hospice routinely uses a numerical or other rating scale for pain assessments.

Guideline:

CES 3 Routine, comprehensive assessments of symptoms are completed on every patient based on the patient's needs and response to treatments.

CES 3.1 Guidelines and/or protocols are developed for the assessment and management of common physical symptoms other than pain, including, but not limited to:

- Dyspnea;
- Nausea and vomiting;
- Anorexia and weight loss;
- Dehydration;
- Anxiety;
- Confusion;
- Pressure ulcers;
- Constipation;
- Restlessness and agitation; and
- Sleep disorders.

CES 3.2 The IDT assesses and addresses the patients' nutritional status and implements nutritional care per the treatment plan.

CES 3.3 Education is provided to the patient and family about the disease process and the palliation of the patient's symptoms.

Practice Examples:

- The hospice develops educational tools to utilize in teaching patients and families about the nutritional needs of the terminally ill, including concerns about the patient not eating or drinking enough.
- The hospice has specific bowel protocols for patients on narcotics.
- The hospice has textbooks and other resources available to the staff about palliation of symptoms.
- Routine symptom assessment includes a severity rating and alleviating and/or exacerbating factors.

Guideline:

CES 4 The pharmaceutical needs of inmate patients are met, consistent with applicable state and federal laws and regulations and accepted standards of practice. The inmate patients receive coordinated and accurate communication, information and education about their medication, medication profile and the results of medication monitoring.

CES 4.1 A patient-specific medication profile is maintained and periodically reviewed to monitor for medication effectiveness, actual or potential medication-related effects, and untoward interactions.

CES 4.2 The organization has a process to review all prescriptions for the appropriateness of the medication and the dose, frequency and route of administration.

CES 4.3 Written policies and procedures are developed in compliance with applicable state and federal laws and regulations governing the prescribing, dispensing, labeling, compounding, administering, transporting, delivering, controlling, storing and disposing of all medications and biologicals.

CES 4.4 Pharmaceutical services are available 24 hours a day, seven days a week.

Practice Examples:

- The pharmacist provides consultation regarding complex medication regimens and educational opportunities and updates for the hospice team members.
- The hospice has a policy for disposal of narcotics.
- The hospice nurse reviews all written medication information with the family and/or caregivers.

Guideline:

CES 5 Diagnostic services are provided that are necessary for the management of symptoms according to the patient's plan of care.

CES 5.1 Criteria are developed regarding the provision of laboratory, radiology or other diagnostic assessments.

Practice Examples:

- Current competency evaluations related to instrument usage are documented on all hospice staff performing blood-glucose monitoring.
- Quality-control checks are performed and documented for each glucometer for each day that it is used.
- The IDT considers information from the attending physician, accepted standards of practice related to palliative care, and inmate patient/family preferences when determining whether to include a specific diagnostic assessment or therapy in the inmate patient's plan of care.

Guideline:

CES 6 Interventions to assist the inmate patient in meeting his/her preferences with a changing environment or life circumstances are based on a thorough psychosocial assessment initiated at the time of admission and continued throughout the course of care.

Inmate patient care is not interrupted by changes of housing assignment within the facility, by transfer to other facilities or by release from the system, in accordance with correctional policy.

Guideline:

CES 7 Transfers, discharges and revocations are planned and managed in a manner that ensures coordination and continuity of care for patients, families and service providers.

CES 7.1 The hospice has written policies and procedures pertaining to transfer, discharge and revocation.

CES 7.2 Appropriate education is provided on the hospice's plan of care and philosophy whenever there are changes in the patient's care-setting.

CES 7.3 Transfer, discharge and revocation practices include:

- A process for ongoing evaluation of the patient's status and eligibility for hospice care;
- Interdisciplinary discharge planning that addresses the patient's and family's needs and goals;
- A coordinated transfer among all involved providers;
- Facilitation of a planned, well-communicated and effective transition for the patient, family and caregiver; and
- A mechanism for follow-up communications with the hospice, where appropriate.

Practice Examples:

- Written transfer information is provided by the hospice whenever a patient transfers to another care setting. The recorded information includes, but is not limited to, the following:
 - Services being provided;
 - Specific medical, psychosocial, spiritual or other problems requiring intervention or follow-up; and
 - Follow-up activities planned by the hospice IDT.
- A step-by-step plan for discharge and revocation is developed by the hospice team to ensure that well-coordinated transfers to other levels of care occur and that referrals to other appropriate resources are made when indicated.
- A written discharge summary is completed in a timely manner for all discharged patients.

Guideline:

CES 8 The hospice/facility develops, implements and evaluates a plan for environmental safety and security.

CES 8.1 The hospice/facility develops, implements and evaluates a plan that addresses:

- Building safety and security;
- Staff safety and security;
- Equipment safety; and
- Patient and family safety and security.

CES 8.2 The hospice addresses staff safety and security during new-employee and volunteer orientation and on an ongoing basis as needed and when changes in policies and procedures occur. Staff safety and security include:

- General safety and self-defense measures;
- The hospice's policies and procedures related to unsafe situations; and
- Physical safety (e.g., body mechanics and back safety).

Practice Examples:

- There is a written policy that describes actions to be taken when employees or volunteers find themselves in unsafe situations.
- An annual safety in-service is provided to all staff and volunteers.
- The hospice references OSHA and NIOSH standards regarding parameters for lifting.

Guideline:

CES 9 The correctional facility develops, implements and evaluates a plan for emergency-preparedness.

CES 9.1 The hospice has a written emergency-preparedness plan that provides for the continuation of services in the event of an emergency. The emergency-preparedness plan addresses the following:

- Chain of command for implementation of the plan;
- Notification and assignment of staff responsibilities;
- Communication among staff and volunteers;
- Alternative resources and travel routes;
- Means of prioritizing, identifying and responding to patient care needs with the goal of preventing or diminishing the effects of the disaster;
- Types of anticipated nature and civil disasters (e.g., hurricanes, tornadoes, floods, earthquakes, chemical spills and inclement weather as appropriate to the geographical area where the hospice resides);
- Time frames for the initiation of the plan;
- Education of the patient/family to the emergency-preparedness plan; and
- Recovery and re-establishment of normal operations.

CES 9.2 The hospice orients all employees to the emergency-preparedness plan.

Practice Examples:

- A telephone tree is set up to facilitate communication with the staff during an emergency.
- The emergency-preparedness plan is reviewed with all new employees and volunteers during orientation.
- The hospice/facility considers preparation for disasters, e.g., multiple storms or extended utility loss.
- The hospice has an internal plan related to its involvement in the greater community as to its role in response to a natural or civil disaster.

Guideline:

CES 10 The correctional facility develops, implements and evaluates a plan for the management of infectious and hazardous material and wastes.

CES 10.1 The hospice implements a written plan that addresses:

- Identification of infectious and hazardous materials and waste;
- Proper storage, transportation and disposal of infectious hazardous materials and waste;
- Compliance with all applicable laws and regulations related to infectious and hazardous material and waste;
- Precautions, procedures and personal protective equipment (PPE) to be utilized when handling infectious and hazardous materials and waste; and
- Employees' right to know about infectious and hazardous material and waste (e.g., availability of Material Safety Data Sheets (MSDS)).

Practice Examples:

- MSDS are available on all hazardous materials used by staff in performing their duties and responsibilities.
- Hazardous materials are appropriately labeled.
- Sharps containers are clearly labeled as "hazardous waste" or color-coded and are properly disposed of according to policy.

Guideline:

CES 11 The hospice's/facility's infection-control program conforms to the guidelines set by government agencies, professional associations and applicable laws and regulations.

CES 11.1 The hospice/facility has a written blood-borne-pathogen exposure-control plan and a respiratory-protection plan that are reviewed with all staff and volunteers during orientation and on an annual basis.

CES 11.2 The hospice/facility has developed a policy and procedure for dealing with epidemics. The plan includes:

- Patient management strategies;
- Staff protection and management strategies; and
- Identification and transmission education.

Practice Examples:

- Infections are reported to the state's Department of Health when required.
- TB skin-testing is routinely performed every 12 months (or sooner when indicated) for staff who provide direct patient care.
- The hospice has a blood-borne-pathogen exposure-control plan, and staff members participate in an annual in-service on the plan.
- All clinical staff members are in possession of personal protective equipment and practice using standard precautions.
- All hospice staff and volunteers receive instruction and comply with hand hygiene according to CDC guidelines.

Guideline:

CES 12 The correctional institution maintains an infection-control program that is monitored, reviewed, evaluated and updated annually.

Practice Examples:

- The hospice's/facility's Performance Improvement Committee regularly reviews reports and data related to infection-control activities.
- At least one aspect of care related to infection control is evaluated annually (e.g., TB skin-test conversions, catheter-related infections, employee illnesses) with the goal and a plan for improvement.

Guideline:

CES 13 The correctional facility develops, implements and evaluates a plan for fire safety and prevention.

CES 13.1 The hospice has a written plan for fire safety in the hospice's environment that includes:

- Evacuation procedures and escape routes;
- Management of fire extinguishers;
- Protection of patients, staff ,visitors and property from fire and smoke; and
- Policies for using smoking materials in all settings.

CES 13.2 The hospice provides staff education related to fire safety, prevention and response

Practice Examples:

- Fire safety is included in new employee and volunteer orientation.
- Staff members receive annual in-service education on fire safety.
- Families receive instruction regarding fire prevention and development of an evacuation plan.

Guideline:

CES 14 The correctional facility develops, implements and evaluates a plan for the management of utility systems.

CES 14.1 The correctional facility develops, implements and evaluates a plan for utility-systems management within the hospice that provides for a safe and comfortable environment that addresses potential risks and failures to include:

- Computer backup;
- Telephone backup systems;
- Utility systems' failure (e.g., electrical system); and
- Communication systems' failure.

CES 14.2 The hospice addresses the safety of utility systems in the patient's environment to include:

- Assessing utility requirements for medical equipment used in patient care;
- Assessing environmental requirements for medical equipment;
- Assessing safety issues relating to electrical outlets, grounding, circuit overload, etc.;
- Providing education for all patients, family members, caregivers and employees on the safe use of medical equipment;
- Providing education on methods of contacting the hospice during communication systems' failure; and
- Exploration of community resources, as indicated, to provide for adequate utilities for patient comfort.

Practice Examples:

- Patients receive verbal instructions and related teaching materials for any medical equipment.
- Inmate patients utilizing oxygen have a backup source of oxygen in case of a system failure.
- Patients are on a utility priority list in the event of a power outage.
- Patients have adequate warmth, light, etc., to meet basic comfort needs.

Guideline:

CES 15 The hospice ensures that medications and nutritional products are properly transported, handled, stored and prepared.

CES 15.1 Medications and nutritional products are properly stored. Storage considerations include:

- Securing medications in accordance with law and regulation;
- Safe storage (e.g., proper temperature, attention to expiration dates, controlled ventilation and humidity); and
- Proper labeling (e.g., medications are stored according to the label, package insert or other written instructions).

Practice Examples:

- Expired medications and nutritional products are disposed of promptly and properly.
- All medications and nutritional products are appropriately labeled.

Guideline:

CES 16 The hospice adopts, implements and assesses the facilities plan for reporting, monitoring and following up on all incidents.

16.1 The hospice/facility has written policies and procedures that direct the reporting of all incidents and ensure adequate follow-up and tracking of all incidents.

16.2 Incidents to be reported are clearly identified by the hospice/facility and include, but are not limited to:

- Adverse outcomes, including drug reactions and complications of treatment;
- Staff endangerment or injury;
- Patient or family injury, including falls; and
- Problems related to the safe handling and use of narcotics.

16.3 The hospice/facility designates a person responsible for:

- Investigating all incidents;
- Taking follow-up actions as necessary;
- Aggregating incident data to monitor for trends; and
- Utilizing the data for risk management.

16.4 The hospice/facility ensures adequate record keeping and reporting of incidents in compliance with state and federal law.

Practice Examples:

- The hospice/facility has a form for documenting incidents.
- Incident reports are reviewed and summarized with patterns and trends analyzed on a regular basis.
- Incidents involving a premature, unexpected or accidental death or a suicide will receive an investigation to identify the root cause and prevent a similar event.

Guideline:

CES 17 The hospice/facility provides for the safe and effective use of medical equipment.

CES 17.1 When the hospice provides medical equipment directly or by contract, a system is in place to ensure the quality of the medical equipment and related services.

CES 17.2 The hospice ensures that equipment hazards, defects and recalls are appropriately addressed and reported as required by the Safe Medical Devices Act.

CES 17.3 The hospice complies with the manufacturer's instructions, state and local laws regarding the use of medical equipment.

Practice Examples:

- There is a procedure for reporting and responding to defective medical equipment.
- There is an adequate back-up source for oxygen in case of a power failure.

Guideline:

CES 18 The hospice maintains a comprehensive, timely and accurate record of services provided in all care settings for each patient.

CES 18.1 There are written policies and procedures that address the content, maintenance, security and access to hospice clinical records. These policies and procedures conform to all state and federal laws.

CES 18.2 A standardized format that is descriptive, timely and accurate is used to document the services provided in all care settings.

CES 18.3 Documentation in the clinical record includes:

- A medical history, including clinical evidence of the terminal prognosis on admission;
- An age-appropriate physical assessment of the patient by the hospice nurse;
- A psychosocial assessment of the patient, family and caregiver;
- An IDT plan of care;
- Signed physician's orders for care;
- Persons to contact in an emergency;
- A signed informed consent and evidence that the patient has received a statement of his or her rights and responsibilities;
- The patient's decisions regarding end-of-life care;
- Advance directives information;
- Identification of other agencies involved in care;
- Communication regarding care or services to be provided and care coordination; and
- Additional information as required by law and regulation.

CES 18.4 When services are provided under a contractual agreement, a copy of the clinical record or a summary of services provided by the other organization or individual is included in the hospice clinical record.

CES 18.5 Forms utilized in the clinical record are reviewed according to established policy and revised as appropriate.

CES 18.6 The clinical record contains a discharge summary for every discharged patient.

CES 18.7 The clinical record is completed within the time frame specified by the hospice for every discharged patient.

Practice Examples:

- Clinical records of discharged patients are reviewed to verify that a discharge summary was completed in a timely manner.
- Patients are informed that protected health information is collected and maintained and may be shared with other providers as a part of their plan of treatment.
- When transferring to another facility, the transferring hospice provides a transfer summary of all care provided, a copy of the interdisciplinary plan of care, copies of signed consents for care, copies of certifications of terminal illness, and other information as requested by the receiving hospice.

INCLUSION AND ACCESS (IA)

Principle: *Promoting inclusiveness in the corrections community by ensuring that all people – regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age, disease or other characteristics – have access to programs and services.*

Guideline:

IA 1 A periodic corrections community-needs assessment, with special attention to securing access to care for underserved populations in the community, contributes to the development and implementation of hospice services.

IA 1.1 Palliative care is available to inmate patients in as wide a range of housing settings as health care and security can accommodate.

IA 1.2 Plans for palliative care are based on a needs assessment of the inmate population, characteristics of the physical plant, medical-care capabilities, and other resources.

IA 1.3 Care plans are reviewed by the interdisciplinary team (IDT) at least every two weeks, or when the inmate patient's condition changes, and are revised to reflect the changing needs of the inmate patient and family.

IA 1.4 The IDT identifies and incorporates specialized professionals and paraprofessionals to meet the specific needs of inmate patients and their families of choice as identified in the plan of care.

IA 1.5 Nursing services are based on initial and ongoing assessments of the inmate patient's needs by a registered nurse and are provided in accordance with the IDT's plan of care.

IA 1.6 Nursing services are available 24 hours a day, seven days a week to meet inmate patients' nursing needs in accordance with the plan of care.

IA 1.7 Counseling services are based on initial and ongoing assessments of the inmate patient's and family's needs by a qualified counselor or social worker and are provided in accordance with the IDT's plan of care, utilizing community resources as needed.

IA 1.8 Spiritual care and services are based on an initial and ongoing documented assessment of the inmate patient's and family's spiritual needs by a qualified chaplain member of the IDT, utilizing community resources as needed.

IA 1.9 The program accurately represents its services to the institutional community, inmate families and the public.

IA 1.10 All persons involved with the program acknowledge and respect each inmate patient's and family's values and beliefs regarding end-of-life issues.

Guideline:

IA 2 The hospice facilitates access to care by providing services, staff and management that are sensitive to the culturally diverse needs of the community it serves.

IA 2.1 A patient-centered, individualized plan of care is developed and maintained by the IDT, in collaboration with the patient.

IA 2.2 The IDT identifies and incorporates specialized professionals and paraprofessionals to meet the specific needs of inmate patients and their families of choice as identified in the plan of care.

IA 2.3 All staff members receive orientation, training, development opportunities, and continuing education on end-of-life care, appropriate to their responsibilities. Continuous education is available for staff, contractors and volunteers.

IA 2.4 Staff and volunteers reflect the diversity of the inmate patients served, whenever possible.

Guideline:

IA 3 Bereavement education and supportive services are offered to the community at large.

IA 3.1 Advance care planning is strongly encouraged and may be required for participation in specific hospice programs.

IA 3.2 Deaths that occur in the correctional facility are handled with the utmost respect and compassion toward the inmate patient and family.

IA 3.3 Bereavement services are provided through a defined program in order to help inmate patients, families of choice, volunteers, staff and other inmates cope with the losses that occur during illness and after the eventual death of the inmate patient.

IA 3.4 A plan of bereavement care for families of choice and caregivers identifies bereavement problems and needs, interventions, goals and outcomes, and is developed and documented for families and caregivers. Ongoing care for family members in the community may include referrals to community agencies equipped to provide bereavement support and counseling.

IA 3.5 Bereavement education and supportive services are offered to the larger correctional community on an ongoing basis.

IA 3.6 A mechanism to evaluate bereavement services on a regular basis is maintained.

IA 3.7 Staff has access to current information on palliative care and bereavement.

Guideline:

IA 4 The organizational leaders ensure that inmate patient care and services provided are appropriate to the needs of the population served.

IA 4.1 The program's leaders provide evidence of effective strategic planning, and resource management is addressed.

IA 4.2 A well-organized review and improvement process, which is supported by the facility administrator, is implemented throughout the program.

ORGANIZATIONAL EXCELLENCE AND ACCOUNTABILITY (OEA)

***Principle:** Building a culture of quality and accountability within our organization that values collaboration and communication and ensures ethical business practices.*

Guideline:

OEA 1 Hospice accurately represents its services to the inmate population, families of inmate patients and staff.

OEA 1.1 Inmate patient information and materials accurately explain the benefits, scope, capabilities and limitations of the hospice program.

Practice Examples:

- Potential inmate volunteers will be informed about the full extent of their duties and obligations.
- A hospice brochure will be developed that will explain the program. The brochure will be distributed throughout the correctional facility.

Guideline:

OEA 2 Processes are designed to collect and manage information to support the activities of the hospice.

OEA 2.1 The hospice has a plan for monitoring the allocation and utilization of inmate patient services in all care settings that includes:

- Appropriate admissions;
- Delays in admissions or in the provision of interdisciplinary team (IDT) services;
- Provision of bereavement services to family members; and
- Outcome data.

OEA 2.2 Data are routinely collected and reviewed to monitor the allocation and utilization of services and minimally includes:

- Average and median length of stay;
- Days of service;
- Timeliness of admission;
- Services provided by professional team members and inmate volunteers, as well as community volunteers
- Diagnosis and demographic information, such as ethnicity, religious background and age group; and
- Additional data required for facility reports and compliance with any applicable law and regulation.

Guideline:

OEA 3 Data is collected and distributed to appropriate individuals in a timely manner.

OEA 3.1 Data information is communicated in summary form at least annually to hospice staff, other staff and inmate volunteers as required.

OEA 3.2 There is evidence that data collected has been reviewed, analyzed and has informed decision making throughout the program.

WORKFORCE EXCELLENCE (WE)

Principles: *Fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability and workforce excellence, through professional development, training and support to all staff and volunteers.*

Hospice organizational leaders ensure that the number and qualifications of staff and volunteers are appropriate to the scope of care and services provided by the hospice program.

Guideline:

WE 1 The hospice/facility identifies and maintains an appropriate number of qualified staff and volunteers to meet the unique needs of the inmate patients and families.

WE 1.1 The interdisciplinary team (IDT) consults with a qualified, trained professional in the area of ethical medical care or a medical ethics committee whenever ethical dilemmas arise in the care of inmate patients and their families.

WE 1.2 The IDT identifies and incorporates specialized professionals and paraprofessionals to meet the specific needs of inmate patients and families as identified in the plan of care.

WE 1.3 Staff is prepared for the demands of a disaster that has a negative impact on, or severely limits, the institution's operation.

WE 1.4 Administrative policies define the roles and responsibilities of all staff, contractors and volunteers.

WE 1.5 All staff receives orientation, training, development opportunities and continuing education on end-of-life care, appropriate to their responsibilities. Continuous education is available for staff, contractors and volunteers.

WE 1.6 Adequate supervision and professional consultation by qualified personnel is continuously available to program staff and volunteers.

Practice Examples:

- Appropriate staff verifies licenses and maintains documentation in a personnel record.
- The hospice maintains accurate, up-to-date personnel records to support proof of current licensure, certification or other required credentials.
- Appropriate staff identifies specific educational needs of staff for end-of-life care.

Guideline:

WE 2 The hospice recruits staff and volunteers to reflect the variety and diversity of the communities served.

WE 2.1 Staff and volunteers reflect the diversity of the inmate patients served, whenever possible.

Practice Examples:

- Recruitment efforts are made to hire staff and volunteers when the diversity of staff does not correlate with the diverse population served.
- Community centers/associations, churches/synagogues are utilized to recruit ethnic groups not well represented on the hospice's staff.

Guideline:

WE 3 The hospice maintains a consistent, nondiscriminatory process for recruiting, interviewing and selecting staff with optimal qualifications, including competence and license validation.

WE 3.1 Administrative policies define the roles and responsibilities of all staff, contractors and volunteers.

WE 3.2 A routine competency assessment/performance evaluation is in place for all staff and volunteers responsible for providing patient care activities.

WE 3.3 Hospice volunteers are provided who are specially trained in the care of the inmate patient and in other aspects of the program's operation and who are capable of assisting inmate patients without making value judgments.

Practice Examples:

- Potential employees receive a job description for the position for which they are applying.
- Supervisors annually evaluate the accuracy of a job description with input obtained from each employee and make revisions as necessary.

Guideline:

WE 4 The hospice/institution has established personnel policies to direct employment practices that include:

1. Recruitment;
2. Hiring practices;
3. Benefits;
4. Grievance procedures;
5. Employee responsibilities;
6. Staff conflict-of-interest;
7. Performance expectations and evaluations/competency assessments;
8. Disciplinary actions;
9. Retention activities and efforts; and
10. Termination.

WE 4.1 Administrative policies define the roles and responsibilities of all staff, contractors and volunteers.

WE 4.2 All infirmity and hospice staff members receive orientation, training, development opportunities, and continuing education on end-of-life care, appropriate to their responsibilities. Continuous education is available and provided for staff, contractors and volunteers.

WE 4.3 A competency assessment/performance evaluation is in place for all staff and volunteers responsible for providing patient care activities.

WE 4.4 Volunteers meet as a group at least monthly, or more frequently if necessary, to receive clinical supervision, support and education.

Practice Examples:

- A written policy exists directing the regular review of all personnel policies and procedures.
- Expertise in the area of regulatory requirements related to human resources is utilized in the development of all hospice personnel policies and procedures.

Guideline:

WE 5 All staff receives orientation, training, development opportunities and continuing education appropriate to their responsibilities.

WE 5.1 All staff receives orientation, training, development opportunities and continuing education on end-of-life care, appropriate to their responsibilities. Continuous education is available for staff, contractors and volunteers.

Practice Examples:

- A relationship exists with state/community hospice programs that promote shared training, education and consultation.
- A monthly calendar of available educational opportunities is published and distributed to staff.
- A structured orientation program is in place for all new employees and includes orientation to the hospice and hospice care.

Guideline:

WE 6 The organizational leaders ensure that continuous education is made available for all leaders.

WE 6.1 All staff receives orientation, training, development opportunities and continuing education on end-of-life care, appropriate to their responsibilities. Continuous education is available for staff, contractors and volunteers.

WE 6.2 A relationship exists with state/community hospice programs that promotes shared training, education and consultation.

Practice Examples:

- The hospice administrator has attended continuing-education programs on topics where learning needs were identified.
- The hospice has made educational sessions available to the governing body members and the correctional community.

Guideline:

WE 7 Hospice staff members have access to current, relevant information.

WE 7.1 Staff members have access to current information on palliative care and bereavement.

Practice Examples:

- Hospice staff members have access to the Internet, which makes research and current information readily available.
- A resource library and/or resource materials are maintained and accessible to all staff, inmate volunteers and patients.

Guideline:

WE 8 The hospice develops and implements a competency-assessment program for all staff and volunteers responsible for providing patient-care activities.

WE 8.1 The program's leaders with support of facility management ensure compliance with professional, legal and regulatory requirements and standards.

WE 8.2 The program's leaders with support of facility management ensure effective strategic planning and resource management.

WE 8.3 Actual improvements in processes or outcomes as a result of the performance-improvement activities are demonstrated, and the improvements are maintained over time.

Practice Examples:

- Supervisors regularly observe staff members providing direct care and evaluate their competency.
- When a staff member's performance results in an adverse outcome, the staff member is involved in a retraining program or disciplinary action.

Guideline:

WE 9 The hospice utilizes and values specially trained, caring volunteers who are capable of assisting the population served by the hospice.

WE 9.1 Volunteers who provide psychosocial support and other services do so in accordance with the inmate patient's plan of care.

WE 9.2 All staff receives orientation, training, development opportunities and continuing education on end-of-life care, appropriate to their responsibilities. Continuous education is available for staff, contractors and volunteers.

WE 9.3 Adequate supervision and professional consultation by qualified personnel is continuously available to program staff and volunteers.

WE 9.4 Volunteers, whether inmates or community members, receive specialized training related to care giving in a correctional setting.

WE 9.5 Volunteers meet as a group at least monthly, or more frequently if necessary, to receive clinical supervision, bereavement support and training.

Practice Examples:

- Volunteer recruiting activities are regularly scheduled and include various media, such as print and electronic newspapers, newsletters, bulletins and other broad-based community resources.
- Staff and volunteer selection and evaluation methodologies include screening, reference checks, annual performance evaluations and observation of care.

Guideline:

WE 10 Adequate supervision and professional consultation by qualified personnel are available to staff and volunteers during all hours.

WE 10.1 Adequate supervision and professional consultation by qualified personnel is continuously available to program staff and volunteers.

Practice Example:

- An on-call system ensures the availability of expert advice to on-call staff.

Guideline:

WE 11 The IDT members provide quality, coordinated care as defined by current professional, competency and credentialing guidelines that relate to the team member's practice specialty and principles of IDT practice.

WE 11.1 An IDT assesses the inmate patient's needs and plans, delivers and evaluates each patient's care and services.

WE 11.2 The IDT consists of appropriate representatives of all disciplines who are significantly involved in rendering care. At a minimum, it consists of a physician, nurse, mental health representative, chaplain and facility security staff. Others may serve as IDT members when needed, including, but not limited to, social worker dietitians, pharmacists, complementary therapists, a volunteer coordinator, an inmate patient's family member, the inmate patient, other caregivers, volunteers and others, as appropriate.

WE 11.3 A qualified health-care professional coordinates the IDT.

WE 11.4 The IDT consults with a qualified, trained professional in the area of ethical medical care whenever ethical dilemmas arise in the care of patients and families.

WE 11.5 A patient-centered, individualized plan of care is developed and maintained by the IDT, in collaboration with the inmate patient.

WE 11.6 A written plan of care is developed for each inmate patient within 24 working hours of admission.

WE 11.7 Communication concerning the care plan and status of the inmate patient is provided to the inmate patient and to designated family members with consent of the inmate patient.

WE 11.8 Care plans are reviewed by the IDT at least every two weeks, or when the inmate patient's condition changes, and revised to reflect the changing needs of the inmate patient and family.

WE 11.9 The IDT identifies and incorporates specialized professionals and paraprofessionals to meet the specific needs of each inmate patient and family as identified in the plan of care.

WE 11.10 Advance care planning is strongly encouraged and may be required for participation in specific hospice programs.

WE 11.11 The medical director or designee reviews, coordinates and oversees the management of medical care for all inmate patients.

WE 11.12 Nursing services are based on initial and ongoing assessments of the inmate patient's needs by a registered nurse and are provided in accordance with the IDT's plan of care.

WE 11.13 Nursing services are available 24 hours a day, seven days a week to meet inmate patients' nursing needs in accordance with the plan of care.

WE 11.14 Counseling services are based on initial and ongoing assessments of the inmate patient's and family's needs by a qualified mental-health worker and are provided in accordance with the IDT's plan of care, utilizing community resources as needed.

WE 11.15 Spiritual care and services are based on an initial and ongoing documented assessment of the inmate patient's and family's spiritual needs by a qualified chaplain member of the IDT, utilizing community resources as needed.

WE 11.16 The pharmaceutical needs of inmate patients are met, consistent with all applicable regulations and acceptable standards of practice. Inmate patients receive coordinated and accurate communication, information, instruction and education about their medication, medication profile and results of medication monitoring.

WE 11.17 The IDT assesses and plans nutritional care with the goal of meeting the unique nutritional needs of each inmate patient.

WE 11.18 Diagnostic services comply with all applicable laws and regulations and meet the needs of the inmate patient.

WE 11.19 Quality care and services are delivered in a manner that is consistent with community standards.

WE 11.20 The physical environment meets the needs of inmate patients and caregivers.

WE 11.21 Pain and other symptoms are assessed and alleviated to the greatest extent possible.

Practice Examples:

- Care coordination and effective communication among the IDT members are evidenced by documentation contained in the clinical record that records the achievement of goals or outcomes.
- The IDT interventions reflect cooperation and coordination among members.

Interdisciplinary Team

MEDICAL DIRECTOR/ATTENDING PHYSICIAN

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Guideline:

WE 12 The hospice medical director or designee reviews, coordinates and oversees the management of medical care for all inmate patients in the hospice program.

Practice Examples:

- The medical director has a leadership role on the IDT.
- The medical director/health practitioner recommends an inmate patient for admission to the hospice program.

Guideline:

WE 13 The patient's health-care practitioner provides initial and ongoing medical services to the inmate patient.

Practice Examples:

- Progress reports regarding hospice inmate patients are available to all health-care practitioners.
- All attending physicians receive an explanation of their responsibilities annually.

NURSING

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Guideline:

WE 14 Hospice nursing services are based on initial and ongoing assessments of the inmate patient's needs by a registered nurse and are provided in accordance with the IDT's plan of care.

WE 14.1 A qualified health-care professional coordinates the IDT.

WE 14.2 Nursing services are based on initial and ongoing assessments of the inmate patient's needs by a registered nurse and are provided in accordance with the IDT's plan of care.

WE 14.3 Nursing services are available 24 hours a day, seven days a week to meet inmate patients' nursing needs in accordance with the plan of care.

WE 14.4 Medications and nutritional products are properly stored and prepared.

WE 14.5 Psychosocial/spiritual care services assist the inmate patient to avoid isolation, bring closure, find emotional peace, gain acceptance, make connections as desired, and receive human contact.

Practice Examples:

- A complete physical assessment is performed and documented for each patient upon admission.
- Each nursing visit includes a reassessment of the inmate patient's physical status.

SOCIAL WORK/COUNSELING

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Guideline:

WE 15 Hospice social work/counseling services are based on initial and ongoing assessments of inmate patient's and family's needs by an accredited social worker or counselor and are provided in accordance with the IDT's plan of care.

WE 15.1 Social work/counseling services include:

- Identifying the inmate patient's and family's psychosocial needs;
- Assessing and strengthening the inmate patient's coping skills;
- Assessing and enhancing the responsiveness of the environment and connecting the inmate patient family with community resources as needed;
- Providing interventions for specific symptom relief (e.g., fear, grief, depression, anger);
- Screening for psychopathology and educating and intervening accordingly;
- Assessing and referring for ongoing bereavement services;
- Documenting problems, psychosocial assessment, appropriate goals, care provided, interventions and inmate patient's response to each intervention;
- Maintaining the dignity of the dying inmate patient;
- Supporting the inmate patient's unique spiritual and cultural beliefs;
- Providing holistic family-centered care across treatment settings;
- Consulting and collaborating with the IDT; and
- Reporting abuse and neglect.

Practice Examples:

- A psychosocial assessment is completed on each inmate patient, and the findings are shared with the IDT.
- The social worker evaluates the inmate patient's and family's adaptation state, related needs and opportunities for growth.
- The social worker identifies a spouse at high risk for complicated grief and refers him/her to appropriate services.
- The social worker plans a family conference with the inmate patient, appropriate hospice team members and other appropriate persons.

SPECIALIZED PROFESSIONALS/PARAPROFESSIONALS

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Guideline:

WE 16 The IDT identifies and incorporates specialized professionals and paraprofessionals to meet the specific needs of inmate patients and families as identified in the plan of care.

WE 16.1 The IDT identifies and incorporates specialized professionals and paraprofessionals to meet the specific needs of inmate patients and their families as identified in the plan of care.

Practice Examples:

- The nursing assessment includes a complete nutritional assessment/screening.
- The physical therapist providing treatment to an inmate patient attends the IDT meetings and contributes to the plan of care.
- Complementary therapists, including but not limited to, music therapists, art therapists, or massage therapists, are utilized to meet the specific needs of inmate patients.

SPIRITUAL CARE

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Guideline:

WE 17 Hospice spiritual care and services are based on an initial and ongoing documented assessment of the inmate patient's and family's spiritual needs by qualified members of the IDT (clergy or someone with equivalent education, training and experience) and provided according to the IDT's plan of care.

WE 17.1 Spiritual care and services are based on an initial and ongoing documented assessment of the inmate patient's and family's spiritual needs by a qualified chaplain member of the IDT, utilizing community resources as needed. Spiritual care may include:

- Identifying the inmate patient's and family's spiritual, cultural, religious, ceremonial and artifact needs;
- Supporting the inmate patient's unique spiritual and cultural beliefs;
- Soliciting, and securing the assistance of, community spiritual leaders of an inmate patient's particular spiritual and religious practice;
- Maintaining the psycho-spiritual dignity of the dying inmate patient;
- Providing interventions for specific symptom relief from spiritual pain (e.g. guilt, anxiety, anger, loss, and aloneness);
- Supporting and facilitating the patient's decision to create a living legacy or life review;
- Preparing patient and family for reconciliation and restoration, when needed;
- Providing a safe environment for patient and family to reconcile differences, when needed;
- Consulting and collaborating with the IDT;
- Providing bereavement follow-up with family and friends; and
- Assessing patient and family satisfaction of the psycho-spiritual care and support patients receive in the hospice.

Practice Examples:

- The hospice chaplain coordinates spiritual services, thereby assuring that the inmate patient's and family's spiritual and religious needs are met.
- The hospice chaplain prays with the inmate patient who requests prayer.
- The hospice chaplain ensures that approved religious artifacts are used by inmate patients upon request, (e.g. prayer beads, Bible, Koran, spiritual readings, prayer rugs and prayer shawls).
- The hospice chaplain ensures that approved religious rituals are observed at the request of inmate patients (e.g. baptism, prayer for the sick, Native American Smudge Ceremonies and songs and washing ceremonies).
- The hospice chaplain provides bereavement follow up with family and friends with memorial services, phone calls, bereavement letters and referrals to local community services.
- The hospice chaplain provides prayer, meditation and scripture reading at the request of the inmate patient.

VOLUNTEERS

...

Guideline:

WE 18 The hospice volunteer services include the involvement of community volunteers and a cadre of inmate volunteers who are specially trained in the care of the inmate patients who are terminally ill. The volunteers are also trained in other aspects of the hospice program's operation or mission.

WE 18.1 Caring volunteers are provided who are specially trained in the care of the inmate patient and in other aspects of the program's operation, and who are capable of assisting inmate patients without making value judgments.

WE 18.2 Volunteers, whether they are inmates or members of the community, receive specialized training related to care giving in a correctional setting.

WE 18.3 Volunteers meet as a group at least monthly, but weekly if necessary, to receive clinical supervision, training and support.

Practice Examples:

- The hospice recruits and trains an adequate number of volunteers to fill requests made by the IDT.
- The hospice realizes and documents cost savings through the use of volunteers.

ORGANIZATIONAL ACCREDITATION

Principle: Utilizing NHPCO’s “Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings” as a guide for developing and implementing hospice in corrections in concert with American Correctional Association and National Commission on Correctional Health Care accreditation standards.

This section of the Quality Guidelines document is for the placement of organization-specific standards that each end-of-life care-program must meet as prescribed by the specific accreditation bodies whose approval is required, e.g. ACA , NCCHC, and State regulatory bodies.

COMPLIANCE WITH LAWS AND REGULATIONS (CLR)

Principles: *Ensuring compliance with applicable laws, regulations and professional standards of practice and implementing systems and processes that prevent fraud and abuse.*

Guideline:

CLR 1 The correctional facility's leaders maintain and support full compliance with legal and regulatory requirements and standards of practice within the correctional environment.

CLR 1.1 The administration ensures that all individuals who provide inmate patient and family services are competent to provide such services.

CLR 1.2 Mechanisms are in place to address the recommendations made in the reports received from authorized regulatory and accrediting bodies (e.g., NCCHC and ACA).

Practice Examples:

- Results of surveys are documented in governing-body meeting-minutes.
- Ongoing mock surveys or self-assessments are conducted to identify areas for improvement, and changes are made based on the findings.
- The facility has a procedure for reporting and investigating compliance concerns.

Guideline:

CLR 2 The facility has a program to identify, prevent and correct practices that are fraudulent or abusive.

CLR2.1 The facility uses generally accepted medical guidelines within corrections to determine whether or not a referred inmate patient qualifies for hospice care according to facility policy.

CLR 2.2 The facility regularly monitors its compliance with state and/or federal regulatory requirements.

Practice Examples:

- The hospice develops a compliance program and standards-of-care manual and provides related staff education.
- There is a procedure for reporting suspected fraud and abuse that protects the reporter from retribution.
- The facility develops standards of conduct for staff related to fraudulent practices.

STEWARDSHIP AND ACCOUNTABILITY (SA)

Principles: *Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight with the State Department of Corrections or Federal Bureau of Prisons.*

Hospice has an organizational leadership structure that permits and facilitates action and decision-making by those individuals closest to any issue or process.

Guideline:

SA 1 The organizational leaders have processes to review and approve the hospice's mission, purpose, vision and policies that include active participation and input by all stakeholders.

SA 1.1 End-of-life programs and services are managed by a clearly defined organizational structure that identifies the roles, responsibilities and authority of every stakeholder and facilitates participation in decision-making by individuals closest to an issue or process.

SA 1.2 The hospice program's mission, purpose, vision, policies and procedures are clearly described.

SA 1.3 There is a process that facilitates annual review of the hospice program's mission, purpose, vision, policies and procedures.

Practice Examples:

- The management and staff can verbalize the mission and vision statements of the hospice.
- The hospice has a process for the regular review and revision of policies and procedures.

Guideline:

SA 2 The governing body oversees the process of selection and evaluation of the hospice coordinator/director and provides ongoing support.

SA 2.1 Administrative policies define the roles and responsibilities of all staff, contractors and volunteers.

Practice Examples:

- A performance appraisal tool is developed and utilized in evaluating the hospice coordinator/director.
- The hospice coordinator/director performs a self-evaluation as part of his/her annual performance evaluation.
- As part of the evaluation discussion, goal setting for the staff member is included.
- A committee structure exists that permits internal and external consumers to participate in the hospice evaluation and planning.

Guideline:

SA 3 The organizational leaders continually evaluate and assess the hospice program's performance.

SA 3.1 There is a well-organized review and improvement process that is implemented throughout the program and is supported by the facility administrator.

Practice Examples:

- The governing body assesses its educational needs and plans for regular, planned educational opportunities.
- A formal governing-body orientation is developed and implemented.

Guideline:

SA 4 The hospice coordinator/director has full responsibility for the day-to-day operations of the hospice program.

SA 4.1 The program's leaders ensure effective strategic planning and resource management.

Practice Examples:

- The hospice coordinator/director's position description is written and includes qualifications and responsibilities.
- A written performance evaluation of the hospice coordinator/director is conducted on an annual basis.

Guideline:

SA 5 Administrative policies define the roles and responsibilities of the governing body, administration and the interdisciplinary team (IDT).

SA 5.1 Administrative policies define the roles and responsibilities of all staff, contractors and volunteers.

Practice Examples:

- Written policies and procedures in the operations manual of the hospice state the roles of the various components, including the governing body, administrative staff and IDT members.
- There is a written description of responsibilities for members of the governing body.

Guideline:

SA 6 Information is protected against loss, theft and destruction.

SA 6.1 Information needed to operate the program efficiently is identified, collected and maintained in a manner that respects the inmate patient's confidentiality.

SA 6.2 Information is collected and disseminated to appropriate individuals in a timely manner. A comprehensive, timely, accurate record of services provided in the institution is maintained.

SA 6.3 Staff has access to current information on palliative care and bereavement.

Practice Examples:

- Hospice clinical records are retained for five years past the completion of bereavement care as allowed by prison policy.
- A labeled or identified collection of information is readily accessible by stakeholders.

Guideline:

SA 7 Confidentiality of information is maintained.

SA 7.1 Confidentiality of information related to inmate patient care is maintained.

Practice Examples:

- All staff members, volunteers, vendors and visitors who come into contact with patient information sign a confidentiality agreement on hire and prior to any exposure to inmate patient or family information.
- Inmate patients sign a release form prior to the release of information or sharing of any information.

PERFORMANCE IMPROVEMENT (PI)

Principles: *Collecting, analyzing and actively using performance-improvement data to foster quality assessment and performance improvement in all areas of care and services.*

The hospice defines a systematic, planned approach to improving performance. This approach is authorized and supported by the hospice administrator.

Guideline:

PI 1 A well-organized review and improvement process is implemented throughout the program. This process is supported by the hospice administrator and facility senior leadership.

PI 1.1 The correctional governing body requires a process to evaluate the quality and appropriateness of care and services provided by the hospice.

PI 1.2 The correctional facility leaders reprioritize data collection and measurement activities based on situations that require a more focused, intensive review and analysis.

PI 1.3 The correctional facility leaders allocate trained staff to implement and improve the hospice's processes and systems.

PI 1.4 The hospice leadership, staff and volunteers are informed of the results of data collection and improvement actions taken.

PI 1.5 Action plans are established in writing that describe the follow-up actions to be taken in response to data collection and analysis.

Practice Examples:

- Performance-improvement results and action plans considered are documented in minutes.
- A written performance-improvement plan exists and describes the areas targeted for data collection, analysis and improvement and is reviewed on a regular basis.
- The hospice staff can describe improvements made within the hospice program based on performance-improvement activities.

Guideline:

PI 2 The end-of-life quality-improvement program is part of an institutional program for improving performance.

PI 2.1 Changes in the organization's programs and processes are planned, piloted, implemented and evaluated.

PI 2.2 The needs and expectations of key customers and stakeholders (e.g., inmate patients, family members, physicians and referral sources) are considered in the design or redesign process.

Practice Examples:

- The annual budgeting process includes targeted areas for improvement and funding resources required to carry out the performance-improvement program.
- The hospice leaders draft an annual performance-improvement plan that is reviewed by the management team and approved by the hospice administrators.
- Staff and volunteers receive training regarding the hospice's improvement activities during orientation, when assigned to a process-improvement team and throughout their employment.

Guideline:

PI 3 The planning, development, implementation and evaluation of performance-improvement activities are comprehensive and collaborative.

PI 3.1 Performance-improvement planning activities and the selection of areas for in-depth study are determined based on data collected and input by staff, volunteers and leaders.

PI 3.2 The performance-improvement activity results are communicated to staff, volunteers and organizational leaders.

Practice Examples:

- The performance-improvement activities involve collaboration among departments, disciplines and programs, as well as input from individuals impacted by the process targeted for improvement.
- The staff is involved in defining “key processes” to be monitored.
- Process improvement teams involve “stakeholders” and those who work within the process to be improved on a day-to-day basis.

Guideline:

PI 4 Performance and outcome data related to palliative care and program functions are collected, and benchmarks are established.

Practice Examples:

- A documentation system-improvement activity involves the development of an implementation timeline and education of staff regarding the changes in processes made.
- The hospice uses statistical tools to display the results of data collection.
- The hospice identifies external barriers to optimal delivery of care within the institutional environment and acts as an advocate for their removal, where possible.

Guideline:

PI 5 The hospice collects performance and outcome data related to inmate patient care and hospice functions.

PI 5.1 Data are collected on the staff’s and volunteer’s opinions of the hospice program, inmate patient’s and family’s needs, and what improvements could be made.

PI 5.2 There is a mechanism to review routine data collected to determine if adverse patterns or trends are identified that negatively affect care and/or place the inmate patient or staff at risk. When adverse patterns or trends are identified, follow-up actions are taken. Routine data collected by the hospice include, but are not be limited to:

- Data related to utilization, staffing and allocation of services;
- Inmate patient and family satisfaction data including complaints about care;
- Incident reports;
- Medical errors;
- Interdisciplinary team (IDT) processes;
- Collaboration between the general prison operations and the hospice operations;
- Medication administration; and
- Other data collected as defined by the hospice.

PI 5.3 There is a process to conduct analysis of underlying causes or associated causes when an undesirable outcome or sentinel event takes place.

- An undesirable outcome or sentinel event is defined by the hospice or larger organizational structure, such as the Department of Corrections or the Federal Bureau of Prisons.

Practice Examples:

- The hospice utilizes an annual self-evaluation tool that includes opportunities for employees to suggest processes that need improvement.
- Satisfaction surveys are sent to team members after the inmate patient's death, and the results are aggregated and analyzed.
- Incident reports are summarized, and if patterns or trends are identified, the data are further analyzed.
- As the hospice provides inpatient hospice-based care, data are collected and monitored regarding the administration of medications.

Guideline:

PI 6 The hospice staff demonstrates and documents actual improvements in processes or outcomes as a result of the performance-improvement activities and the improvements that are maintained over time.

PI 6.1 The desired performance outcome is quantified for each performance-improvement activity.

PI 6.2 Any process change is evaluated over time, and the results are assessed and communicated throughout the hospice.

Practice Examples:

- An annual performance-improvement evaluation is completed noting areas of actual improvement.
- A summary report from each process-improvement team is submitted to the hospice administrator/ stakeholders and includes actual improvements realized.
- Improvement efforts are monitored for three-to-six months following the implementation of a successful action.

QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

Glossary

Active Treatment – Potentially life-prolonging treatments.

Advance Care Planning – The ongoing process of structured discussion and documentation of health-care decision-making that involves the inmate patient, preferably with consultation with his or her physician and support of the family appointed by the inmate patient as proxy decision-maker.

Acute/General Inpatient Care – Short-term, intensive hospice services provided in an appropriately licensed or certified skilled-nursing or hospice facility or hospital to meet the inmate patient's need for skilled nursing, symptom management or complex care

Advance Directive – An instruction such as a durable power of attorney for health care, a directive pursuant to inmate patient self-determination initiatives, a living will or an oral directive that states either a person's choices for medical treatment or, in the event the person is unable to make treatment choices, designates who will make those decisions.

Assessment – Procedures by which the inmate patient's and family's strengths, weaknesses, problems, needs and opportunities for growth are identified.

Attending/Primary Physician – A licensed doctor of medicine or osteopathy who is designated by the inmate patient as the physician responsible for providing his or her medical care.

Bereavement Care – Services provided to help inmate patients, family and caregivers cope with the losses occurring during the illness and death of the inmate patient. This may include referral of family to a community resource.

Caregiver – Any person, compensated or uncompensated, designated to provide emotional support or physical care to a hospice patient.

Community – A group of patients or a defined geographic area served by a hospice program (e.g., correctional facility).

Comorbid/Comorbidity – Known factors or pathological disease entities impacting the primary health problem and generally attributed to contributing to increased risk for poor health-status outcomes.

Complementary Therapies—Non-traditional interventions used for health promotion and therapeutic treatment for chronic and acute illnesses, pain management and palliative care. These non-traditional approaches include but are not limited to therapeutic touch, aroma therapy, acupressure, reflexology, visualization and imagery,

Contracted Services – Services provided to a hospice program or its patients by a third party under a legally binding agreement that defines the roles and responsibilities of the hospice program and contracted service provider.

Cultural Diversity – Variance in aspects of race, gender, nationality, age, creed, religion, sexual orientation, disability, lifestyle, diagnosis, family/support structure, financial status and social strata in the corrections community.

Discharge – The point at which a living inmate patient’s active involvement with the hospice program is ended and the hospice program no longer has active responsibility for the care of the inmate patient.

Do Not Resuscitate Orders – Orders written by the inmate patient’s physician that stipulate that in the event the inmate patient has a cardiac or respiratory arrest, cardiopulmonary resuscitation will not be initiated or performed.

End-of-life Care – Medical care and supportive services that an individual with an advanced disease receives in the last phase of life.

Facility-Based Care – Hospice services delivered in a place other than the patient’s place of residence, such as a freestanding hospice facility, nursing home or hospital inpatient unit.

Family – A group of two or more individuals, as identified by the inmate patient, related by ties of blood, legal status or affection and who consider themselves a family unit. For the purposes of these standards, this can include other inmates.

Fiduciary – A person who is acting in another’s interest. When used to define the responsibilities of individual members of a governing body (e.g., directors), it means that a legal relationship exists requiring directors to act in the best interests of the entity or organization and its mission and not their own; acting with prudence and diligence; refraining from self-dealing; avoiding conflicts of interest or any appearance thereof; and not usurping corporate opportunities for their own benefit.

Governing Body – A group of individuals who have the full legal, financial, strategic-planning, operational and policy-making responsibilities for a hospice program.

Grief – Emotional suffering characterized by a sad and lonely state as a reaction to loss caused by bereavement. Hospice care includes services that support and facilitate this process.

Holistic Care – Care that focuses on the physical, psychosocial, emotional and spiritual needs and concerns of the inmate patient and family.

Home – An inmate patient’s place of residence.

Hospice Aide/Volunteer – An individual trained to provide personal care to the inmate patient in either an infirmary or cell.

Hospice Clinical Record – The record maintained for each hospice inmate patient/family that documents all care provided by the interdisciplinary team in all care settings.

Hospice Inpatient Facility – Inpatient facility used, (e.g., correctional facility operated or leased by a hospice) for the purpose of providing inpatient palliative care.

Hospice Physician – A licensed doctor of medicine or osteopathy designated by the hospice program to provide medical care to the hospice’s inmate patients (this may or may not also be the hospice medical director).

Informed Consent – A process in which information that specifies the type of care to be provided by the hospice program and the potential and actual risks and benefits of a given procedure is exchanged between the hospice program and the inmate patient, and permission is granted by the inmate patient in writing.

Inmate Patient – A person who is under the observation, treatment or care of a hospice program for an illness, disease or injury.

Inpatient Services – A formally organized service that is designed to provide inmate patients and family care within an institutional setting that is coordinated by the hospice interdisciplinary team.

Inpatient Settings – A facility where specific levels of skilled nursing care are provided to meet the needs of the inmate patient and family.

Interdisciplinary Team (IDT) – Representatives of disciplines involved in the inmate patient’s care, including physicians, nurses, mental-health counselors, chaplains, security personnel, volunteers and others, as needed.

Interdisciplinary Team Meetings – Regularly scheduled, periodic meetings of specific members of the interdisciplinary team to review the most current inmate patient and family assessment, evaluate the care needs and update the plan of care.

License (Hospice) – A license granted by the state in which hospice care is provided that permits an organization to practice “hospice care” for a specific period of time under the rules and regulations set forth by the state in which the license was issued.

Medical Director – A licensed doctor of medicine or osteopathy who is designated by the hospice as assuming the overall responsibility for the medical component of the hospice program.

Mental-Health Representative – Social worker, counselor, psychologist or other professional with responsibility for mental-health consultation or referrals.

Nursing Facility – Multi-occupant facility that provides primary caregiver services predominantly hired by the facility.

Organizational Leaders – Individuals, compensated or uncompensated, who are charged with the responsibility of implementing the hospice program’s mission, vision, goals and strategic plans.

Outcome – Any end result attributable to health services interventions, including changes in physical, psychological, social and spiritual well-being and levels of functioning.

Palliative Care – Patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Patient/Family/Caregiver as Unit of Care – A philosophy asserting that the impact of terminal illness on the inmate patient and family is acknowledged and the inmate patient’s and family’s needs are considered in developing the plan of care and providing hospice care.

Performance Improvement – The continuous measurement, assessment and adaptation of functions and processes intended to increase the probability of achieving desired utilization, intervention and end-result outcomes.

Plan of Care – An individualized plan based on inmate patient needs and preferences that identifies services to be provided.

Primary Caregiver – The person whom the inmate patient designates as providing him or her with emotional support and/or physical care.

Principle – A fundamental tenet of the hospice-care philosophy.

Prognosis – The probable course of a disease process.

Program’s Leaders – Individuals who are charged with the responsibility of implementing the end-of-life care program’s mission, vision, goals and strategic plans.

Psychosocial Support – Activities designed to meet the psychological and social needs of the inmate patient.

Qualified – A person with the required education, training and experience to meet the job-specific legal and licensing requirements and who has the sensitivity to address the unique needs of the inmate patient and family.

Spirituality – A belief /belief system which has as it’s key elements- meaning, hope, relatedness and connectedness. It is whatever the individual takes to be of highest value in his/her life. Spirituality may or may not be a connection to religious values

Staff – Paid or contracted employees or volunteers who provide services to the hospice program.

Staff Support – Organized activities provided to hospice employees or volunteers to assist them in coping with work-related loss, grief and change.

Standard – A norm that represents excellence in hospice practice and is an agreed-upon criterion for measuring quality in hospice care.

Team Coordinator – A qualified health-care professional responsible for coordination of assessment, planning and implementation of the care plan by the interdisciplinary team.

Terminal Illness – An illness that results in a limited life expectancy if the illness runs its normal course.

Volunteer – A person trained by the hospice program who provides services without monetary compensation to the hospice program or its inmate patients and families of choice. Volunteers, whether inmates or community volunteers, shall be carefully selected and screened.



QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

RESOURCES

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HOSPICE/ADULT-CARE PROGRAM

RIGHTS AND RESPONSIBILITIES

The Hospice/Adult Care Patient has the following rights:

1. To be cared for by a team of professionals and volunteers who will provide high-quality, comprehensive, comfort-oriented services as needed and appropriate.
2. To have a clear understanding of the availability and access to program services and the program team.
3. To have appropriate and compassionate care, regardless of diagnoses, race, age, creed, disability and sexual orientation.
4. To be fully informed regarding health status. To have the opportunity to participate in the planning of their health care. To have assistance in identifying the services and treatments that will assist them in reaching their goals.
5. To be fully informed about the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as appropriate to their own personal wishes.
6. To be treated with respect and dignity for their person, family, caregivers and property.
7. To have caregivers who are trained in effective ways of caring for them when they are no longer able to provide their own care.
8. To confidentiality with regard to information concerning their health status, as well as other details regarding their incarceration or personal history.
9. To voice grievances concerning their care or treatments without being subject to discrimination or reprisal and to have such grievances investigated.

The Hospice/Adult Care Volunteer has the following Patient responsibilities:

1. To be responsive to changes in the patient's needs.
2. To help the patient express concerns and to support decisions.
3. To evaluate the presence or absence of a safe environment for the patient.
4. To report on the level and types of assistance needed by the patient.
5. To assist the patient in requesting additional help or services.
6. To help the patient interact positively.

7. To assist the patient in developing realistic goals.
8. To allow the patient to talk or not talk about their condition.
9. To alert the patient when a visit will be missed.
10. To ask the patient what they want to do.
11. To support other team members and staff in their care of the patient.
12. To be truthful. To be kind. To be respectful.

Adapted from

Dixon Correctional Center

Dixon , IL

PATIENT SATISFACTION QUESTIONNAIRE

- _____ I have been treated with courtesy and respect.
- _____ I have been consulted about my needs and wishes.
- _____ I have found the hospice staff communication with my family helpful.
- _____ I am satisfied with the overall hospice care.
- _____ My physician helped me/my family to understand my medical condition.
- _____ Overall, I would rate my physician.
- _____ Nursing staff members were professional and compassionate.
- _____ Overall, I would rate the nursing staff members.
- _____ My physical pain level has been adequately managed.
- _____ The social worker listened to me and supported me/my family emotionally.
- _____ My psychosocial pain has been managed well.
- _____ Overall, I/my family would rate the social worker.
- _____ The chaplain listened to me and provided spiritual support for me/my family.
- _____ My spiritual pain is being addressed appropriately.
- _____ Overall, I would rate the chaplain.
- _____ Overall, I would rate the inmate PCS workers/volunteers.
- _____ Overall, I would rate the community PCS volunteers.
- _____ Overall, I would rate the dietician.
- _____ Overall, I would rate the hospice program.

Comments: How can we improve our program (e.g., special needs/services not being addressed)?

Provided by

California Medical Facility

Robert Evans Alexander Memorial
Hospice

Vacaville, California



QUALITY GUIDELINES FOR HOSPICE AND END-OF-LIFE CARE IN CORRECTIONAL SETTINGS

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