POLICY TITLE: HOSPICE CARE POLICY NUMBER: 18.10.1 CHAPTER 18: HEALTH CARE SERVICES		PAGE 1 OF 6
STATE of MAINE DEPARTMENT of CORRECTIONS Approved by Commissioner:		PROFESSIONAL STANDARDS: See Section VIII
EFFECTIVE DATE: October 30, 2014	LATEST REVISION: November 21, 2022	CHECK ONLY IF APA [ ]

I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 1403.

II. APPLICABILITY

All Departmental Adult Facilities

III. POLICY

It is the policy of the Department to provide hospice care to terminally ill adult residents, including hospice care in a Department infirmary or other housing unit.

IV. DEFINITIONS

1. Health care provider – for purposes of this policy, physician, physician assistant, or nurse practitioner.

V. CONTENTS

VI. ATTACHMENTS

None

VII. PROCEDURES

Procedure A: Hospice Interdisciplinary Team (IDT)

1. If a facility houses terminally ill adult residents, it shall offer hospice care.

2. A Hospice Interdisciplinary Team (IDT) consisting of representatives from various disciplines shall work collaboratively to provide direction and coordination of hospice care. The facility Chief Administrative Officer, or designee, in consultation with the facility Health Services Administrator (HSA), or designee, shall select team members to serve on the IDT. The IDT shall consist of:
    a. the Department's Regional Medical Director, or designee;
    b. the HSA, or designee;
    c. a case manager;
    d. a security supervisor, or designee;
    e. the facility program coordinator, or other designated staff; and
    f. other facility staff and/or a representative from a community hospice care provider.

3. The Chief Administrative Officer, or designee, in consultation with the HSA, or designee, shall select one of the team members to serve as a facilitator for the IDT.

4. The Chief Administrative Officer, or designee, shall ensure that an orientation about hospice care is provided to IDT members, as needed.

5. The IDT shall review the plan of care for each resident who has been admitted to hospice care. The plan of care shall address the physical and emotional needs of the resident during hospice care.

6. The facility Director of Nursing, or designee, shall ensure that the plan, including any update to the plan based on recommendations from the IDT, is in the resident's electronic health care record.

7. The IDT shall meet at least every two (2) months, and more frequently as needed, to review the plan of care for each resident receiving hospice care.

Procedure B: Admission to Hospice Care

1. Any facility health care provider may decide to evaluate a resident's need and desire for hospice care at any time.

2. Other facility health care staff or a case manager may request a facility health care provider to evaluate a resident's need and desire for hospice care.

3. A resident may request a facility health care provider to evaluate their need for hospice care.

4. The health care provider shall document the request, if applicable, as well as whether an evaluation is warranted, in the resident's electronic health care record.

5. If the health care provider decides to evaluate a resident for hospice care, whether upon request or otherwise, they shall document the evaluation in the resident's electronic health care record. This shall include, at a minimum, the following information:
    a. date and time of evaluation;
    b. diagnosis of terminal illness, if applicable;

c. whether the resident has refused curative treatment and/or no further curative treatment of the illness would be feasible;

d. prognosis of life expectancy; and

e. the resident's ability to give informed consent for admission to hospice care, if applicable.

6. A resident shall not be admitted to hospice care unless all of the following criteria are met:

   a. the evaluating facility health care provider has provided a diagnosis of a terminal illness with a prognosis of limited life expectancy;

   b. the resident has refused curative treatment and/or no further curative treatment of the illness would be feasible;

   c. the resident has received a thorough explanation of the diagnosis, the prognosis, and the philosophy, goals, and services of hospice care as documented by appropriate facility health care staff;

   d. it has been determined by the evaluating health care provider that the resident has the ability to give informed consent for admission to hospice care and the resident has given such informed consent (or, if applicable, the resident's guardian has given consent and the resident does not object); and

   e. the resident (and the resident's guardian, if applicable) has completed and signed an Advance Directive as set forth in Department Policy (AF) 18.3, Access to Health Care Services.

7. The resident may request the Chief Administrative Officer, or designee, to allow approved family members and/or designated emergency contacts in the community to be present, either in-person or remotely, during the explanation described above. If the resident has a guardian, the guardian shall be present, either in-person or remotely, during this explanation.

8. If the resident has a guardian, the guardian shall be asked to give consent for the resident to receive hospice care. Even if the guardian consents, the resident shall not be provided hospice care if they object.

9. The Department's Regional Medical Director, or designee, after consultation with appropriate health care staff, shall determine whether the resident is medically approved for admission to hospice care and shall notify the Chief Administrative Officer, or designee, of that determination.

10. If the resident is medically approved for hospice care, they shall be admitted to hospice care unless the safety of the resident or others or the security of the facility prevents admission as determined by the Chief Administrative Officer, or designee.

11. If a resident who is admitted to hospice care is not in a Department infirmary, the Regional Medical Director, or designee, after consultation with appropriate health care staff, shall determine whether admission to a Department infirmary is medically indicated.

12. If medically indicated, the procedure set forth in Department Policy (AF) 18.10, Infirmary Services shall be followed, and, if the resident is authorized for admission to a Department infirmary, the resident shall be admitted to the infirmary and be provided hospice care there, unless there is no appropriate infirmary bed available, or safety or security considerations preclude the placement.

13. If, for a resident who is admitted to hospice care, admission to an infirmary is not medically indicated or is not authorized, there is no appropriate infirmary bed available, or safety or security considerations preclude admission to the infirmary, arrangements for the provision of hospice care in another housing unit shall be made by the facility Chief Administrative Officer, or designee, in consultation with the Department's Regional Medical Director, or designee, and, as appropriate, the Department's Director of Classification, or designee.

Procedure C: Hospice Care

1. A resident receiving hospice care shall receive the following services:
    a. assistance with the following: mobility, reading, writing letters, meals, and other similar activities;
    b. companionship and emotional support from resident hospice workers, if applicable;
    c. assistance with grooming and dressing; and
    d. sitting vigil by resident hospice workers, if applicable, or family members and/or designated emergency contacts in the community.

2. A resident hospice worker shall not be assigned to provide services to another resident admitted to hospice care unless the resident admitted to hospice care signs an appropriate release of information form.

3. The failure of a resident to sign the form shall not disqualify the resident from receiving hospice services but means that those services shall not be provided by another resident.

Procedure D: Discharge from Hospice Care

1. A resident shall be discharged from hospice care if any of the following criteria are met:
    a. the resident requests discharge;
    b. a facility health care provider evaluates that the resident's condition has improved to the extent that they no longer have a diagnosis of a terminal illness with a prognosis of limited life expectancy, and the Department's Regional Medical Director, or designee, after consultation with appropriate health care staff, determines that discharge from hospice care is medically approved;
    c. the resident seeks curative treatment;
    d. the resident (or the resident's guardian, if applicable) has revoked the Advance Directive;
    e. it is necessary for the safety of the resident or others or the security of the facility as determined by the Chief Administrative Officer, or designee;
    f. the resident is transferred to supervised community confinement;

g. the resident finishes their term of imprisonment; or

h. the resident dies.

2. The following steps shall be taken when a resident is discharged from hospice care:

   a. a facility health care provider shall document the discharge from hospice care and include any orders, as appropriate, for continuity of care. The documentation shall include, but not be limited to: services provided; physical, emotional, or other problems requiring intervention or follow-up; a referral to a community hospice care provider, if appropriate; and any additional information that would be helpful in order to ensure resident comfort;

   b. the HSA, or designee, shall notify the IDT, and, if applicable, the resident hospice workers; and

   c. the HSA, or designee, shall notify the Chief Administrative Officer, or designee, who shall notify family members and/or designated emergency contacts in the community, if appropriate.

Procedure E: Hospice Vigil

1. When in the opinion of a facility health care provider, a resident receiving hospice care has an approximate one week or less of life expectancy, the Department's Regional Medical Director, or designee, if in agreement with the opinion, shall, unless the resident objects, declare the appropriateness of initiating a vigil.

2. The Health Services Administrator (HSA), or designee, shall inform the IDT, the terminally ill resident and, if applicable, the resident hospice workers of the decision to initiate a vigil.

3. If applicable, the terminally ill resident shall be asked whether there any resident hospice workers who they do not wish to sit vigil and those wishes shall be respected.

4. A maximum of two (2) resident hospice workers shall be allowed to sit vigil at any time.

5. The Chief Administrative Officer, or designee, shall notify the resident's family and/or designated emergency contacts in the community of the decision to initiate a vigil, if requested by the resident.

6. The Chief Administrative Officer, or designee, may allow extended visits and/or exceptions to visitor authorization requirements as described in Department Policy (AF) 21.4, Resident Visitation in order for a family member and/or designated emergency contacts in the community to sit vigil.

7. Unless an exception is made by the Chief Administrative Officer, or designee, whenever a visitor is present, resident hospice workers sitting vigil, if any, shall return to their housing unit and shall be informed by security staff when to return to sit vigil.

8. A visitor's vigil may be terminated at any time by security staff if it is determined that the visitor's behavior places the safety of the resident or others or the security of the facility at risk. If this occurs, an incident report shall be written with a copy to the Shift Commander and the HSA, or designee, who shall inform the IDT.

9. All persons sitting vigil shall be required to step out of the terminally ill resident's room and wait in a designated area when patient care services are being discussed or provided by facility health care staff or at any other time for any other reason deemed necessary by health care staff or security staff.

10. The vigil shall end when the resident dies or if the resident requests that the vigil be ended.

11. The vigil shall also be ended if a facility health care provider evaluates that the resident's condition has improved so that the resident's death is no longer imminent, and the Department's Regional Medical Director, or designee, agrees.

12. The HSA, or designee, shall notify the Chief Administrative Officer, or designee, IDT, health care staff, security staff, and other appropriate staff whenever a vigil ends or is ended. If applicable, the HSA, or designee, shall also notify the resident hospice workers of the ending of the vigil. The Chief Administrative Officer, or designee, shall notify the resident's family members and/or designated emergency contacts in the community, if applicable.

VIII. PROFESSIONAL STANDARDS

None