OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-G-11

SUBJECT: CARE FOR THE TERMINALLY ILL/HOSPICE

PHILOSOPHY: The Oregon Department of Corrections (ODOC) recognizes that dying is part of the normal process of living and those inmate/patients who are in the last stages of a terminal illness often will require a “special” kind of care. ODOC therefore adopts a palliative care Hospice approach to end-of-life care in which the physical, social, spiritual and emotional needs of dying inmate/patient are addressed. The desired outcomes of palliative/Hospice care are: safe and comfortable dying, self-determined life closure and effective grieving. Palliative/Hospice care affirms life and neither hastens nor postpones death.

POLICY: Palliative/Hospice care will be provided for inmate/patients who are diagnosed with a terminal illness and a prognosis of months rather than years. All care will be clinically-directed by an interdisciplinary team consisting of patients and their families, professionals and volunteers. Members of the hospice interdisciplinary care team shall include, but are not limited to: practitioner, Medical Services Manager or designee, Registered Nurse, BHS professional, representation from institution administration, representation from security, representation from Religious Services, representation from Food Services, representation from the inmate/patient hospice volunteers, and inmate/patient family.

REFERENCE: HS P&P #P-A-08, Communication on Patients’ Health Needs
HS P&P #P-D-05, Hospital and Specialty Care
HS P&P #P-G-01, Chronic Disease Services
HS P&P #P-G-02, Patients with Special Health Needs
HS P&P #P-G-03, Infirmary Care

PROCEDURE:

A. Eligibility for palliative/Hospice care:
   1. Patients become eligible for palliative/Hospice care when they are diagnosed with a terminal disease and a prognosis measured in months rather than years. The treating provider shall discuss the diagnosis, prognosis and treatment options, with the patient which will include palliative/Hospice care.

B. Admissions to palliative/Hospice care:
   1. Medical Services staff will make a referral to the institution Medical Services Manager, or designee, for the admission to the palliative/Hospice care program.
   2. The Medical Services Manager, or designee, will request from the treating practitioner the patient’s diagnosis and estimated prognosis.
3. If the patient’s medical condition meets the criteria in (A), “Eligibility for palliative/Hospice Care,” the Medical Services Manager, or designee, shall meet with the patient to inform him/her of the care that is available and to determine if the patient wishes to participate in palliative/Hospice care.

4. The Medical Services Manager, or designee, will notify the Chief Medical Officer and schedule an interdisciplinary care conference within seven days to review the patient’s condition and level of care needed.

5. The interdisciplinary care conference will include all members of the interdisciplinary care team as listed in the policy statement.

6. Upon placement of the patient in the palliative/Hospice care program, the Medical Services Manager, or designee, will stamp “Hospice Care” on the progress note to indicate the admission of the patient into the palliative/Hospice care program and will review the hospice treatment plan which will be placed in the front of the patient’s health care record.

7. The infirmary care of the palliative/Hospice Program is staffed by nursing personnel. The number of patients and care requirements will be considered by the Medical Services Manager, or designee, in staffing palliative/Hospice care.

8. Nursing care is provided according to procedures per community standards, as well as through other written instructions. These are available in the Health Services Infirmary area.

9. Inmate orderlies/volunteers will be assigned to assist the patient as necessary with activities of daily living in accordance with Policy and Procedure #P-C-06, Inmate/patient Workers.

10. Ongoing interdisciplinary team care conferences will be scheduled as deemed appropriate by the interdisciplinary team.

11. Hospice forms are attachments 1-7.

C. Admission Assessments:

1. At the time of admission to the palliative/Hospice program, all patients shall receive a comprehensive assessment to include:
   - The patient’s symptoms, pertinent medical history, medication and allergy history, and a full physical assessment.
   - An initial pain assessment with the goal of achieving the patient’s preferences for pain management.

2. BHS will conduct a psychosocial assessment to include matters related to the end of life, as well as issues identified by the patient as important and relevant.

3. Religious Services will conduct a spiritual assessment which identifies the patient’s beliefs and/or philosophies and which honors these in all care decisions and a bereavement assessment which identifies significant
persons in the patient’s life who may need support following the death of the patient.

4. The interdisciplinary team will formulate a written care plan.

- The written plan of care is based upon all of the assessments, and is developed for each patient and family prior to providing care.

- The plan should include the desired goals or outcomes; the patient’s problems/issues/needs and opportunities for growth, the scope and frequency and type of services to be provided including the interdisciplinary team interventions, pharmaceuticals and any medical equipment to be provided.

- The interdisciplinary team shall review and revise the plan of care every two weeks or as necessary to reflect the changing needs of the patient/family. The Medical Services Manager, or designee, will be responsible for the coordination of care.

D. Responsibilities of certain health care providers during palliative/hospice care:

1. The Chief Medical Officer, or designee, (provider) will:

   a. Complete a comprehensive assessment (which would include symptom or system specific examinations) and develop a plan of clinical care detailing treatment, pain control and resuscitation status for presentation at the interdisciplinary case conference within 48 hours.

   b. Have regular contact with and make complete progress notes on all palliative/Hospice care patients.

   c. Note all changes in plans of care in the progress note. Physician orders will be written as indicated.

   d. Attend and participate in the interdisciplinary team care meetings on all palliative/Hospice care patients.

   e. If/when the physician believes that end of life care in a community setting is appropriate; a referral is made through the Health Services process for evaluation and consideration of the Early Medical Parole process.

2. The Medical Services Manager, or designee, will:

   a. Schedule interdisciplinary team meetings.

   b. Coordinate with security special visits when appropriate for palliative/Hospice care patients and their family.

   c. Be responsible for ensuring that all aspects of care are carried out and that goals of the interdisciplinary treatment plan are met.

   d. Consistent with state regulations, facilitate the early release of a terminally ill inmate/patient in a timely manner when appropriate.
e. Arrange for the utilization of a private room for the palliative/Hospice inmate/patient when appropriate.

f. At the time of a palliative/Hospice inmate/patient’s imminent death, shall notify the facility Officer in Charge and start a vigil.

g. After each inmate/patient’s death, arrange for health services staff involved in the patient’s care to access ESS and arrange for the orderlies to access counseling and other bereavement services as necessary.

3. Infirmary Nurse is responsible for:

a. Ensuring that the practitioner orders are processed and carried through.

b. Completing a daily nursing assessment, and complete an entry on the patient’s progress note at least every shift or as ordered by the practitioner.

c. Notifying the Chief Medical Officer or treating practitioner of any significant changes in the inmate/patient’s condition.

d. Ensuring that treatment orders, medications, etc. are administered as prescribed and documented and that activities of daily living are met.

e. Providing at the end of each shift, a report to be given to the oncoming infirmary nurse.


E. Monitoring and Review:

1. Palliative/Hospice admissions and assignments to the infirmary shall be monitored by the Chief Medical Officer and Medical Services Manager for clinical appropriateness, quality of care and pain management.

2. Palliative/Hospice admissions, average daily census and average length of stay shall be tabulated on the monthly statistical report and submitted to the Health Services Administration according to Policy and Procedure P-A-04, Administrative Meetings and Reports.

F. Training:

1. All services shall be provided by appropriately qualified, trained staff and inmate/patient volunteers.
1. What is your understanding of your present medical condition?

2. Have you ever received mental health treatment in the past? If so, when and for what reason?
   a. Were you prescribed mental health medication at that time? Do you recall what?
   b. Were you hospitalized for your condition?
   c. For how long a period did you receive mental health treatment?
   d. Were there any other periods in your life when you received mental health treatment?
   e. Have you ever made a suicide attempt? When and how?

3. Do you feel that you need mental health treatment at the present time? If so, what symptoms are you currently experiencing?

4. Would you like to speak with a mental health professional about your feelings and concerns regarding death?
5. What are the things that you have concerns about leaving undone, such as religious, legal, or family matters? Can a mental health professional help with connecting you to people who could help with these matters?

6. What are the other ways a mental health professional might help you while you are in the hospice program?

Conclusions:

I. Based on the results of this intake screening, BHS will conduct a more in-depth assessment for mental health need.
   Yes___  No___

   Note: If conducted, the in-depth Mental Health Assessment will be filed in the mental health section of the medical chart.

II. Mental health recommendations regarding hospice services:

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

   BHS Staff Signature: ___________________________  Date:__________
   BHS Staff Title: ________________________________
Consent for Hospice Philosophy As My Plan of Care

Name of Patient ________________________________ SID# __________________

Hospice philosophy is rooted in the concept of comfort and care as opposed to curative care. It has an emphasis on effective pain management and symptom control to improve the quality of life when an illness cannot be cured or even controlled. The purpose of my choosing to be part of this type of care is to make this last part of my life as filled with care and comfort as possible.

I, ___________________________, voluntarily and knowingly execute the following document as consent for hospice care. The meaning and effect of this document has been fully and clearly explained to me, and I completely understand its terms, how they apply to my medical care, and their likely effects in the event the terms of this document need to be put into place. The terms and meaning of this document were explained to me on, __________ by __________ at which time I had the opportunity to ask questions in order to fully understand the terms of this document. Therefore, I __________________________, hereby request that I receive care based on the hospice philosophy explained to me by __________________________.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain. _____ (Inmate/patient Initials)

I understand that in choosing this care, if my heart stops or my breathing stops, no medical care will be started. _____ (Inmate/patient Initials)

I understand that I can withdraw from this comfort care philosophy whenever I want and return to aggressive care aimed at controlling my illness. _____ (Inmate/patient Initials)

I give permission for a Hospice Counselor to contact the following person(s) to provide emotional support to them during my illness and after my death. _____ (Inmate/patient Initials)

Name and Telephone Number: __________________________________________
Relationship: ______________________

Name and Telephone Number: __________________________________________
Relationship: ______________________

Name and Telephone Number: __________________________________________
Relationship: ______________________
# Intake and Care Plan

**Name:** __________________________  **SID#:** __________

**DOB:** ______________

**Date of Hospice Admission:** ______________

**Diagnosis:** ________________________________________________

**Attending Practitioner:** __________________________

**Nurse Manager:** __________________________

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<th>Reviewed/Completed</th>
<th>Yes</th>
<th>No</th>
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<tbody>
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<td>Handbook issued</td>
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<tr>
<td>Consent for evaluation obtained</td>
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<td>Practitioner’s Referral Obtained</td>
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<td>Consent for Program signed</td>
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<td>Nursing Intake Assessment</td>
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<td>Health Service Emergency Notification sheet updated</td>
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<tr>
<td>Mental Health Referral</td>
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<td>Religious Service Referral</td>
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<td>Living Will</td>
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<tr>
<td>Durable Medical Power of Attorney</td>
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<td>Post Order-life-sustaining intervention</td>
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<td>Is the patient able to make care decisions for themselves?</td>
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<tr>
<td>Comments:</td>
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**Hospice Volunteers:** __________________________

**Inmate/patient Family:** __________________________

**Family Members in the community:** __________________________

**Other Significant Relationships:** __________________________

**Date patient informed of diagnosis and prognosis:** ______________

**Has the patient informed family/friends of his/her diagnosis and prognosis?** __________

- Do they discuss the diagnosis/prognosis openly together? __________

**Favorite Foods:** __________________________

**Home Town:** __________________________
Oregon Department of Corrections
Health Service
Hospice

Intake and Care Plan

Career:_____________________________________________________

Hobbies:____________________________________________________

Other:_______________________________________________________

Patient Strengths:___________________________________________

Patient Wishes/Concerns:_____________________________________

Patient Wishes at Time of Death (who they would like present):________

Family Members Wishes and Concerns:___________________________

What arrangements have been made for the remains?_____________________

• Does the family outside of the prison intend to claim the body?_______

Religious preference?_________________________________________

• Preference of Clergy:________________________________________

• Frequency of Clergy Visits:____________________________________

• Specific Religious or Spiritual Concerns:________________________

Staff Concerns:_______________________________________________

Bereavement Needs: _____ Mild _____ Moderate _____ Severe

Patient’s presenting physical symptoms and needs:____________________

Plans/Goals/Comments:_______________________________________

_________________________________________________________________

Person completing this form:________________________________________

Signature/Date
Oregon Department of Corrections
Health Services
Hospice

PRACTITIONER’S REFERRAL

Referral Date: _____________

Referred to: _______________

Practitioner requesting referral to Hospice Program: ______________________________________

Patient Name: _______________ DOC #: ___________ Location: ___________

Charge: _______________ Sentence: _______________ SSN: _______________

DOB: ___________ Age: ______ Race: _____ Marital Status: ____ Religion: ___________

Diagnosis: ___________________________ Prognosis: ___________________________

Has the patient been told he is terminally ill? _____Yes _____No

Is patient aware of referral to Hospice? _____Yes _____No

Has practitioner verified prognosis? _____Yes _____No

Date referral is received: __________________

Person receiving referral: __________________

Personnel Notified of Referral

<table>
<thead>
<tr>
<th>Personnel Notified of Referral</th>
<th>Acceptance</th>
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<tbody>
<tr>
<td>• Medical Services Manager</td>
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<tr>
<td>• Attending Practitioner</td>
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<tr>
<td>• Nurse Manager</td>
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<td>• Executive Assistant to Superintendent</td>
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<td>• Behavioral Health Services</td>
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<td>• Security</td>
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<tr>
<td>• Assistant Superintendent of Program Services</td>
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<tr>
<td>• Chaplain</td>
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<td>• Food Services</td>
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<td>• Other</td>
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Recommending Practitioner’s Signature: ________________________ Date: ______
Oregon Department of Corrections
Spiritual Assessment/Entry Interview

Name:________________________ Age:_______ Faith:____________________

Name of Pastor or Spiritual Advisor:______________________________________

Current Significant Relationships (Inmate/patient Family and Community Family):
__________________________________________________________
__________________________________________________________
__________________________________________________________

Life Guiding Beliefs (Spiritual or Religious):______________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

Specific Spiritual or Religious Requests for Personal Care or Care of Loved Ones:
__________________________________________________________
__________________________________________________________
__________________________________________________________

Wishes for Significant Items of Property:______________________________
__________________________________________________________
__________________________________________________________

Wishes for Bodily Remains:___________________________________________
__________________________________________________________
__________________________________________________________

Relationship to and Feelings about Death:______________________________
__________________________________________________________
__________________________________________________________

Pastoral/Ministerial Visits Scheduled: Dates & Times
__________________________________________________________
__________________________________________________________
__________________________________________________________

Other:___________________________________________________________
__________________________________________________________
__________________________________________________________

Chaplain Name:________________________
Signature:________________________
Date & Time:________________________
Oregon Department of Corrections
Hospice Program Volunteer Agreement

I, __________________________________________, SID# ______________, agree to serve as a volunteer with the program at _________. I agree to volunteer (Institution/Facility Name) until such a time as when I inform the hospice in writing that I wish to resign. The hospice reserves the right, at its discretion and upon explanation to me, to terminate my affiliation with the hospice. I may not subsequently represent the hospice without the hospice's knowledge and permission.

As a volunteer, I understand that my responsibilities will include the following:

- Visits with the inmate/patient in the housing unit where he resides.
- Documentation of initial and subsequent visits.
- Light duties such as emotional support, respite care, errand-running, and personal care.
- Participation in volunteer support meetings, and in-services education up to at least 30 hours a year.

I understand that any patient/family information to which I have access through volunteer care conferences, individual conferences, or patient/family contact is privileged and shall be held in strict confidence. Patient/family information I acquire will only be shared with appropriate hospice personnel. I also understand that while volunteering I must abide by any institutional rules and regulations and that my volunteer status does not automatically shield me from disciplinary action for clear violations or those rules and regulations. Any violation of the above agreement will include, but not limited to, removal from the hospice program.

Volunteer Inmate/patient Signature and SID#

__________________________

Date

Hospice Coordinator Signature

__________________________

Date

Hospice Volunteer Coordinator Signature

__________________________

Date
Oregon Department of Corrections
Health Services
Hospice

Annual Interview
Of Inmate/patient Volunteers for Hospice

Name ____________________________ SID# ________ Current Date _________________

Date of Volunteer Enrollment ____________________________

List areas of assignments this year: ___________________________________________

___________________________________________________________________________

Has participation in the hospice program met your expectations? Explain
___________________________________________________________________________

___________________________________________________________________________

Do you want to continue as a volunteer? _____Yes _____No

Are there any changes you would like to make concerning your future assignments?
_____Yes _____No – Explain: ________________________________________________

___________________________________________________________________________

Comments by Volunteer: _________________________________________________

___________________________________________________________________________

Comments by Volunteer Coordinator: _________________________________________

___________________________________________________________________________

Signature of Volunteer ____________________________ SID# ________________

Signature of Volunteer Coordinator _______________ Date _________________
1. Patients diagnosed with terminal illness and in the last stages will be provided with the opportunity to receive end-of-life care using a hospice model.

2. End-of-life care will be coordinated utilizing an interdisciplinary team approach.

3. The interdisciplinary team at Snake River Correctional Institution may consist of the Chaplain assigned to Health Services, a representative from Behavioral Health Services, the Program Counselor assigned to the patient, Health Services staff, Chief Medical Officer, other health care or non-health care providers as deemed necessary by the Medical Services Manager and Chief Medical Officer, and Security staff assigned to Health Services or as designated by the Security Manager assigned to Health Services.

4. Patients diagnosed with terminal illness who choose not to participate in an end-of-life care program will be provided with care respectful of physical, emotional, and spiritual needs specific to the end of life.

5. Visits from significant others to terminally ill patients in the infirmary will be coordinated through Health Services, Security, Religious Services, and Program Counseling.

6. Support through the “Critical Incident Stress Debriefing Program” will be available to all staff involved in providing care to terminally ill inmate/patients.

7. Inmate/patient orderlies/volunteers utilized in providing care to terminal patients will be provided with opportunities for support through the Religious Services Department.

8. Memorial remembrance services for deceased inmate/patients may be coordinated and conducted by Religious Services. Attendance at these memorials will be open to inmate/patients and staff.