HEALTH SERVICES BULLETIN NO**: 15.02.17**

SUBJECT: PALLIATIVE CARE PROGRAM GUIDELINES

EFFECTIVE DATE: 02/2/2018

I. PURPOSE

The purpose of this health services bulletin (HSB) is to provide guidance to institutional health services personnel about the Palliative Care Program.

Prior to conducting screening and evaluation activities outlined in this HSB, the inmate will be provided reasonable accommodations or auxiliary aid(s) or service(s) based on their disability.

These standards and responsibilities apply to both Department staff and Comprehensive Health Care Contractor (CHCC) staff.

II. DEFINITIONS

Compassionate Care Unit: Designated area in institution where palliative care services are provided.

Palliative Care: Treatment that enhances comfort and improves the quality of an individual's life when curative treatment is no longer productive for the patient. This is achieved through the management of physical, spiritual, social, and psychological needs. It involves medical care and supportive services that an individual with advanced stage terminal illness receives in the last phase of life. It includes the use of an interdisciplinary team, including volunteers from within and without the correctional community.

Vigil: An organized effort to provide every palliative care patient with sustained support and companionship through the hours immediately preceding her/his death and at the moment of death. During a Vigil, Impaired Inmate Assistants and family members, working in shifts, sit at the patient's bedside. Those in attendance may talk to the patient, read to him, pray for him, or simply sit quietly.

Auxiliary Aids and Services: refers to devices and/or services that provide assistance to allow otherwise eligible individuals with documented impairments and/or disabilities equal access to the Department's programs, services and/or activities.

Adaptive Devices refers to devices or medical support equipment prescribed for an inmate with a documented impairment and/or disability and approved by the Office of Health Services or its designees. Adaptive Devices include, but are not limited to orthopedic prostheses, braces, or shoes, crutches, canes, walkers, wheelchairs, hearing aids, prescription eyeglasses, artificial eye(s), dental prostheses, and/or breathing devices.

III. INTERDISCIPLINARY TEAM (IDT)

Staff members who provide services to a Palliative Care Patient/Family are organized into IDT. Members of each IDT work in a collaborative manner to meet the needs (physical, psychosocial and spiritual) of the patient/family. Each Palliative IDT shall include:

Attending Physician or Chief Health Officer (CHO)/ Institutional Medical Director
Health Services Administrator (HSA) or designee
Registered Nurse (RN)
Chaplain
Security Representative
Classification Representative
Mental Health Representative

A. Regulations

1. The IDT establishes an individualized Plan of Care for each palliative patient. (See A. 6. Palliative Plan of Care)

2. Members of the IDT meet together to establish, review, and update the Plan of Care for each patient.

3. The IDT provides and supervises palliative care. If a disagreement occurs regarding a proposed intervention, the CHO/ Institutional Medical Director acts as final arbiter.

4. The IDT establishes policies governing day-to-day provision of palliative care to include housing accommodation, adaptive device, auxiliary aid, or service, to ensure a lifestyle quality such as normally experienced by other inmates to the extent the inmate's condition allows.

5. Members of the IDT provide mutual support and support for other providers of palliative care.

6. A Palliative Plan of Care is developed from the information gathered from the patient assessments completed by members of the IDT. Through the process of assessment, which is ongoing, members of the IDT identify patient strengths, problems, and needs; establish goals and objectives; and design and evaluate interventions. The fundamental goal of the Plan of Care is to achieve palliation of distressing symptoms through aggressive management of identified problems and through proactive strategies to prevent new problems from

occurring. The patient participates in the creation and revision of the Plan of Care according to the ability of each to do so.

B. Time Parameter

1. Patients are admitted to the Palliative Program whenever their medical needs dictate admission.
2. Upon admission, the physician's assessment and the RN's initial nursing assessment must be completed before the Plan of Care can be established. Pri

C. Documentation: The Plan of Care must include the following:

1. Identified patient strengths, problems, and needs.
2. Determination of a do not resuscitate order (DNRO) and/or advance care directive.
3. Goals and objectives that are realistic, achievable, and measurable for each discipline and service.
4. Types and frequency of services to be provided to each patient.
   a. The RN/LPN will do an initial SOAP note at the beginning of each eight (8) hour shift on Form DC4-701, "Chronological Record of Health Care".
   b. The RN/ LPN will chart any PRN notes on Form DC4-701.
5. Names of all contributors as well as the names of each person assigned to provide care.

IV. PALLIATIVE CARE COORDINATOR

A. Health Services Director or designee will designate an individual to coordinate the Palliative Care Program.

B. Palliative Care Coordinator (or designee) guidelines:

1. Develop, assess, and revise the Palliative Care Health Services Bulletin.
2. Oversee the operation of the Palliative Care Program.
3. Work in a collaborative manner with the IDT to correct problems that arise.
4. Keep abreast of information relevant to the Palliative Care Program and Compassionate Care component.

5. Oversee the education of the IDT, Impaired Inmate Assistants (as outlined in the Nursing Manual) volunteers, and staff whose responsibilities necessitate significant and ongoing contact with palliative patients.

6. Review all patient referrals received from the Regional Medical Director (RMD) and Utilization Review to monitor and track transfer to the Palliative Care Program.

7. Meet with each patient to provide a thorough explanation of the Palliative Care Program after referral from the RMD.

V. CHIEF HEALTH OFFICER (CHO)/ INSTITUTIONAL MEDICAL DIRECTOR

A. CHO/ Institutional Medical Director guidelines:

1. Acts as attending physician to all palliative patients.

2. Assists in overall planning for the Palliative Care Program at her/his institution.

3. Provides advice and consultation to the IDT.

4. Provides supervision and direction to assure that all care adheres to ethical, professional, and medical standards.

5. Acts as the final arbiter of all medical and paramedical questions.

6. Participates in the work of the IDT as a team member.

7. The CHO/ Institutional Medical Director at the referring institution is responsible for completing the "Palliative Care Program Physicians Referral Form," DC4-760E, and verifying consent for Palliative Care is in medical record.

B. Medical Services Regulations

1. The CHO/ Institutional Medical Director shall attend to all patients admitted to the Palliative Care Program.

2. The CHO/ Institutional Medical Director or her/his designee shall remain available at all times twenty-four (24) hours a day, seven (7) days a week.

3. Medical services provided shall comply with accepted standards of practice.

4. The CHO/Institutional Medical Director /attending physician shall complete an initial physical assessment within twenty-four (24) hours of admissions, or

if admitted on the weekend the first twenty-four (24) hours of return to work week. This assessment shall be documented in the medical record.

VI. REGISTERED NURSE

A. The Registered Nurse shall provide and direct nursing services, provide case management services, and give supportive care to palliative patients.

B. RN Guidelines:

1. The transferring facility RN shall complete all required documentation.

   a. Complete “Palliative Care Program Nurses Referral Form,” DC4-760F and verify that the consent for Palliative Care is in the medical record.

   b. Include instructions and counseling provided for patient at discharge. (In the event of Conditional Medical Release, or transfer to another Palliative Care facility.)

   c. Complete transfer section of Form DC4-760A, "Health Information Transfer/Arrival Summary".

2. The receiving facility RN shall complete all required documentation.

   a. Arrival section of Form DC4-760A.

   b. Initial nursing assessment on Form DC4-732, "Infirmary/Hospital Admission Nursing Evaluation.

   c. On-going assessments on Form DC4-701, "Chronological Record of Health Care", throughout her/his length of stay. (See section III. C. 4a. and 4b.)

3. Communicates identified ADA impairments and/or disabilities to the institutional ADA Coordinator based on DC4-732, Infirmary/Hospital Admission Nursing Evaluation.

4. Within twenty-four (24) hours of admission confer with the attending physician/CHO/ Institutional Medical Director to obtain orders for treatment, medication, advanced directives and release of information as indicated by the patient.

5. Works with the patient’s attending physician/CHO/Institutional Medical Director to plan intervention, which demonstrates a comprehensive knowledge of pain and symptom control.

6. Ensures that nursing provided by subordinates is delivered in a manner consistent with palliative goals and objectives.

7. Participates in the work of the IDT as a team member.

8. Assumes responsibility for the management of patient care and coordination of services of other disciplines between meetings of the IDT.

    a. Monitors the overall well-being of patient and coordinates the services of other disciplines to meet needs as needs arise between meetings of the IDT.

    b. Documents the patient's Plan of Care as conceived by the IDT.

VII. MENTAL HEALTH SERVICES

A. Mental Health Services are provided in collaboration with other services in the Interdisciplinary Team, and in accordance with the guidelines established herein.

B. Mental Health guidelines:

1. The Mental Health Department shall designate a Psychologist or Behavior Specialist to be the Palliative Care Representative for inmates with diagnosed mental disorders, i.e., inmates classified Mental Health Grade S-2 and above. Inmates without a mental disorder shall be seen and evaluated as a result of staff referral or inmate request.

2. Upon the patient's admission to palliative care, the RN Palliative Care Representative will send a referral to the Mental Health Palliative Care Representative via form DC4-529.

3. Pursuant to receiving the staff referral, the Palliative Care Program Mental Health Representative shall meet with the inmate to assess the inmate's mental status and, as clinically appropriate, provide services in accordance with HSB 15.05.14, Mental Health Services and HSB 15.05.11, Planning and Implementation of Individualized Mental Health Services. Inmates with a Mental Health Grade of S-1 may be seen as per provisions for brief supportive counseling in HSB 15.05.18, Outpatient Mental Health Services.

4. The Palliative Care Program Mental Health Representative shall attempt to obtain the patient's written consent to release relevant mental health information to family members if patient designates individuals for that information.

5. The Mental Health Representative shall collaborate with other members of the IDT and shall provide clinically appropriate mental health interventions to meet the objectives of the Plan of Care.

VIII. PASTORAL CARE

A. Chaplain services are provided in conjunction with other services in the IDT, and in accordance with the following guidelines established here.

B. Chaplain guidelines:

1. Pastoral Care shall be offered to all palliative patients.

2. The Chaplain shall visit each palliative patient within seventy-two (72) hours of admission to the Program to complete a spiritual assessment and to offer pastoral care.

3. The Chaplain shall speak with family members who live outside the prison system during patient/family visits.

4. Based upon the Plan of Care, the Chaplain may provide:

   a. Spiritual counseling/support in keeping with the patients' beliefs.

   b. Facilitation of communication between the patient or family member and a clergyman or spiritual counselor of her/his or her choosing.

   c. Consultation and education to patients and family members.

5. If Pastoral Care is provided through a relationship with clergy and/or spiritual counselors who are not Palliative personnel, the coordination of care shall be documented in the clinical record.

6. The Chaplain shall participate in the work of the IDT as a team member.

7. The Chaplain will be the designated representative to notify family of the death of a palliative care patient.

IX. IMPAIRED INMATE ASSISTANT COORDINATOR

A. The Health Services Administrator shall serve as the Impaired Inmate Assistant Coordinator (IIAC) of the Palliative Care Program.

B. IIAC (or designee) guidelines:

1. Help recruit, coordinate training, and supervise a group of Impaired Inmate Assistants.

2. Plan Impaired Inmate Assistant outreach activities meant to develop and enhance knowledge and awareness of the Palliative Care Program throughout the prison population.

3. Organize initial training and ongoing education for Impaired Inmate Assistants in accordance with regulations set forth in the Palliative Care Mission Statement and in the Nursing Manual.

4. Organize monthly meetings of the Impaired Inmate Assistants with these goals:

    a. To provide a forum for discussion of relevant issues.
    b. To disseminate information.
    c. To facilitate mutual support among volunteers/orderlies.

5. Develop Impaired Inmate Assistant assignments with the assistance of the Medical Staff.

6. Oversee Impaired Inmate Assistants' performance in the Palliative Care Program with the assistance of Medical Staff.

7. Organize a session(s) after each patient's death to allow those Impaired Inmate Assistants affected to review their experience and to process their feelings with support and counsel.

8. Conduct annual interviews with each Impaired Inmate Assistant with these goals:

    a. To encourage each volunteer/orderly to examine her/his experience with the program.

    b. To solicit feedback about the quality of the program.

9. Administer survey tools for Program evaluation.

10. Participate in the work of the IDT as a team member.

11. Serve as a liaison between the Impaired Inmate Assistants and the IDT.

12. Serve as a liaison between the Impaired Inmate Assistants and the Health Services Staff.

13. Ensure that each Impaired Inmate Assistant completes all annual requirements as listed on DC4-526C, Inmate Orderlies and Assistants Annual Training Checklist.

14. Maintain an active Impaired Inmate Assistant Roster, DC4-760G. The roster shall record each Impaired Inmate Assistant's name, DC number, housing unit, EOS date, and the date of initial orientation completion (as indicated by their completed DC4-526, Inmate Orderlies and Assistants Orientation and Training Checklist).

15. Provide security with a current Impaired Inmate Assistant's roster at all times.

X. IMPAIRED INMATE ASSISTANTS

A. Inmate Assistant guidelines:

1. Impaired Inmate Assistants shall be selected and trained in accordance with Procedure 403.011, "*Inmate Assistants for Impaired Inmates*", and the Nursing Manual. Training shall be documented on form DC4-526, Inmate Orderlies and Assistants Orientation and Training Checklist.

2. The IIAC or designee shall assign tasks to the Impaired Inmate Assistants to meet patient needs identified by the IDT. Assignments are made on an individual basis after careful consideration of many variables. Variables include:

   a. The strengths and interest of the Impaired Inmate Assistant.

   b. The particular demands of the work at hand.

   c. The characteristics and preferences of the patient and family member. An Impaired Inmate Assistant's effectiveness, and therefore quality of care, is increased when her/his proclivities and abilities match the role assigned him.

3. Impaired Inmate Assistants aid in administrative functions related to patient care and provide Palliative Care patients with support, companionship, and practical assistance. Different roles demand different emotional, intellectual, and physical commitments. Impaired Inmate Assistants differ one from the other in the commitment each is able or willing to make. Furthermore, the capabilities of each individual Impaired Inmate Assistant will fluctuate as he acquires experience with the Program and as he endures the emotional stress related to the work. The IIAC or designee and the Impaired Inmate Assistants

must maintain open communication to facilitate appropriate Impaired Inmate Assistant assignments, and the inmate must know that he may decline without prejudice any assignment that he feels unable or unwilling to perform. Impaired Inmate Assistants will not act in the capacity of an American Sign Language Interpreter for the patient, or in any capacity which impedes the patient's right to obtain an effective accommodation as defined by the Americans with Disabilities Act .4. The Impaired Inmate Assistant may also at any time, choose to withdraw completely from the Impaired Inmate Assistant Program for personal reasons. The inmate will need to complete and submit form DC4-526D, *Inmate Assistant Request for Withdrawal From the Program.*

5. Impaired Inmate Assistants training forms will be filed as follows:

Form	Original Medical Record	Copy Classification Record
DC4-526 – Inmate Orderlies and Assistants Orientation & Training Checklist	X	X
DC4-526A – Inmate Assistant ID Badge and Duty Log Protocol	X	X
DC4-526B – Wheelchair Attendant – Requirements & Training Handout	X	X
DC4-526C – Inmate Orderlies and Assistants Annual Training Checklist	X	X
DC4-526D – Inmate Assistant Request for Withdrawal from Program	X	X
Nursing Manual, Appendix I - Form A – Personal Protective Equipment in Common Inmate Orderly & Assistant Tasks	X	X
Nursing Manual, Appendix I - Form B – Daily Patient Intake and Output	X	X
Nursing Manual, Appendix I - Form C – Inmate Assistant's ADL Work and Report Sheet	X	X

XI. COMPASSIONATE CARE UNIT (CCU) VIGIL

A. A Vigil shall be organized and implemented when, in the opinion of the medical staff, a Palliative Care patient is within forty-eight (48) hours of her/his death.

B. Procedure

1. In preparation for the Vigil: The IIAC shall place a list of Impaired Inmate Assistants scheduled to sit with the patient in succession over the forty-eight (48) hours in the patient's medical record.

2. The Vigil is initiated by the Palliative Care RN on duty after consultation with the patient's attending physician.

3. The RN who initiated Vigil shall notify the Correctional Officer/Shift Supervisor who shall summon the appropriate Impaired Inmate Assistants.

The Palliative Care RN on duty shall work with security to call Impaired Inmate Assistants to the Infirmary in succession, as Vigil progresses.

a. The Impaired Inmate Assistant will be responsible for all hygiene care needed as well as being a presence at the bedside throughout the Vigil.

b. The Impaired Inmate Assistant may read, speak softly, or pray with the dying inmate per instructions by medical staff.

c. The Impaired Inmate Assistant will sit at the bedside of the dying inmate until relieved by another scheduled Impaired Inmate Assistant or until the inmate dies.

4. The RN who initiates Vigil shall notify the Chaplain or her/his designee on duty who shall call family members to tell them of the patient's condition.

5. Vigil shall end (1) when the patient dies, or (2) when the RN in consultation with the patient's attending physician determines that the Vigil is no longer medically appropriate.

6. The IIAC shall schedule Impaired Inmate Assistants to sit with the patient until Vigil is over.

XII. TIME OF DEATH

A. It is the policy of the Compassionate Care Unit at the time of an inmate's death to continue to provide professional and ethical standards of care per 33-602.112, HSB 15.09.09, and Procedure 602.031.

B. Procedure

1. The RN will notify the attending physician or if after hours, the on-call physician, when there are no detectable vital signs.

2. The physician will make the determination of death, and will be responsible for contacting the District Medical Examiner per FS 406.11.

3. The RN will notify the institutional Chaplain who is responsible for notifying the designated family members of the death of the inmate if the family is not present at the time of death.

4. The RN will notify the Impaired Inmate Assistant Coordinator who is responsible for notifying the Impaired Inmate Assistants who assisted in the care of the deceased.

5. If the family is present at the time of death, the medical staff will allow them 1/2 hour with the deceased to establish closure.

6. The Chaplain may organize a memorial service to commemorate the CCU patient.

XIII. REFERRALS

A. It is the policy of the Palliative Care Program to process referrals to the program in a consistent manner in a way which shall promote continuity of care. Any patient or family member may request an explanation of Palliative Care Services. Inquiries will be answered by the HSA or by her/his designee. An inquiry, however, is not a referral. If a patient requests admission to the Program after hearing an explanation of Palliative Care, the HSA shall confer with the patient's physician or with the CHO/ Institutional Medical Director to determine whether a referral is appropriate in accordance with the admission criteria set forth in Section XIV. A family member may request in writing a referral be made to the Palliative Care Program. This request must be made to the Regional Medical Director.

B. Guidelines

All Palliative Care Medical Transfers will be in accordance to HSB 15.09.04, Utilization Management Procedures, Section VIII.

1. If referral is appropriate, the patient's physician or the CHO/Institutional Medical Director shall be responsible for submitting a referral to the Palliative Care Program. If at that time it is determined that the referral is not appropriate, the attending physician/CHO/Institutional Medical Director may submit another referral at a later date if the patient's conditions appear to warrant another review.

2. Referrals are made either in writing, in person, or over the phone by contacting the RMD and completing the Referral Forms. (DC4-760E and/or DC4-760F)

3. Upon receipt of the referral, the RMD shall speak with the referring physician to confirm that the patient has been given all pertinent information regarding her/his diagnosis, prognosis, and treatment options.

4. The RMD shall verify that the patient no longer wishes curative treatment, but requests Palliative Care.

5. The RMD shall review the inmate's current medical record and determine if referral is appropriate at that time.

6. After this confirmation, the Palliative Care Coordinator or designee will be notified by the RMD. The coordinator shall then meet with the patient to provide a thorough explanation of the Palliative Care Program.

7. If the patient requests time to consider her/his decision or opportunity to discuss her/his decision with others, time shall be allowed and reasonable efforts shall be made by the IDT to facilitate discussion.

8. If admission criteria are not met as determined by the RMD and referring physician, the HSA shall meet with the patient to explain the decision not to admit.

9. If patient meets admission criteria, the RMD shall notify Utilization Management to process the transfer.

XIV. ADMISSION

A. It is the policy of the Palliative Care Program to admit patients to the program based upon admission criteria and procedure. Patients shall be admitted regardless of sex, color, national origin, political affiliation, sexual orientation, religion, handicap, or ability to pay.

B. Admission Criteria

1. The patient has a diagnosis of a terminal illness or other condition, with a life expectancy measured in weeks or months.

2. No further treatment of the disease is feasible or the patient refuses treatment.

3. There is reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the Palliative Care Program.

4. There is adequate and appropriate IDT available to provide the services required.

5. The patient has received a thorough explanation of the following:

   a. her/his diagnosis;
   b. her/his prognosis;
   c. the philosophy, goals, and treatment services of the Palliative Care Program.

6. The patient requests admission to the program.

C. Admission Procedure

1. On the day of admission, the admitting nurse shall meet with the patient to confirm her/his decision to enter Palliative Care, to examine with the patient the "Informed Consent for Palliative Care/CCU (Compassionate Care Unit) Program," DC4-711J, and to discuss the patient's rights and responsibilities as a Palliative Care patient.

2. Upon admission, referral via DC4-529 shall be made to the Palliative Care Mental Health Representative who will subsequently complete and document the results of a mental status exam in the medical record. The Mental Health Representative will provide services as clinically appropriate and required by departmental policy.

3. The Chaplain shall visit each palliative patient within seventy-two (72) hours of admission to the Program to complete a spiritual assessment and to offer pastoral care.

XV. DISCHARGE

A. It is the policy of the Palliative Care Program to discharge patients from CCU based solely upon established criteria and in accordance with set procedures.

B. Patient Discharge Criteria

1. A patient shall be discharged from the Palliative Care Program upon her/his death.

2. A patient shall be discharged from the Palliative Care Program upon her/his request.

3. A patient shall be discharged from the Palliative Care Program if her/his prognosis improves so that the admission criteria regarding prognosis is no longer met.

4. A patient shall be discharged from the Palliative Care Program if (s)he is to be released from prison.

C. Patient Discharge Procedure

1. When the patient is discharged upon her/his death, these steps shall be taken:

a. The Palliative Care RN on duty at the time of death shall complete the Discharge Summary.

b. The Palliative Care RN shall notify the IIAC and the Chaplain of the patient's death.

c. The IIAC shall notify the Impaired Inmate Assistants and members of the IDT of the patient's death.

d. The Chaplain or her/his designate shall notify in person, by phone, or in writing family members designated by the patient within and/or without the prison.

2. When the patient is discharged upon her/his request, these steps shall be taken:

a. The IIAC shall meet with the patient to discuss the reason for her/his decision to leave the Program. (This information is useful in the ongoing effort to maintain program excellence. Patient may leave the program at any time without prejudice).

b. The attending physician or the RN shall document the patient's request and discharge.

c. The IIAC shall notify other members of the patient's IDT.

d. The IIAC shall notify the Impaired Inmate Assistants.

e. The IIAC or a designee shall notify the family members.

f. The patient's attending physician shall write appropriate orders to direct care.

3. When the patient is discharged because of improved prognosis, these steps shall be taken:

a. The attending physician or the RN shall document the patient's discharge.

b. The IIAC shall notify the Impaired Inmate Assistants.

c. The IIAC or a designee shall notify family members.

d. The attending physician shall write appropriate orders to direct care.

4. When the patient is discharged because he is released from prison, these steps shall be taken:

a. The attending physician or the RN shall document the patient's discharge.

b. The IIAC shall notify the Impaired Inmate Assistants.

c. The IIAC or her/his designee shall facilitate the patient's admission to Palliative Care outside of prison.

d. The RN shall complete the Discharge Summary for use by the receiving agency. The Discharge Summary shall include report of:

(1) Services provided.
(2) Specific medical, psycho-social, or other problems requiring intervention or follow-up.

XVI. PERSONNEL TRAINING AND EDUCATION

A. It is the policy of the Palliative Care Program to provide relevant education and training to (1) IDT, (2) Impaired Inmate Assistants, and (3) all staff whose responsibilities necessitate significant and on- going contact with Palliative Care patients.

B. IDT

1. The HSA shall bear responsibility for the organization and supervision of staff education and training.

2. Staff members newly assigned to the Palliative Care Program shall be provided orientation to the Palliative Care Program within one (1) month of assignment.

3. Content of orientation shall include but shall not be limited to:

a. CCU Philosophy, Goals and Objectives
b. Definition of Palliative Care
c. Conceptual Framework of Palliative Care Program
    (1) Core Services
    (2) IDT
    (3) Patient/Family Focus
d. Delineation of Services Provided
e. General Responsibilities of Each Discipline
f. Responsibilities of IDT
g. CCU Vigil
h. Impaired Inmate Assistants
    (1) Roles (Levels I-IV – See Nursing Manual)
    (2) Responsibilities
    (3) Restrictions

(4) Demonstrated Skills (DC4-526 Inmate Orderlies and Assistants Orientation & Training Checklist)
(5) Impaired Inmate Assistants Log (DC4-526A Impaired Inmate Assistant ID Badge and Duty Log Protocol)

i. Referral Admission and Discharge
j. General Policies for All Services
k. IDT shall be provided in- service education on a quarterly basis. This frequency is a minimum standard.
l. In-service presentations shall be designed to review topics that promote quality of care. Topics shall include, but shall not be limited to:
(1) Effective Pain and Symptom Assessment and Management
(2) Basic Aspects of Psychosocial Assessment
m. Communication Skills
(1) Patient/Family Response to Terminal Illness and Death
(2) Family Response to Bereavement
n. Understanding the Final Messages of the Dying
(1) Symbolism and Metaphor
(2) Near Death Awareness
(3) Near Death Experience
o. Working with inmates with disabilities, and the accommodations provided.

C. Palliative Care Impaired Inmate Assistants

1. The IIAC shall have responsibility for the organization and supervision of Impaired Inmate Assistant training.

2. New Impaired Inmate Assistants shall receive a minimum of thirty (30) hours of training before significant contact with the Palliative Care patient or their families. (See Procedure 403.011 and the Nursing Manual as referenced previously).

3. Impaired Inmate Assistants shall be provided in-service education quarterly. This frequency is a minimum standard.

4. Content of in-service education shall reflect Impaired Inmate Assistants' interests and identified training needs.

5. Impaired Inmate Assistants are required to complete annual requirements in a timely manner as listed on DC4-526C, Inmate Orderlies and Assistants Annual Training Checklist.

D. Department Staff with significant on-going patient/family contact

1. The IIAC shall work in collaboration with administrative staff to organize training for personnel in this category.

2. Security personnel assigned to the Palliative Care Infirmary shall be included in this category.

3. Impaired Inmate Assistants shall be included in this category.

4. Training content may be specific to the needs of the trainee, and may include the following:

a. CCU Philosophy, Goals and Objectives
b. Definition of Palliative Care
c. Patient/Family Focus
d. "Family" defined
e. Services Provided to CCU Patients and Families
f. CCU Vigil
g. CCU Volunteers/Orderlies
   (1) Roles
   (2) Responsibilities
   (3) Restrictions
   (4) Volunteer/Orderly Log
h. CCU Admission Criteria
i. Working with inmates with disabilities, and the accommodations provided.

E. A CCU Library/Resource Center shall be maintained within the Palliative Care Infirmary. IDT, Impaired Inmate Assistants, Palliative Care Patients, and their families shall have access to material stored there. Materials will be available in an alternate format if needed to accommodate an individual's disability.

XV. RELEVANT FORMS

A. DC4-526, Inmate Orderlies and Assistants Orientation & Training Checklist
B. DC4-526A, Inmate Assistant ID Badge and Duty Log Protocol
C. DC4-526C, Inmate Orderlies and Assistants Annual Training Checklist
D. DC4-526D, Inmate Assistant Request for Withdrawal From the Program
E. DC4-701, Chronological Record of Health of Health Care
F. DC4-711J, Informed Consent for Palliative Care/ CCU Program
G. DC4-732, Infirmary/Hospital Admission Nursing Evaluation
H. DC4-760E, Palliative Care Program Physician Referral Form
I. DC4-760F, Palliative Care Program Nurse Referral Form

J. DC4-760G, Inmate Assistant Roster
K. DC4-529, Staff Request/Referral

Health Services Director	Date
This Health Services Bulletin Supersedes:	TI dated 6/4/4 and 9/1/5. HSB 15.02.17 dated 8/17/2013 and 7/22/14