Management of Terminal Illness

724.1 PURPOSE:

To ensure the medical and mental health needs of a terminally ill youth booked into a Juvenile Detention and Assessment Center JDAC(s) and Treatment Facility (TF) are met through established clinical practice guidelines and community standards of care. The care shall be aimed at supporting continuity of specialty care, with dignity and respect for the youth's needs.

724.2 DEFINITIONS:

Hospice: A program which delivers medical and support services aimed at providing comfort for the individual youth who is terminally ill.

724.3 GUIDELINES:

A. At any time the medical care of the youth exceeds the level of care available within the JDACs and Treatment Facilities (TFs), every effort shall be made to commence a special MDT to discuss alternative housing and treatment options, such as alternative levels of care, which may include acute hospitalization, hospice services, and/or house arrest.

724.4 RESPONSIBILITIES:

I. Probation Officer and Transportation Officers:

A. Collaborate with the Supervising Correctional Nurse I/II to ensure continuity of care is met.

B. Ensure all recommendations of the Multidisciplinary Team (MDT) are followed should youth require alternative care and services.

II. Compliance Unit:

A. Complete appropriate section in the Accommodation Referral Form (Attachment A).

B. Participate in MDT process.

C. Collaborate with the Health Service Manager (HSM), Superintendent, Probation Officers, and schools in coordinating alternative care and services for youth.

III. FAST:

A. Meet with the youth to review any psychological issues related to terminal illness.

B. Attend MDT and provide any pertinent information regarding the youth's behavioral health issues.

C. Follow up on any behavior health issues discussed during MDT and document in the CE.

D. Document information and recommendations made at the end of the MDT in CE, no later than one (1) business meeting.

IV. Correctional Nurse I/II:

A. Complete an Accommodation Referral Form (Attachment A) once a youth is identified/diagnosed with a terminal illness.

B. Implement all physician orders, medical treatment plan directives, and appointments for youth.

C. Participate in the MDT process.

V. Supervising Correctional Nurse I/II:

A. Initiate a Medical Treatment Plan.

B. Participate in the MDT process.

VI. Health Services Manager (HSM):

A. Collaborate with the Chief Medical Officer, Supervising Correctional Nurse I/II, the youth's primary care provider, pediatrician, and/or consultant physician to ensure continuity of care is met.

B. Collaborate with the Supervising Correctional Nurse I/II and Superintendents in preparation of alternative housing services and care, such as: House arrest, acute hospitalization, or hospice care.

C. Initiate a special Multidisciplinary Team (MDT) meeting to discuss the medical and psychological care needs of the youth.

D. Initiate or facilitate the early release of terminally ill youth in a timely manner consistent with the laws of jurisdiction.

E. Provide the youth's parent(s)/guardian(s) sufficient and relevant information to make informed decisions, including the process for obtaining specialty/second opinion consultations.

VII. Chief Medical Officer:

A. Collaborate with the Health Services Manager and Supervising Correctional Nurse I/II when a youth has been identified with a confirmed diagnosis of terminal illness.

B. Collaborate with the youth's primary care provider, pediatrician, and/or consultant physician.

C. Ensure medical treatment and care is provided at a level consistent with community standard.

D. Ensure appropriate pain management is provided and documented in the Electronic Health Record (EHR).

724.5 ATTACHMENT:

See attachment: Management of Terminal Illness Attachment A (Lexipol 9-30-22).pdf

Attachments

Management of Terminal Illness Attachment A (Lexipol 9-30-22).pdf

ACCOMMODATION REFERRAL FORM

A REFERRAL SHALL BE COMPLETED FOR ANY YOUTH THAT MEETS THE FOLLOWING CRITERIA:
Any youth who has a record of or has a reported mental, physical or educational impairment/disability that substantially limits one or more major life activities (such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, etc.) or requesting an alternate meal plan.

FACILITY: ☐ HDJDAC ☐ CVJDAC ☐ GATEWAY to ARISE **DOE:** _____

YOUTH'S NAME: «Full Name» **PIN:** «PIN»

DOB: «Date of Birth»

****THIS SECTION TO BE COMPLETED BY PCO/PCSI****

I. IDENTIFICATION

1. ☐ **IEP/Special Education/Language Interpreter ONLY**
   - ☐ The youth/parent has indicated the existence of an IEP or current identification as a Special Education student.
   - ☐ Youth requires a language interpreter for basic communication.

   Language is: _____.

MUST distribute form to all:
1. Compliance Officer (email: [redacted])
2. SB County School (copy)
3. Unit/Youth's File (original, unless forwarding to Medical Services)

Date distributed (required): _____

2. ☐ **Disabilities, Deformities, Special Needs and/or a 504 plan**

   Reported/observed disability, deformity and/or special need: _____.

   Describe: _____.

MUST distribute form to all:
1. Medical Services (original)
2. FAST (copy)
3. SB County School (copy, for 504 plans ONLY)
4. Unit/Youth's File (Copy)

Date distributed (required): _____

3. ☐ **Alternate Meal Plan**
   - ☐ Youth is requesting a vegetarian alternate meal plan.
   - ☐ Youth is requesting a vegan alternate meal plan.

   Comments: _____.

**Forward to Medical Services for clearance prior to implementation **

PCO/PCSI Printed Name & Signature Date

****THIS SECTION TO BE COMPLETED BY MEDICAL SERVICES/FAST ONLY****

II. MEDICAL SERVICES/FAST EVALUATION

1. Disability, Deformity, Special Need and/or 504 plan: _____.
2. Describe how the disability affects a major life activity/activities of daily living: _____.
3. Describe the immediate reasonable accommodations, if known: _____.
4. Medically cleared for alternate meal plan: ☐ YES ☐ NO. Comment: _____.

MUST distribute form to all:
1. Compliance Officer ([redacted])
2. Medical Services (copy)
3. FAST (copy)
4. SB County Schools
5. Watch Commander/Name: _____
6. Place in health record (original)
7. Food Services (if applicable)

Date distributed: _____

Date accommodation documented on Health Kardex and CE: Special Instructions (special medical condition [M-MH5]) Date: _____

Medical/FAST Printed Name & Signature Date

ACCOMMODATION REFERRAL FORM

****THIS SECTION TO BE COMPLETED BY COMPLIANCE UNIT****

III. COMPLIANCE UNIT

YOUTH'S NAME: «Full Name» PIN: «PIN»

1. Referral received on: _____

2. Revised accommodation plan, if necessary: _____.

Completed/Updated referral form was forwarded//emailed to the following on: _____.

☐ Watch Commander/Name: _____ ☐ Unit (for placement in youth's file)

☐ Medical Services ☐ FAST ☐ Food Services ☐ SB County Schools

_____ _____

Compliance Officer Printed Name & Signature Date

IV. Additional Comments:

_____.