Supplemental Sample Policies

General Policies

I. Declaration of Brain Death

Policy

This policy establishes the criteria and procedure for the declaration of death on the basis of neurological criteria.

Definitions

Brain death: the irreversible cessation of all functions of the entire brain, including the brainstem.

Appropriate period of observation: the minimum amount of time that must pass between the performance of the initial examination to determine whether brain death has occurred and the second examination (if a second exam is required).

Examining physician: the physician who performs a clinical brain death examination and meets the qualifying criteria. The term "examining physician" may refer to one or more physicians involved in the clinical brain death examination.

Apnea: the absence of respiration and a terminal PCO2 greater than 60 mmHG or a terminal PCO2 at least 20mmHG over the initial normal baseline PCO2.

Requirements for Physicians Authorized to Declare Death on the Basis of Neurological Criteria

A physician performing a clinical brain death examination shall be a plenary licensed physician and shall hold the following qualifications, depending on the age of the patient for whom a declaration of brain death is being assessed:

Age of Patient:	Physician Qualifications:
Between 7 days and 2 months old	Specialist in neonatology, pediatric neurology, or pediatric neurosurgery
Between 2 months and 12 months old	Specialist in pediatric critical care, pediatric neurology, or pediatric neurosurgery
Over 12 months old	Neurologist, neurosurgeon, critical care specialist, trauma surgeon; or any physician who has been granted privileges by the hospital to perform a brain death evaluation.

Procedure

A person may be pronounced dead if a physician meeting the requirements determines, in accordance with the criteria set forth in this section, that brain death has occurred.

The examining physician who is to pronounce brain death shall do the following:

1. Determine, based on history and clinical findings, a reasonable basis to suspect that brain death has occurred. Brain death may be suspected when the etiology of the insult or injury is

sufficient to cause brain death and, in the judgment of examining physician, the neurological damage is irreversible:

2. Exclude complicating medical conditions that may confound the clinical assessment of brain death.
3. Perform a clinical examination to evaluate the patient for a determination of brain death. The following clinical findings, if present, are indicative of brain death:
   - a determination that supraspinal motor response(s) to pain is or are absent;
   - a determination that brainstem reflexes are absent.
   - the presence of apnea.
   - When, in the judgment of the examining physician, a clinical examination cannot be performed because of the nature of injuries, intoxication, patient instability, electrolyte imbalances or other reason, a confirmatory test, such as an intracranial blood flow, four-vessel cerebral angiography, radionuclide angiography, transcranial Doppler ultrasound, CT angiogram, or MR angiogram, shall be substituted for the clinical examination, and the diagnosis shall be established by a confirmatory test or by a repeat clinical examination.
4. If the individual to be declared brain dead upon the basis of neurological criteria is or may be an organ donor, neither the examining physician nor the corroborating physician shall have any responsibility for any contemplated recovery or transplant of that individual's organs, including, but not limited to, being the organ transplant surgeon, the attending physician of the organ recipient, or in any other way an individual subject to a potentially significant conflict of interest relating to procedure for organ procedures.
5. Death shall not be declared based on neurological criteria if either the examining physician or the corroborating physician has any reason to believe, on the basis of information in the

individual's available medical records or provided by a member of the patient's family or any other person knowledgeable about the patient's personal religious beliefs, that such a declaration would violate the personal religious beliefs of the patient. In these cases, death shall be declared and the time of death fixed solely upon the basis of cardio-respiratory criteria.

6. If the family, healthcare agent, or other authorized surrogate objects to the declaration of death based on neurological criteria, reasonable accommodations shall be made while the family or surrogates are helped to accept the finality of the death. These accommodations include but are not limited to continued mechanical organ supports for a limited time, pastoral care intervention, clinical ethics consultation, and other forms of assistance the care team considers appropriate. Likewise, if the family or surrogates requests that mechanical supports continue while immediate family travels to the hospital, that accommodation shall be considered and, if possible, extended by the care team for a reasonable time. In both instances, the family and surrogates shall be told explicitly that temporarily continuing the mechanical supports is <u>for the benefit of the family, not because it will change the patient's condition</u>.
7. If, after reasonable accommodations have been made, the family is still unable to accept the determination of death according to neurological criteria, the attending physician shall refer this matter to the Director of Bioethics for review. The Director of Bioethics shall convene a subcommittee of the Biomedical Ethics Committee, consisting of three to five members. The Director of Bioethics and the subcommittee shall meet with the physicians and the family/surrogate shall be invited to participate. In addition, the family/surrogate shall be offered the opportunity to meet with the full Biomedical Ethics Committee.

The Biomedical Ethics Subcommittee and, when requested by the family, the Biomedical Ethics Committee shall consider the relevant facts of the case, the family's concerns, and determine the reasonable accommodations that can be made in the context of professional practice and standard of care. The Director of Bioethics shall notify Chief Medical Officer and General Counsel and the attending physician of its determination. The Director of Bioethics shall present the Committee's determination to the family/surrogate, explaining that it represents the position of the Medical Center.

8. The examining physician shall document in the patient record the results of all tests performed.

II. Donation after Cardiac Death

Background

Most deaths are declared by an absence of cardio-respiratory function. As a unifying concept, all deaths occur when there is a permanent loss of the entire brain function. Thus, if there is no circulation to the brain for a sustained period, injury to the brain is permanent. The absence of a heartbeat during that period can be simultaneously used to declare death by cardiovascular criteria, but it is also as a sign that there is no blood flow to the brain.

The Medical Center strives to provide an ethically justifiable policy and procedure that respect the rights of patients to have unwanted life-supporting measures discontinued and to donate organs upon their death, known as donation after cardiac death (DCD). When patients or their surrogates (within certain parameters) decide to forgo life-sustaining treatment, these guidelines authorize a care plan that forgoes unwanted interventions and focuses on comfort measures.

All capable adult patients have the right to elect organ donation in the event of death. While the vast majority of organ donors have been persons declared dead according to neurological criteria, it is ethically appropriate to allow patients who die after withdrawal of unwanted life support to proceed with organ donation, even though such donation will necessitate declaration of death based on cardio-pulmonary rather than neurological criteria.

Purpose

The purpose of this policy is to outline the steps necessary to ensure that all patients or their surrogates are able exercise the right to discontinue unwanted life-supporting interventions and proceed with organ donation following death, declared on the basis of cardio-pulmonary criteria.

Principles

1. All capable adults have the right to make informed choices regarding their medical treatment. This right remains, even when a patient no longer has decision-making capacity. Thus, capable patients, appointed healthcare agents, or other surrogates authorized to make treatment decisions on behalf of incapacitated patients have the ethical and legal right to

a) forgo unwanted life-sustaining medical treatment, and/or.

b) consent to donate the patients' organs and/or tissues following death.

2. Forgoing unwanted life-sustaining treatment and donating organs and/or tissue are independent decisions and shall be considered and implemented entirely separately. Accordingly, the decision to discontinue unwanted life-sustaining treatment shall be made independent of and prior to any consideration of the patient's donor status.

3. Appropriate candidates for organ donation shall be limited to those patients on life-sustaining treatment for whom withdrawal of that therapy is likely to result in death within a short period of time (e.g., patients who are ventilator-dependent).

4. While the withdrawal of unwanted life-sustaining treatment and the recovery of organs and/or tissue are entirely separate functions, both shall be carried out with scrupulous attention to the comfort and dignity of the patient.

5. The withdrawal of life-sustaining treatment and declaration of death shall be performed by an attending physician with critical care privileges.

6. Healthcare professionals involved in the patient's care must not be involved in the process of organ recovery. The sole responsibility of clinical professionals is to optimize the patient's care. When the decision has been made to discontinue unwanted life-sustaining treatment, the process shall be done in a manner that demonstrates respect for the patient's autonomous choice and promotes patient comfort. An important objective of this policy is that the interest in recovering organs shall not influence or interfere with optimal patient care.

7. Ensuring patient comfort is the clinical and ethical justification for using medications and dosage shall be carefully titrated accordingly. With the consent of a capable patient or the surrogate(s) of an incapacitated patient, other medications, which may enhance organ viability, shall be given. This policy explicitly prohibits any intervention intended to shorten the patient's life.

8. Healthcare professionals shall not be required to participate in the procedures described herein if such participation would conflict with their personal, ethical or religious convictions A physician with critical care privileges who is unable to participate in DCD because it would

violate personal, ethical or religious convictions is responsible for making that conflict known in advance, identifying another physician with critical care privileges capable of and willing to assume responsibility for performing the DCD functions, and effecting a timely transfer of the patient's care to that critical care physician.

9. Any member of the healthcare team who perceives ethical conflict regarding either discontinuing unwanted life-sustaining treatment or recovery of organs and/or tissues is encouraged to request a clinical ethics consultation by contacting the Director of Bioethics.

Procedure for Inpatients

A DNR order must be entered in the medical record and the decision to forgo unwanted life-sustaining treatment must be documented in the medical record. Discussions with the capable patient or authorized surrogate that led to these decisions must be documented in the medical record:

a) Only after the decision to discontinue unwanted life-sustaining treatment has been made and documented shall the Organ Sharing Network be notified about a potential DCD donor.
b) If the patient or surrogate initiates the discussion of potential organ and/or tissue donation, the patient's physician or designee shall ensure that the Organ Sharing Network is notified to assess medical suitability prior to cessation of mechanical ventilation.
c) Organ recovery may proceed only if the capable patient has previously indicated intention to be an organ donor (e.g., declaration on a driver's license); or the capable

patient or authorized surrogate consents to organ recovery upon death of the patient and signs the appropriate consent forms.

d) During discussion about organ recovery, the patient or surrogate must be explicitly advised that additional medications may be given to the patient, with the intention of enhancing organ viability and improving organ function in transplant recipients.

Verification and Certification of Death by Cardio-respiratory Criteria

1) The physician certifying death must not be involved either in recovering organs or the care of any of the transplant recipients. Completion of the death certificate and death summary in the medical record are the responsibility of the attending physician or the designee.

2) The surgical team responsible for organ recovery shall in no way participate in the weaning process or in the donor's care.

3) No organs may be recovered until death has been certified. To keep warm ischemia time to a minimum, all other appropriate preparations for the recovery operation (such as cleansing of the skin, draping of the field and cannulation of the artery and vein) may take place prior to death (with appropriate consent). No incision shall be made until the patient has been pronounced dead.

4) Because of obvious concerns regarding conflict of interest, the criteria to be used in this policy are, therefore, more stringent than the standard clinical practice for declaring death in other patients who are designated "DNR," but who are not candidates for organ donation. Clinical definitions of cardiac arrest, such as the absence of a palpable pulse in a large artery (i.e., the

carotid, femoral or brachial artery); do not suffice for this application. The absence of a clinical palpable pulse does not necessarily mean cessation of mechanical activity of the heart.

5) The diagnosis of death by traditional cardio-pulmonary criteria requires confirmation of correct EKG lead placement and confirmation of absent pulse via a femoral artery catheter. The pulse pressure must be zero or by definition, the heart is beating. In addition to pulselessness, the patient must be apneic and unresponsive to verbal stimuli.

a) Given the above, any one of the following electrocardiographic criteria shall be sufficient for certification of death:

- five minutes of ventricular fibrillation;
- five minutes of electrical asystole (i.e., agonal baseline drift only); or
- five minutes of electromechanical dissociation.

Review

All cases shall be reviewed in a timely basis by a committee composed of the co-chair of the Biomedical Ethics Committee (or designee), the Administrator of Peri-operative Services, and representatives from the ICU, Social Services, and Pastoral Care). The purpose of this review is to

- ensure adherence to the above principles and compliance with the above procedures;
- identify problems and complications, potential or actual, and recommend changes intended to correct or prevent them; and
- protect the interests of the donor, recipients, the institution, and involved healthcare professionals.

III. Managing Requests for Treatment Judged to be Medically Futile or Harmful

General

Purpose

To provide a procedure to guide physicians, nurses, and other healthcare professionals in managing requests for treatment considered either medically futile or harmful to the patient. These requests should be addressed by confirming the futile and/or harmful nature of the treatment and making repeated efforts to reach consensus with the requesting patient, family or other surrogates. Ultimately, requests for such treatments may and should be refused by the attending physician. Care professionals have no ethical obligation to attempt a life-sustaining treatment that is deemed to be futile or harmful, even if the treatment is requested by the patient, family or other surrogate decision maker. To force physicians to provide medical treatments that are clearly futile or harmful would violate their ethical obligations to their patients and undermine the ethical integrity of the medical profession.

Policy

It is the goal of the Medical Center to improve patients' prognoses, well-being, and general state of health. That goal does not include needlessly prolong suffering or the dying process when the patient is in the terminal phase of a disease or injury.

The Medical Center respects the patients' rights to consent to or refuse any medical or surgical treatment, including the withholding or withdrawing of life-sustaining treatment under legally prescribed circumstances. While respect for patient autonomy is a fundamental ethical principle of the practice of medicine, it is not absolute. There may be circumstances in which physicians' clinical judgment takes precedence over the preferences of the patient, family or other surrogate decision maker. Therefore, requests for treatment that is medically futile or harmful may and

should be refused by the physician. Refusal of the requested care shall in no way represent abandonment of the patient.

Definitions

Medically Futile Treatments

Treatments that offer no reasonable possibility of a meaningful extension of life or improvement of the patient's quality of life, or other significant benefit for the patient.

Medically Harmful Treatments

Treatments that are reasonably expected to produce significant suffering or other burdens for the patient, and offer no reasonable possibility of any compensating benefit sufficient to justify the suffering or other burdens.

Decision-Making Capacity

Decision-making capacity is a patient's ability to understand and appreciate the nature and consequences of healthcare decisions, including the benefits and risks of each, and alternatives to any proposed care, and to reach an informed decision. A patient's decision-making capacity is evaluated relative to the demands of a particular health care decision.

Comfort and Supportive Care

Treatment, even that which is aggressive in nature, should provide for the physical and psychological comfort of the patient.

Procedure

1. ***Determination of medical futility*** can be made at any point. A DNR order or an order to forgo life-extending treatment should be addressed with sensitivity to the patient, family, surrogate[1] and healthcare team. Comfort and supportive care measures, which include the provision of

medication for symptom management and appropriate nursing care, shall be provided to every patient throughout the therapeutic continuum.

2. In discussion with or about all patients, the attending physician shall elicit the following from the patient/family/surrogate the patient's values, goals and preferences:

a) as expressed directly by the patient verbally or in the form of an advance directive; or

b) as accurately as can be determined from what the patient has stated in the past about the present or similar conditions; or

c) as deduced from the patient's lifelong pattern of conduct, decision making, religious beliefs or moral convictions.

These factors should be discussed in the context of the present clinical condition. It is recommended that the above communication efforts take place as follows:

a) If the patient exhibits decision-making capacity, discussion should take place at the bedside with the patient and involved family members; or

b) If the patient lacks decision-making capacity, discussion should take place in the form of a meeting with the family and/or surrogate in a private location.

3. During the discussion with the patient/family/surrogate, an attempt shall be made to arrive at a consensus regarding whether a treatment is judged to be medically futile or harmful and, therefore, shall not be provided. The attending physician shall identify and clarify issues that are in dispute or not fully understood by the patient/family/surrogate and attempt to resolve any areas of conflict between the physician's judgment, recommendation and goals, and the patient's/ family's/surrogate's values, goals and preferences.

4. If consensus has not been reached regarding treatment that is judged futile or harmful, the Department Chair shall be notified immediately by the physician and a second medical opinion

shall be obtained from an attending physician chosen by the appropriate Department Chair. If the patient/family/surrogate requests an outside physician, with appropriate expertise, to review the case, the Medical Center shall make reasonable efforts to facilitate such a review.

If the second opinion differs (i.e., does not concur that the requested treatment would be futile or harmful), the attending physician shall

- arrange to transfer the patient's care to another physician with the assistance of the Department Chair and Chief Medical officer, if needed~~;~~ or
- request a review by the Biomedical Ethics Committee or a subcommittee.

5. If the second physician concurs with the attending that the requested treatment(s) would be futile or harmful, but the patient/family/surrogate persists in the request, the attending physician shall refer this matter to the Director of Bioethics for review. The Director of Bioethics shall select a subcommittee of the Biomedical Ethics Committee, consisting of one to three members with relevant clinical expertise. The Director of Bioethics and the subcommittee shall meet with the physicians and the patient/family/surrogate. The Biomedical Ethics Committee shall arrive at its own conclusion about whether the requested treatment is futile or harmful, document its judgment in the medical record, and fully discuss its determination with the patient/family/surrogate, Chief Medical Officer and General Counsel and the attending physician.

6. If at any time a consensus with the family is reached that the requested treatment would be futile or harmful according to the definitions set forth in these guidelines, a DNR order may be entered on the chart and/or the treatment judged to be medically futile or harmful shall not be performed by the attending physician.

7. If the determination of the Biomedical Ethics Committee supports the decision of futility but consensus with the patient/family/surrogate is not reached, and the attending physician is unable to find another physician and/or facility willing to provide the requested care, the attending physician shall inform the family that it may seek legal intervention during the next three (3) business days, after which time, the attending physician may place a DNR order on the chart and/or decline the request for treatment judged to be medically futile or harmful, ensuring that the entire above process has been thoroughly documented in the patient's medical records.

Specialized Policies

I. Advance Directives and POLST in Nursing Home

Policy

The Nursing Home supports the rights of a resident to prepare Advance Directives expressing their wishes or designating another person to make treatment decisions for them, if the resident becomes incapable of communicating his/her wishes and choices directly. This includes the right to accept or refuse life-prolonging measures and other treatments.

Upon admission, residents are provided information regarding their rights under State law regarding health care decision making as well as organ donation. The Home staff offers assistance to residents wishing to exercise this right and provides ongoing opportunities for discussion of advance care planning. Advance Directives are reviewed, during initial and quarterly care plan meetings, and residents without Advance Directives are offered the opportunity to meet and discuss Advance Directives with their social worker and/or treatment

team. Advance Directives and signed acknowledgement that such information has been received is noted in the medical record. While the Nursing Home believes it is in the best interest of residents to prepare Advance Directive statements, the Home does not require such declarations be presented to the facility as a condition of admission.

Within the boundary of applicable laws, regulations and policies, staff members will honor resident wishes regarding use of life-prolonging measures and other health care treatment, in accordance with the Advance Directive's instruction.

Procedure

1. Prior to or upon Admission to the Home, a representative of the Social Services/Admissions department will ask the resident/representative about the existence of any advance directives, including the POLST form.
2. If the resident has an Advance Directive, it will be submitted upon admission and will become a part of the resident's medical record.
3. If the resident does not have an Advance Directive, a representative of the social services department will provide the resident/representative with information about Advance Directive, including the POLST form, if appropriate.
4. An acknowledgement of receipt of this information, signed by the resident or representative, will be placed in paper medical record. Notation regarding the presence of advance directives will be placed in Advance Directive section of paper medical record and in the EMR.

5. Advance Directives, including the POLST form, are reviewed during initial care plan and ongoing care plan meetings.
6. Advance Directives are defined as preferences or medical orders regarding treatment options and can include: Living Will/Instructive Directive, Health Care Proxy, Combined Directive, Do Not Resuscitate. In addition, there are the following:
    - **Do Not Hospitalize**—A medical order written by the physician which states that the resident is NOT to be hospitalized, even if s/he has a medical condition that may normally require hospitalization.
    - **POLST** (Practitioner Orders for Life Sustaining Treatment)—A medical order signed by the physician that provides instructions for a range of life-prolonging interventions based on the patients/representatives goals of care.
    - **Feeding Restrictions**—Indicates that the resident, legal guardian, health care proxy or representative does NOT wish for the resident to be fed by artificial means if s/he isn't able to be nourished by oral means.
    - **Medication Restrictions**—Indicates that the resident, legal guardian, health care proxy or representative does NOT wish for the resident to receive life-sustaining medications.
    - **Other Treatment Restrictions**—Indicates that the resident, legal guardian, health care proxy or representative does NOT wish for the resident to receive certain medical treatments, such as: blood transfusions, tracheotomy, respiratory intubation, etc.

7. In the absence of an advance directive, a social worker, physician, and/or mental health professional, will assess the resident's capacity for decision making and proceed accordingly.

If the resident cannot provide informed consent for medical treatment, the Nursing Home will initiate the procedure with the responsible party and physician to determine a health care decision maker.

POLST Specific Protocol

1. If the POLST conflicts with the resident's previously expressed health care instructions or advance directive, then—to the extent of the conflict—the most recent expression of the resident's wishes governs.
2. If the individual, or when the individual lacks decision-making capacity, the legally recognized health care decision-maker, expresses concern about the POLST form, or if there has been a significant change in the individual's conditions or wishes, then the physician/advanced practice nurse will be notified by social services to discuss the potential changes with the individual or, if the individual lacks decision making capacity, the legally recognized decision maker.
3. At any time, an individual with decision-making capacity can revoke the POLST form or change his/her mind about his/her treatment preferences by executing a written advance directive or, after consultation with their physician/advanced practice nurse, a new POLST. The new POLST form must be signed by the physician/advanced practice nurse and the individual, and the revoked POLST must be voided. If the individual decides to revoke the POLST form, their physician/advanced practice nurse will be notified by social services and appropriate changes to the physician/advanced practice nurse's orders

will be obtained as soon as possible to ensure that the individual's wishes are accurately reflected in the plan of care.

II. Ethics Case Consultations in Hospice

Purpose

To identify the processes by which a case consultation may be requested, implemented, documented and reported. Consultations regarding issues other than those raised in the course of care of specific patients—"non-case consultations"—are addressed in a separate procedures document.

Procedure

1. Types of Ethics Case Consultations: There are two types of ethics case consultations: FHCDA and Standard. A FHCDA Ethics Consultation shall be done in accordance with, and as required by, the Family Health Care Decision Act ("**FHCDA**") and relates to Surrogates (as defined in "Identifying a Surrogate" Policy), or physicians, as the case may be, making health care decisions on behalf of a patient who lacks capacity. The FHCDA applies when (a) a patient lacks capacity and (b) the patient has not formally appointed a Health Care Agent or have an Article 81 guardian appointed under the Mental Hygiene Law. A Standard Ethics Consultation shall be done any other time an ethical issue arises and any individual requests an ethics consultation. Both the FCHDA Ethics Consultation and the Standard Ethics Consultation shall be referred to together in this Policy as a "**Consult**."

2. FHCDA Ethics Consultation Committee Composition: For a FHCDA Consultation, the Ethics Review Committee (the "**Committee**") shall be comprised of at least five (5) members, each of whom has a demonstrated interest in the medical, public health and social needs of those who are ill. The Committee must include at least one (1) member who is a physician, one (1) member who is a registered nurse, and one (1) member who is a Health or Social Services Practitioner. Of the two (2) remaining members, at least one (1) member must be a person who is entirely independent of the Hospice, meaning that he/she does not have any governance, employment or contractual relationship with the Hospice.

   If a Committee member is connected with the case, this member may not participate in the Committee's consideration of that case in the role of Committee member; and another person who fills that membership requirement shall be appointed to the Committee for such case (e.g., if the physician on the Committee is connected with the case, then another physician not connected with the case will need to be appointed). A Committee member who is "connected" with the case is a Committee member who is (a) also a family member of the patient, or (b) also an attending physician or health or social service practitioner who has been directly involved in the patient's care on an ongoing basis, or (c) also has a relationship with the patient and/or patient's family which may present a conflict of interest, as determined by the Chair.

3. Access: Any employee, patient, family member, Surrogate, Health Care Agent, Guardian or contracted service provider may request a Consult. A person connected with the case, even if this person is usually a Committee member, may still request a Consult and present his or her views during the Consult in the role of clinician. Description of the

consult process, including instructions for initiating a Consult, shall be widely distributed, and will be included in patient admission packets, new employee orientation, and the online policies and procedures available to all Hospice employees via the Intranet.

4. Availability: Consults shall be available during normal business hours and efforts shall be made to request a Consult as soon as ethical issues become apparent, certainly before the ethical issue(s) become urgent. In the rare circumstance when an emergency Consult is required outside of normal business hours, the Consult can be initiated through the on-call administrator, who will call a Chair, if appropriate.
5. Purpose: The goals of Consults may vary widely and will relate specifically to the reason(s) for which Consults were requested. Broadly, the goals of an ethics consultation are to identify, analyze, and resolve ethical questions or concerns in a safe and respectful atmosphere with attention to the interests, rights, and responsibilities of all those involved. Consults may result in agreement upon a specific, principled resolution to the ethical question, or may define a range of ethically acceptable actions.

   A consult is intended to provide a forum in which all parties involved can

a. express their expectations, hopes and concerns as they relate to the proposed care or actual care or services being provided to the patient;
b. identify the core ethical values informing those expectations, hopes and concerns;
c. explore ways in which such expectations, hopes and concerns are reflected in the current goals of care and care plan for the patient;
d. if conflict is present, explore and identify the possible sources of conflict;
e. identify and evaluate options for proceeding, informed by the (i) the goals of the patient's care; (ii) the patient's preferences, if known, or the patient's best interest, if his/her

preferences are not known; (iii) the mission and values of Hospice, and (iv) norms and standards drawn from the healthcare ethics literature;

f. articulate any recommendations resulting from (a)–(e) above.

6. Initiation: A Consult is initiated by contacting one of the chairs of the ethics committee (each a "**Chair**").

7. Background work: Upon accepting the request for Consult, the Chair or his/her designee will request additional information and documentation from the requester and, as appropriate, other relevant parties to develop an ethics history underlying the request for the Consult, including, but not limited to, the following:

   a. brief history of the patient's condition, prognosis, and time on service with Hospice;

   b. (If patient has capacity) discussion with the patient regarding decision making capacity, the patient's preferences relevant to the Consult, the patient's preferred proxy decision maker(s) should capacity diminish;

   c. (If patient lacks capacity) confirmation and documentation of the patient's lack of decisional capacity, review of the most recent advance directive (if present), determination of whether there is a Surrogate under the FHCDA or an informal patient declaration;

   d. as applicable, confirmation of Agent/Surrogate's understanding of the Agent/Surrogate responsibilities, and willingness to, serve in that capacity;

   e. discussion with the patient's nurse case manager, attending physician, social worker, chaplain, and others, as appropriate, regarding pertinent ethical issue(s) of concern and assessment of the current situation;

f. identification of, and discussions with, other relevant persons involved in the case, e.g., other family members, care providers;

g. identification and review of relevant hospice policies and procedures related to ethical issue(s) of concern; and

h. identification and review of relevant resources in the health care ethics literature related to issue(s) of concern.

8. Consultation Meeting: Scheduling and Invitation:

a. The patient (if decisionally capable), core members (nurse, physician, social worker, chaplain) of the patient's care team, Agent/Surrogate and others involved with the patient's care should be informed that a Consult has been requested and is underway.

b. Following completion of the background work noted above, the Chair or his/her designee will arrange for the Consult meeting to occur at a time convenient to as many Interested parties as possible.

c. The Committee aims to be as inclusive as possible, and unless good cause exists, the capable patient and his/her family members who are actively involved with the patient's care should be invited to any Consult about the patient.

d. An invitation to participate in the Consult shall be provided to all Interested parties; however, consent of the patient, family or any designated representative is not required for a Consult to take place.

9. Consult Meeting Process:

a. The consultation should be facilitated by a Chair or his/her designee in such a manner as is consistent with the relevant literature on ethics case consultation. At a minimum, facilitation should strive to

i. explain the purpose, goals and format of an ethics consultation;

ii. ensure that all parties are afforded an opportunity participate in the consultation;

iii. prevent any party from dominating, being disrespectful, or acting in a manner not conducive to achieving the goals of consultation;

10. Documentation: Each Consult shall be documented shall be in accordance with the following:

a. A Chair or his/her designee shall complete the Ethics Consultation Form and place the completed form, along with any supporting documentation, in secure location determined appropriate by the Chair. Documentation of Consults shall be kept confidential.

b. For Consults regarding a patient who is currently on service, the Ethics Consultation Form shall be placed in the patient's medical records. This entry should include, at a minimum, the following information:

i. the date of the consult,

ii. the reason for the consult ;

iii. the person(s) involved in the consult, their titles and relationship to the patient, if any,

iv. a summary of the patient's diagnosis;

v. an analysis of the ethical issues, which informs any recommendations or follow-ups, if any;

vi. a summary of the materials reviewed in making the recommendations;

vii. actual recommendation and follow-up if any; and

viii. the signature, title and contact information of the person entering this information.

11. Follow-up. Until such time as the Committee develops or adopts a standard instrument to assess consult quality, Committee co-chairs shall follow-up with all interested parties and participants in the consult process within 14 days of the Consult to solicit their feedback on the effectiveness of the consult process. "**Effectiveness**" shall include, but not be limited to, participants' views on (a) the extent to which the consult process successfully achieved the goals set out in paragraph 5 above; (b) the ease and efficiency of initiating the consult process; (c) the accuracy and integration of background work as described in paragraph 7 above; other elements of participants' experience deemed relevant by either Chair.
12. Confidentiality. All exchanges of information and correspondence regarding the deliberations of a Consult and all records or reports created, reviewed or maintained for purposes of a Consult shall be confidential and shall not be disclosed, except as expressly required by law.

III. Responding to a Patient's Desire to Voluntarily Stop Eating and Drinking (VSED) in Hospice

Purpose

The Hospice & Palliative Care Agency recognizes the right of patients with decision-making capacity to exercise their autonomy by making decisions regarding their health care at the end of life, including decisions to voluntarily stop eating and drinking (VSED). This policy and procedure provides guidelines on how to respond to a patient who expresses a desire to VSED.

Policy

It is central to the philosophy of Hospice that its staff shall identify, assess, and respond to each patient's suffering and symptom distress in a manner consistent with the patient's wishes and best practice standards. If death is not imminent from an underlying terminal condition, VSED can hasten the end of life. For this reason, some patients may verbalize a desire to VSED with the intent to hasten their death. A choice to voluntarily stop eating and drinking is a patient-centered decision that is legally and ethically distinct from assisted suicide and euthanasia. Because this action is considered to fall within the well-settled right of capable patients to refuse any unwanted intervention, VSED is an ethical and legal option in all states. In cases where patients with decision-making capacity clearly express their wish to engage the VSED process, the Hospice staff shall provide continued care and support to such patients and their families.

Definition: VSED is the decision by a patient to voluntarily stop eating food and drinking liquids so that death can be hastened and is distinct from (1) a natural reduction in the patient's appetite and interest in food or water that occurs as death becomes imminent, and (2) the refusal of artificial hydration and nutrition. An alternate definition is that VSED is a situation in which "a patient who is otherwise physically capable of taking nourishment makes an active decision to discontinue all oral intake and then is 'allowed to die' gradually, primarily of dehydration or some intervening complication" (Quill, Lo and Brock, 1997).

Oral intake of food and/or liquids is not considered a life-sustaining treatment under applicable laws, and, therefore, a decision to VSED is not considered a decision to withdraw or withhold life-sustaining treatment.

Procedure

1. Once a patient has expressed his/her desire to VSED, the patient's desire, and reasons for that desire, should be explored by the interdisciplinary team (IDT). For patients whose insufficiently relieved suffering or symptom distress are contributing to the request for VSED, members of the IDT should ensure that all reasonable efforts to alleviate physical, spiritual or emotional suffering have been offered to the patient, and that attempts to address such distress and suffering have been documented.
2. A patient's decision-making capacity should be assessed and documented.
3. At a minimum, a clinician from each of the core hospice care disciplines should participate in this discussion and review, and consider the following:
    a. whether the patient has decision-making capacity, as assessed in (2) above;
    b. whether the patient's desires are *rational*;
        i. A rational desire to voluntarily hasten death by stopping eating and drinking is defined as follows:
            1. the patient has a realistic assessment of his/her health status and prognosis, and an accurate understanding of the likely outcome of engaging in VSED;
            2. the cognitive process leading to the decision is unimpaired by mental illness, severe and reversible emotional distress, or delirium; and
            3. the motivational basis of his/her decision would be understandable to the majority of uninvolved observers from his/her community or social group. (Note: "understandable" means "able to be *comprehend*," and does not imply or require that such observers would *agree* with such a decision.)

c. whether the patient's choice is *voluntary*;

i. To determine whether a decision is voluntary, the following factors should be considered:

1. The patient's choice is not made subject to (a) coercion from third parties or (b) lack of disclosure or understanding of relevant information.

2. Best efforts have been made to control pain and/or suffering so that the patient is not experiencing duress.

3. Where possible, the patient is able to explain the reasons for his or her choice and how the choice is consistent with those reasons.

d. whether there is documentation of the patient's wishes regarding life-sustaining treatment and other related decisions. If there is no documentation, the patient's wishes shall be explored and documented before the patient loses capacity to make and articulate those decisions as part of the VSED process;

e. whether psychosocial and spiritual interventions, as assessed and identified by the social worker and spiritual counselor, have been explained and offered to the patient; and

f. whether the patient's support system, (i.e., the patient's involved family, friends, health care agent or surrogate, family employed substitute, and/or home health aide ("Support System"), if any, has been fully engaged in the patient's care to the extent practicable and permitted by the patient, and understands (with the patient's permission) the patient's decision and its likely outcome.

4. The patient and the Support System should be informed about what to expect as the patient continues through the process of stopping all oral intake and how changes in the process

(e.g., the patient choosing to occasionally eat or take sips of water) may alter the patient's experience and prognosis.

5. The willingness of the patient's Support System to support the patient through the VSED process should be assessed, confirmed, and documented. The Support System does not need to agree with the patient's decision but should remain informed, subject to the consent of the patient to do so. If the Support System interferes with the patient's execution of his or her wishes, the IDT should discuss promptly referring the matter to the Ethics Committee.

6. As loss of decision-making capacity is an expected part of the VSED process, a plan for healthcare decisions once the patient loses decision-making capacity should be agreed upon by the patient and health care agent or surrogate, and the plan should be thoroughly documented in the patient's medical record. Patients should be encouraged to discuss their preferences with their health care agent or surrogate. If the patient's wishes regarding VSED deviate significantly from wishes expressed in an earlier advance directive, patients should be encouraged to complete a new advance directive, subject to the provisions of applicable state law.

7. Note that **the *expressed care wishes of a capable patient survive the loss of capacity and must be honored by caregivers***. This means that, after the patient has lost decision-making capacity and the health care agent or surrogate assumes decision making on behalf of the patient, a prior decision by the patient when capable, including the withdrawing or withholding of life-sustaining treatment, which was expressed to a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or licensed clinical social worker in the presence of another witness, ***must be honored*** *by the attending*

physician. The physician shall record the patient's prior decision in the patient's medical record and his/her reliance on that prior decision. The physician shall make diligent efforts to notify the Surrogate prior to implementing any decision and document such attempts in the record.

8. Patients shall be encouraged to sign a DNR order before beginning VSED, following a discussion about the reasons why the order is recommended.
9. The Hospice staff shall provide appropriate support and symptom management for the patient and his/her family once the patient has decided to begin VSED. This includes providing palliation for any symptoms associated with the cessation of eating and drinking, as well as providing ongoing emotional and spiritual support to the patient and the family.
10. If, after a patient has begun VSED, the patient requests food or drink, then food or drink should be offered. If the patient continues to request food or drink, then the nurse should meet with the patient to discuss whether the patient wants to continue with his/her decision. If the patient does not want to continue with VSED, the overall plan must be reevaluated. Regardless of whether the patient continues to have decision-making capacity, the IDT team shall honor the patient's request to resume eating and drinking.
11. The Hospice care shall offer bereavement support and services to the family after the death of the patient.

No Hospice staff member shall be required to provide any care or treatment that violates his or her fundamental moral precepts. Because Hospice staff must not abandon patients who VSED, staff who are not comfortable with a patient's decision must ensure a prompt and orderly transfer of the patient to another staff member who is willing to continue providing care for the patient and family.

Reference: Quill T.E., Lo B., Brock D.W. (1997). Palliative options of last resort: A comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted suicide, and voluntary active euthanasia. *JAMA* 278:2099-2104, 2099.

IV. Informed Consent in Psychiatric Facility

Policy

The Psychiatric Center patients/designees participate in treatment decisions and interventions with the professional staff to the fullest extent possible. It is incumbent upon physicians, nurses, and other professional staff to educate patients as to the benefits and risks of all proposed treatment and to obtain their informed consent to such treatment whenever possible, and as specified below. Relatives may be included in decision making with the permission of the patient.

I. CARE AND TREATMENT: RIGHT TO OBJECT AND APPEAL

All patients may object to any form of care and treatment and may appeal decisions with which they disagree.

1. EMERGENCY TREATMENT

Emergency treatment may be given to any patient, despite objection, in cases where the treatment appears necessary to avoid serious harm to life or limb of the patient.

2. PATIENTS ON VOLUNTARY OR INFORMAL STATUS

Patients who are on voluntary or informal status may not be given treatment over their objection. When any such patient objects to all recommended forms of treatment, the facility director, may, after notification to the patient, discharge the

patient with recommendations for outpatient care if indicated, or, if appropriate, take steps to convert the patient to involuntary status as described in the Mental Hygiene Law.

3. PATIENTS ON INVOLUNTARY STATUS

Patients who are on involuntary status may be given treatment over their objection provided the court has authorized treatment over the patient's objection.

4. OBJECTIONS BASED ON RELIGIOUS BELIEF

If a patient's objection to treatment is based on an assertion that the treatment is in conflict with a religious belief of the patient, treatment will proceed only if authorized by court. Such court order should be obtained through established procedures.

5. PATIENT REPRESENTATION IN THE OBJECTION PROCESS

Patients have the right to request legal counsel or other concerned person to represent them in the formal appeal procedures.

II. SPECIFIC SITUATIONS INVOLVING INFORMED CONSENT

1. EXPERIMENTAL RESEARCH MEDICATIONS

Informed consent for research drugs must be documented.

2. DIAGNOSTIC RADIOLOGY

Informed consent is obtained for diagnostic radiology procedures requiring contrast media (even though such diagnostic studies are performed at outside facilities). Such consent should be documented in medical record.

3. EMERGENCY MEDICAL TREATMENT

In accordance with Mental Hygiene Law, the Psychiatric Center may give any

treatment which appears necessary to avoid serious harm to life or limb of the patient without informed consent with the approval of the Clinical Director.

4. ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy is performed at a designated ECT center.

Informed consent is however, obtained at this facility in accordance with the facility's ECT policy.

5. SURGERY AND OTHER MAJOR MEDICAL TREATMENT INCLUDING HAZARDOUS ASSESSMENT PROCEDURES

The medical staff of the facility performing the procedure obtains informed consent for elective surgery or other major medical treatments. The Psychiatric Center's medical specialist should provide preliminary explanations of the surgery or treatment to the patient, and such explanation documented in the medical record in a progress note.

Additionally, for outpatient procedures, the psychiatrist should provide a written statement of the patient's mental status and capacity to provide consent. This statement should be filed in the medical record and forwarded to the physician at the outside hospital who will be obtaining consent and providing treatment. For inpatient procedures, the treating hospital will determine the patient's capacity to provide consent. The treating psychiatrist at Psychiatric Center should be available for consultation during this determination.

V. Restraint and Seclusion in Psychiatric Facility

A. Policy Statement

The purpose of this policy directive is to set forth conditions and procedures for the use of seclusion and restraint in State-operated psychiatric inpatient facilities. The directive addresses both the use of seclusion and restraint for behavioral management purposes, as well as the use of restraints for medical and post-surgical care.

In this regard, the policy reflects a shift in the focus of requirements governing the use of restraints. Historically, requirements focused on the type of device or restraint being used, and the setting in which it was being employed. Under current federal regulations and JCAHO standards, requirements are tailored to the function or purpose of the restraint, i.e., is the restraint being used for medical or post-surgical purposes or for behavioral management purposes?

In medical or post-surgical care, a restraint may be necessary to ensure good medical outcomes. For example, restraints may be used to prevent an intravenous (IV) or feeding tube from being removed, or to prevent a patient who is temporarily or permanently incapacitated with a broken hip from attempting to walk before it is medically appropriate. In these circumstances, a medical restraint may be used to limit mobility. Seclusion and restraint are interventions to be used only in emergency situations, and also only as a measure of last resort, to avoid imminent injury to the patient or others. The use of seclusion or restraint is considered a treatment failure and serves as a prompt for treatment teams to review the appropriateness of the treatment approaches currently being used for individual patients. It is the goal of the Office of Mental Health to significantly reduce the incidence of emergency situations that necessitate the use of seclusion and restraint, to make the use of seclusion and restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences.

Among the Psychiatric Center's purposes and goals are the provision of a safe and therapeutic environment, the reduction of danger, and the prevention of violent behavior.

Episodes of violent behavior are frequently associated with the use of seclusion and restraint for behavioral management purposes. While it is clear that violent behavior may lead to seclusion and restraint, in other instances violent behavior may begin or increase following the initiation of seclusion and restraint. Statistically, seclusion and restraint are associated with increased risk of injury to both patients and staff.

Seclusion and restraint also may have deleterious effects on patients, including survivors of sexual trauma and/or physical abuse, and patients with hearing impairments who are unable to communicate without the use of their hands. In assessing the need to use these interventions, therefore, the potential for any negative impact of the procedure on the particular patient shall be considered.

The use of seclusion and restraint for purposes of behavioral management can be reduced through the creation and maintenance of an environment which promotes the empowerment of patients, and which emphasizes the education and sensitization of staff regarding the appropriate use of restraint and seclusion. It is the goal of this policy to encourage this result.

B. Definitions

1) **Chemical restraint**, *or a Drug used as a restraint*, means the use of a medication to control behavior or to restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychiatric condition. The use of medication to completely immobilize an individual is considered an inappropriate medical practice, and is prohibited.

2) **Clinical director** or designee means the individual in charge of clinical services at the State-operated psychiatric facility, or a physician designated by that individual to carry out the responsibilities of the head of the clinical

staff described in this directive.

3) **Comfort wrap** means a lightweight blanket or sheet that a person may voluntarily use when they experience the need to feel safer and/or to provide an artificial boundary.

4) **Formal debriefing** means a process designed to rigorously analyze a critical event in order to examine what occurred and to facilitate improved future outcomes by managing the event more effectively or preventing recurrence.

5) **Four-point restraint** means bracelets, encasing the wrists and ankles of a person lying on a bed, which are secured to the bed frame.

6) **Manual restraint** means the involuntary holding or pinning of an individual to restrict movement of the head, arms or body. Manual restraints include, but are not limited to, physical restraints required to facilitate the safe administration of court ordered or emergency medications administered over a patient's objection, physical "take downs," or other physical interventions that are designed to involuntarily hold or pin the individual to restrict movement.

7) **Mechanical restraint** means an apparatus which restricts an individual's movement of the head, limbs or body, and which the individual is unable to remove.

8) **Mechanical support** means a device intended to keep a person in a safe or comfortable position or to provide the stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous solutions or other medically necessary procedures, which the patient can remove at will.

9) **One-to-one constant observation** means a situation in which a staff member is responsible for maintaining continuous watch of a single patient, keeping the patient in view at all times, and, if clinically appropriate, attempting to initiate dialogue with the patient. In this situation, the staff member has no supervisory responsibilities for other patients.

Restraint means any manual method or physical or mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment, attached or adjacent to the patient's body that he or she cannot easily move. For purposes of this policy directive, "restraint" means and includes manual restraint and mechanical restraint.

10) **Seclusion** means the placement of an individual alone in a room or area from which he or she cannot leave at will. This includes restricting the patient's egress through the presence of staff, by coercion, or by imposing implicit or explicit consequences for non-compliance.

11) **Time-out** means a voluntary procedure used to assist the patient to regain emotional control by providing access to a quiet area or unlocked quiet room away from his/her immediate environment. Time-out is not a form of restraint or seclusion. In order for an intervention to be considered time-out, the patient must be permitted to enter the area/room completely voluntarily. Exiting the time out area/room may not be restricted by any means. Each unit will have a designated "Comfort Room," which will be used for this purpose.

The room used for time-out will not be the same room that is used for seclusion.

12) **Wrist-to-belt restraint** means a belt, secured around a person's waist, with attached bracelets which encase the person's wrists. The tethers which secure the bracelets to the belt may be of adjustable lengths, which allow variation in the degree of restriction of the person's arms.

C. General Principles

1) The health and safety of the patient are the primary concerns of the Psychiatric Center at all times. Therefore, whenever a patient demonstrates a need for serious medical attention in the course of an episode of seclusion or restraint, medical priorities shall supersede psychiatric priorities, including the placement of the patient in restraint or seclusion.

2) Seclusion or restraint for behavioral management purposes shall be employed only in emergency situations when necessary to prevent a patient from seriously injuring self or others, and less restrictive techniques have been tried and failed, or in rare instances where the patient's danger is of such immediacy that less restrictive techniques cannot be safely applied.

3) Seclusion or restraint for behavior management is not a substitute for treatment. When it occurs, it indicates the need for a post-event analysis by the staff involved in the procedure, a debriefing by the treatment team and appropriate supervisory staff, and, in some cases, a formal treatment plan review.

4) Seclusion or restraint shall not be used as punishment, for the convenience of staff, or as a substitute for treatment programs.

5) The criterion for release of a patient from seclusion or restraint for behavior management is achievement of a specific behavioral objective, which must directly relate to

the emergency situation that caused the seclusion or restraint episode. Examples that would satisfy this criterion include, but are not limited to, “the patient is no longer threatening to hurt staff”; or “the patient is able to verbalize that s/he is no longer intending to hurt self.”

6) Simultaneous use:

(a) Seclusion and mechanical restraint shall never be used simultaneously

(b) Two forms of mechanical restraint should not be used simultaneously, with the following exceptions:

(i) the use of mitts and helmets together

(ii) the use of manual restraint while placing a patient in mechanical restraint

(iii) the use of chemical restraint with other forms of restraint

7) The decision to utilize seclusion or restraint shall not be based on the individual’s seclusion or restraint history or solely on a history of dangerous behavior.

8) Drug used as a restraint.

(a) The use of drugs as a restraint, while not prohibited, is not considered a standard practice. There may be rare instances where the degree of harm posed by a patient’s behavior necessitates the use of medication to rapidly attenuate the behavior to ensure the safety of the patient and others.

(b) When medication is used to control behavior or to restrict the patient s freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition, the use of the medication shall be deemed a chemical restraint (i.e., a drug used as a restraint).

(c) Use of a drug as a restraint must be immediately reported to the facility’s Clinical Director or designee and the facility Executive Director or designee.

(d) All uses of drugs as a restraint can only be implemented following a written order of a physician.

(e) Monitoring and observation must include post-medication administration assessment by a registered nurse and shall include the same monitoring requirements as any other method of restraint, as set forth in this policy directive, and will be done for a minimum of thirty minutes. The psychiatrist ordering the chemical restraint can increase the duration or frequency of the monitoring as clinically indicated.

9) It is against Psychiatric Center policy to place objects on or over a patient's face during restraint procedures. In situations in which precautions need to be taken to protect staff against biting and spitting during restraint episodes, staff should wear gloves, masks or clear face shields when possible for purposes of infection control.

10) Mitts and helmets: The use of mitts and helmets as an emergency intervention to avoid imminent injury to the patient or others constitutes a restraint for behavioral management purposes and must follow the procedures set forth in this policy directive.

11) A "take down" is always a manual restraint, and therefore must follow the procedure for restraint for behavior management purposes.

12) When manual restraint is required to facilitate the safe administration of court ordered or emergency medications administered over a patient's objection, a physician's order for such manual restraint is required.

13) The use of manual restraint is the only form of restraint permitted with children less than 9 years of age in facilities operated by the Office of Mental Health. Other forms of restraint, as well as seclusion, shall be prohibited for this age group, except upon prior approval on a case-

by-case basis by the Chief Medical Officer of the Office of Mental Health or his/her designee.

14) When manual restraint is used for the purpose of facilitating the placement of a patient in mechanical restraints or secluding a patient, a separate order is not needed for the manual restraint because an order will be written for the mechanical restraint or seclusion. That order covers the total time of both events. Should the combined time for the manual restraint and the restraint or seclusion exceed the limit for such an order (one hour) a second order is required. The entire event must be documented in the patient's clinical record.

15) All clinical staff shall demonstrate competence in alternatives to, and the appropriate application of, seclusion and restraint prior to participating in the restraint or seclusion of a patient. Techniques sanctioned and taught by the Psychiatric Center must be employed.

16) Excessive force shall not be used in initiating the use of seclusion or restraint.

17) To enable staff to check the patient's airway and to prevent the possibility of positional asphyxia, care shall be taken to assure that patients are not placed in a face and chest down position.

18) In the case of patients who are known or reasonably believed to have a history of physical or sexual abuse, or in the case of patients with hearing impairments who would be unable to communicate without the use of their hands, an explanation of why restraint is the most appropriate intervention under the circumstances shall be included in the patient's case record when an order for the use of restraint is written.

19) The standard forms of mechanical restraint are the four-point restraint, wrist-to-belt restraint, mitts, and helmets. The Psychiatric Center shall not use these devices unless the related manufacturer and model have been approved by the Chief Medical Officer of the Office of Mental Health or his or her designee. Such approval shall be interpreted to allow

facility-wide use. Mechanical restraints which employ a locking mechanism released by a key shall never be used or considered approved for use.

20) Facilities may use other types of mechanical restraints for specified patients for a specified period when so authorized by the Chief Medical Officer of the Office of Mental Health or his/her designee.

21) In choosing among the possible forms of intervention for a particular patient, staff shall utilize the least restrictive type which is appropriate and effective under the circumstances and shall only utilize restraint or seclusion as a last resort. Similarly, in cases where restraint or seclusion is used as a last resort, the least restrictive type which is appropriate and effective under the circumstances must be utilized. In determining whether or not a physical intervention rose to the level where it constitutes a manual restraint, reasonable consideration must be given to the nature of the behavior of the patient that precipitated the intervention, the behavior of the patient subsequent to the intervention, federal guidance, clinical judgment, and common sense.

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22) The facility shall convey the intentions of the Office of Mental Health to make the use of restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences, to patients and to those families who, upon patient agreement, are involved in the patient's treatment.

VI. Sexual Activity in Psychiatric Facility

A. Policy Statement

The Psychiatric Center provides treatment to persons with severe and chronic mental illness. The goal of hospitalization is to provide active treatment to persons to enable them to return to community settings and receive appropriate outpatient services.

Sexual behavior of an adult inpatient must be considered by the treatment team in the context of the person's clinical status, individual needs and communal living. The treatment team should take into account the objectives described in the individual treatment plan and the need to provide a safe and therapeutic environment for all patients. For some patients, inpatient treatment is lengthy, and psychiatric rehabilitation is crucial to help them re-learn social and interpersonal skills. Education about appropriate and safe sexual behavior should be an integral component of this rehabilitation process. In addition, in the context of widespread and increasing prevalence of AIDS, all patients should receive education about avoidance of high-risk behavior that might lead to the transmission of HIV infection or other sexually transmitted diseases. As such, the overriding principle is the assurance of safeguards to protect patients at all times.

This policy is applicable to all persons 18 years of age or older who are receiving services at Psychiatric Center. Staff training, patient education, and the placement and supervision of patients must incorporate the principles described in this policy.

B. Principles

1) Sexual feelings are a part of the lives of all individuals, including persons

with psychiatric diagnoses.

2) Patients should be protected from sexual assault or harassment of any kind.

3) Exploitive sexual activity is never acceptable.

4) Sexual activity between patients and staff constitutes patient abuse, and may result in criminal prosecution.

5) Care must be taken to protect patients who are particularly vulnerable (e.g., persons who are acutely ill, highly regressed or otherwise lack the capacity to consent to sexual activity) from psychological harm and exploitation through sexual activity. The concern for safety must be paramount. Therefore, vulnerable patients may be restricted to the ward, placed on a same sex unit, or given special observation. The same is expected for irresponsible patients who may potentially harm others.

6) Care must be taken to protect patients from harm to their physical well-being which may be a result of sexual activity, such as exposure to sexually transmissible disease, HIV infection and unwanted pregnancy.

7) Explicit sexual activity, such as exposure of genitals, self-stimulation or genital contact is not permitted.

8) Limited physical contact as a means of expressing affection (e.g., hugs, greeting or farewell embraces) may be entirely socially appropriate.

9) Treatment teams should consider the following factors, to the extent applicable, in addressing issues of sexual activity for an individual patient:

   a) the length of time already spent in the hospital and likely length of stay, and anticipated opportunities for passes and/or home visits;

   b) the patient's ability to understand his or her right to consent or refuse

to participate in sexual activity;

c) the objectives described in the person's treatment plan including, but not limited to, the fostering of his or her ability to form adult relationships and follow community norms;

d) the patient's current mental status, ability to conform to community norms, and any specific vulnerabilities related to romantic or sexual activities;

e) the patient's level of comfort with his or her chosen sexual roles and preferences;

f) the patient's level of knowledge regarding safe and healthy sexual activity; and any medical conditions of the patient which have significance in relation to sexual activity.

10) Facility staff are responsible for exercising careful, thoughtful judgment with regard to sexual activity involving patients.

11) The Psychiatric Center must make available the following to all adult patients in accordance with the characteristics of the patient population and the clinical condition of individual patients:

a) education related to sexuality and sexual activity;

b) education and information related to the prevention and treatment of HIV infection and sexually transmissible diseases; and

c) family planning information and access to protective devices, including condoms.

C. **Definitions**

1) **Exploitative Sexual Activity** means sexual contact, not necessarily abusive or assaultive in nature, in which participation is encouraged through manipulative or

insidious means.

2) **Nonconsensual Sexual Contact** means sexual contact which involves a person who does not consent to such contact or who lacks the capacity to consent to such contact.

3) **Sexual Abuse** means, as a category of patient abuse, any sexual activity involving a patient and staff member, or any nonconsensual sexual contact involving a patient that is allowed or encouraged by a staff member.

4) **Sexual Assault** means any touching of the sexual or other intimate parts of a person for the purpose of gratifying sexual desires of any of the parties involved. For the purposes of this directive, sexual contact is limited to acts involving at least one person who is a patient.

5) **Sexual Contact** means the intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person.

D. **Staff Responsibilities**

Staff responsibilities cover three types of situations:

(a) Staff responsibilities for an occurrence of patient-to-patient sexual behavior when there is no suspicion of coercion;

(b) Staff responsibilities for an occurrence of patient-to-patient sexual behavior when there is known or suspected coercion;

(c) Staff responsibilities for an occurrence of staff-to-patient sexual behavior.