

*13. HOSPICE CARE

~~In this edition appendix material appears in the main body of the document; however, it remains advisory only.~~

~~Hospice care, a proven, effective, and compassionate service, helps the terminally ill patient through the dying process with dignity and in comfort. Hospice care also helps the family through its loss and bereavement. Hospice can offer terminally ill individuals the option of spending their final weeks and months in their own home. The process of dying is never an easy one, but the final days can be comforting for all involved. Ninety five percent of patients die at home. And the need for services does not end with death; bereavement counseling is available to family members for a year after the death of a loved one.~~

~~Hospice typically has a philosophy that is distinct from other types of care.~~

~~A hospice unit (suite) may be set up in an acute setting or it may be a freestanding building. In either situation, the focus should be on a residential environment in terms of furnishings, accessories, and other design features. Hospice is a medically directed, interdisciplinary program of palliative services for terminally ill people and their families. Hospice emphasizes pain and symptom control provided by a team of professionals that includes physicians, nurses, social workers, chaplains, and volunteers as well as others as needed by the family or patient. Hospice is primarily a concept of care rather than a specific place. The majority of hospice services are delivered in the home or a homelike setting with inpatient care available as needed.~~

~~A13. Hospice Care~~

~~This text is placed in the appendix to solicit public comment:~~

~~To improve the quality of life for terminally ill individuals, their caregivers, families, and loved ones, hospices are becoming increasingly important alternative environments and/or alternative care systems. Hospice facilities are being developed in acute care hospitals, as part of nursing facilities, and as freestanding facilities, with little available guidance as to which functional elements and environmental features are necessary and appropriate. Available books and publications address the rationales and philosophies that motivate hospice care providers. However, no research based guidelines for hospice design and/or construction currently exist.~~

~~Many hospice facilities built to date have been renovations of parts of existing hospital or nursing care facilities. As such, they are too full of compromise to serve as adequate guides to the future of hospice design.~~

~~Hospice design should take into consideration the needs of both the resident and the resident's family. It should allow for private interaction within the family and provide areas where families can gain strength by interacting with each other. Ministrations to families are of great importance in hospices. Family members are usually present in greater numbers and for longer periods than those visiting in acute hospitals; some facilities report that overnight stays by relatives are common. Small residential units with living room type lounges and small dining areas and kitchen facilities are helpful. Staff areas should be unobtrusive and yet be capable of accommodating the needs of nursing staff and the various disciplines involved in care of these residents, which may include social workers, dietitians, and clergy, as well as physicians. Clinical~~

care, while palliative, may still involve intense nursing as these residents become progressively more dependent.

A hospice philosophy may include the following:

? Death is seen as a normal part of life.

? Awareness of death can lead to physical, emotional, social, or spiritual needs.

? Society addresses these needs in the hospital, nursing facility, assisted living, and group home models.

In the hospice facility there is a focus on relief of pain and discomfort. Pain medications and other drugs made necessary by illness may be administered in various forms and are at the heart of hospice resident care. No surgical techniques are used and a physician visits on a scheduled basis or in response to an emergency. In the institutional atmosphere, the technologies should be minimized and a homelike environment should be provided.

Design Considerations for Hospice Environments

Private bedrooms work well for patients whose symptoms are particularly distressing or when the patient has family living at the bedside.

Patients/residents should have a pleasant view and, if at all possible, be able to go outside directly from the room.

A homelike setting is desirable and should include the following:

? A place where all family members, including children, feel free to come and go in a very natural, family-like manner.

? Social areas where family members feel free to bring food and dine together and where they can enjoy music, games, and other activities common to the family unit.

? A place for social activities, where children are welcome and plants are important.

? A balance between privacy and opportunities for social interaction.

The resident areas, such as bedrooms, dining areas, lounges, and surroundings, should be designed to promote privacy and dignity for the resident and family. The interior design of resident use areas should consider lighting, the use of finish materials, furniture arrangement, and equipment to create a residential ambience without compromising the ability of caregivers to attend to the needs of the resident. Resident toilet rooms should be accessible and provide adequate space for staff assistance in wheelchair transfers as necessary.

Resident Rooms

The maximum number of residents in a bedroom should be based on the functional program. Each resident

~~bedroom should~~

~~? Be located at or above grade level.~~

~~? Have provisions to ensure visual privacy for treatment or visiting.~~

~~Artificial lighting should be provided sufficient for treatment and nontreatment needs.~~

~~Each resident room should have a window that can be opened without the use of tools. The windowsills should not be higher than 2 feet, 8 inches (762 millimeters) above the floor and should be above grade. Windows with operable sash should be provided with insect screens. Window openings should be designed to prevent accidental falls when open.~~

~~Each resident room should have convenient access to a toilet room. One toilet room should serve no more than two residents. The accessible toilet room should contain a water closet and a sink.~~

~~The toilet room should be furnished with the following:~~

~~? Grab bars~~

~~? Lavatory with single lever or wrist blade type faucets~~

~~? Mirror~~

~~? Soap, paper towel dispensers, and wastepaper receptacle with a removable impervious liner~~

~~A bathing facility containing either a bathtub or a shower accessible to a wheeled shower chair should be conveniently accessible to resident rooms. An accessible toilet room should be accessible to the bathing room. Bathing "spas," with circulating warm water, are recommended.~~

~~As required by the functional program, the following should be provided:~~

~~? Charting facilities~~

~~? Storage for supplies; resident care equipment; housekeeping equipment; and cleaning supplies~~

~~? Locked medication storage and storage for drugs requiring refrigeration~~

~~? A comfortable and easily accessible sleep area for family members~~

~~A residential kitchen with the cooking unit vented to the outside should be provided.~~

~~Provide dining and/or gathering space for residents and families as required by the functional program.~~

~~Other requirements should include an audible and accessible call system furnished in each resident's room and bathroom, connected to the staff station.~~

~~There should be a visitors'/staff toilet room located near resident and gathering areas.~~

Housekeeping

Housekeeping space should be provided convenient to the resident and service areas.

Clean Linen and Supply

A space sized to store clean linen and supplies, as required by the functional program, should be provided.

Soiled Utility Room

A soiled utility or work room should be provided in accordance with the functional program.

Stretcher and wheelchair storage should be provided

Office space should be provided for persons with administrative responsibilities.

Furnishings and Finishes

Handrails should be provided on both sides of all corridors used by patients.

For each nursing unit or fraction thereof on each floor, the following should be provided: a nourishment station with work space, cabinet, refrigerated storage, and a small stove or hot plate.

Staff work areas in direct care locations should have space for charting, storage, and administrative activities. Depending upon the type of service and care plan to be provided, direct care staff work areas may be accommodated at a piece of residential furniture (such as a table or desk) or at a work counter recessed into an alcove off a corridor or activity space, with computer and communications equipment, storage facilities, etc.

13.1 General Conditions

Hospice care is a medically directed, interdisciplinary program of palliative services for terminally ill individuals and their family members or significant others.

13.1.A. Applicability

Hospice care supports terminally ill persons through the dying process with dignity and in comfort. Hospice is a medically directed, interdisciplinary program emphasizing pain management, symptom control and palliative services provided by a team of professionals that may include nursing staff, social workers, dietitians, volunteers and clergy, as well as physicians who may visit on a scheduled basis or in response to an emergency. No surgical techniques are used. In-patient hospices are part of a continuum of palliative care. They have been developed as new facilities and through renovations.

This chapter covers hospice services, which may be provided in a freestanding facility; represents *minimum* requirements for new construction; and shall not be applied to existing facilities unless major construction renovations (see Section 1.3A) are undertaken. Hospices are typically licensed as either residential or in-patient care facilities. Chapter 13 addresses inpatient freestanding hospices. At the discretion of the authority having jurisdiction, the design concepts presented herein may be applied to hospice programs located in other health care facilities.

13.1.B Ancillary Services

See Sections 8.1.B.

13.1.C Environment of Care

See Section 8.1.C.

13-1-D-13.1.N.

Refer to sections 8.1.D-8.1.N.

13.2 Hospice Facility

Each facility shall comply with the following:

13.2.A. Care Unit Size and Configuration

In the absence of local requirements, consideration shall be given to restricting the size of the care unit to 25 beds.

13.2.B. Patient Rooms

Each patient room shall meet the following requirements:

13.2.B1. Maximum room occupancy shall be one resident unless justified by the functional program. In no case shall bedrooms exceed two occupants. See Section 8.2.B.

Room size shall be based on program of care, distinctive in-room furniture, and clothing storage. If consistent with the functional program, accommodation for dining shall be provided in the resident room.

Access shall be provided to both sides of the resident bed.

13.2.B3. See Section 8.2.B3.

13.2.B4. See Section 8.2.B4.

13.2.B5–13.2.B7. See sections 8.2.B5–8.2.B7.

13.2.B8. Airborne infection isolation room(s). The need for and number of required airborne infection isolation room(s) shall be determined by an infection control risk assessment. Where required, the airborne infection isolation room(s) shall comply with the general requirements of Section 7.2.C.

13.2.C. Service Areas.

See 8.2.C.

13.3 Patient Support Areas

See 8.3.A and 8.3.B.

13.4 Activities

See 8.4.A and 8.4.B.

13.5 Therapy

See 8.5.

13.6 Personal Services (Barber/Beauty) Areas

If these services are required by the functional program, see 8.6.

13.7 Safety

See 8.8.A.

13.7.A1. Doors. See 8.8.A1.

13.7.A2 Windows. See 8.8.A2.

13.8 Outdoor Spaces

Secure outdoor areas shall be available for residents.

13.9 Dietary Facilities

The following facilities shall be provided:

13.9.A. Dining Facilities

If food preparation is provided on site, the facility shall dedicate space and equipment for the preparation of meals. Food service physical environment and equipment shall comply with the locally adopted food and sanitary regulations. Where locally allowed, residential “home-like” kitchen facilities shall be permitted.

Provision shall be made for transport of hot and cold foods, as required by the functional program. Separate dining areas shall be provided for staff and patients. The design and location of dining facilities shall encourage patient use.

13.9.B. Ice-Making Facilities

Ice-making facilities shall be self-dispensing if available for use by patients and/or visitors. Ice-making facilities under the control of the dietary staff and not available for use by patients and/or visitors may be bin type or self-dispensing. These may be located in the food preparation area or in a separate room, and shall be easily cleanable and convenient to the dietary function.

13.14.A2. See 8.14.A2.

13.14.A7. See 8.14.A7.

13.31 Mechanical Standards. See 8.31.

13.32 Electrical Standards. See 8.32.

