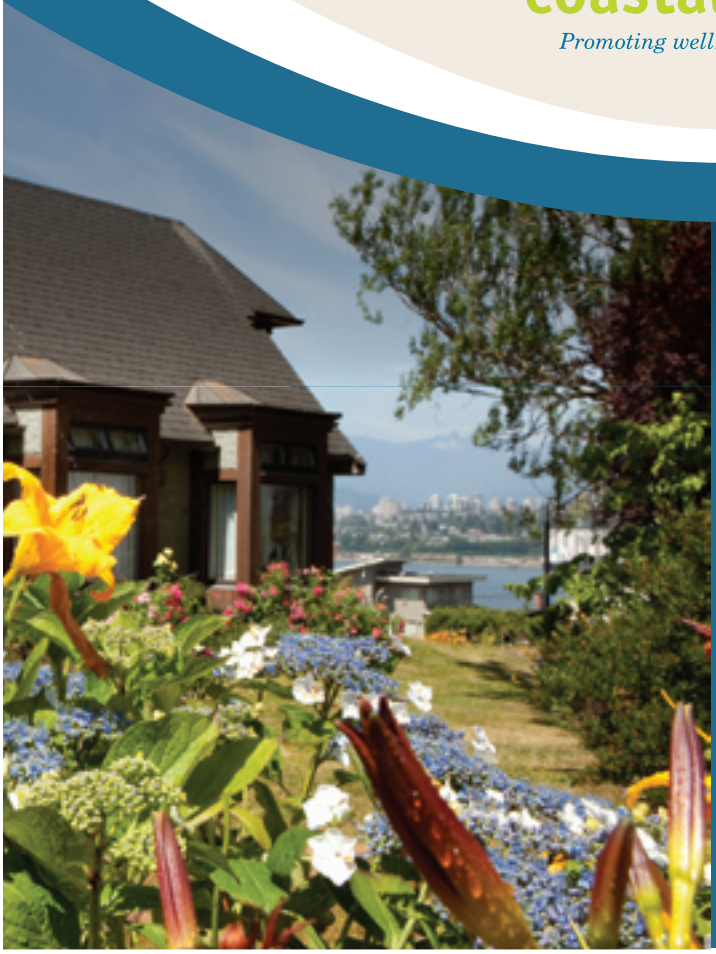
Vancouver Coastal Health: Standards and Guidelines for the Planning, Development and Operations of Hospices

Vancouver CoastalHealth

Promoting wellness. Ensuring care.



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- May's Place
- Cottage Hospice
- Marion Hospice
- Rotary Hospice House
- Richmond Health Services Integrated Hospice Palliative Care Program
- Vancouver Community Palliative Care Program
- North Shore Palliative Care Program
- Sunshine Coast Palliative Care Program

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Introduction

The Standards and Guidelines for the Planning, Development and Operations of Vancouver Coastal Health Hospices (VCH's Hospice Standards and Guidelines) is intended to provide a resource to potential hospice service providers who may be considering opening a hospice within Vancouver Coastal Health's (VCH) boundaries. This document is not intended to replace the dialogue that needs to occur between key stakeholders within our organization and potential hospice service providers, but instead serves as a starting point for this dialogue.

While existing VCH hospices are not expected to adjust to these standards and guidelines, any substantial renovation is expected to follow the standards and guidelines outlined in this document. Where possible, standards and guidelines relating to clinical and operational areas are to be adopted – this is consistent with expectations of the Ministry of Health Services and the public that, regardless of where people live within the health authority, they should receive the same level of access to services and consistency in quality of care.

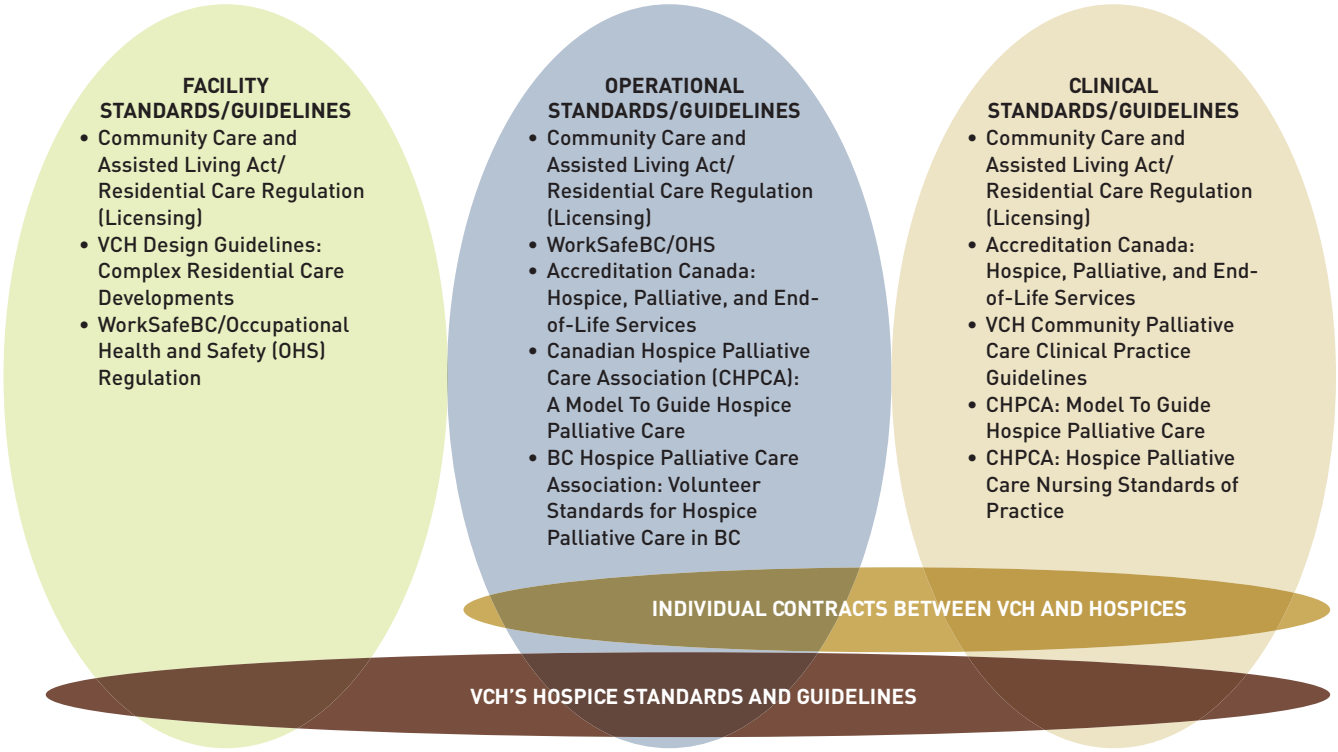
The development of these standards and guidelines consisted of a year-long process that included interviewing current hospice owners, service providers and VCH hospice palliative staff; researching standards and guidelines from other experts in the provision of hospice care; and collaborating with the Hospice Standards and Guidelines Working Group. It brings together the experiences of VCH hospice service providers and key stakeholders with best practices relating to hospices.

This document describes our standards and guidelines relating to hospices, as well as how they fit with other standards and guidelines, regulations and requirements. Our goal is to help our hospice service providers navigate through the wealth of information available and provide a framework that will assist them in the planning, development and operations of their hospice.



How To Use This Document

There are a number of standards, guidelines, regulations and requirements that relate to the development and operations of hospices. Those outlined in the diagram below are only a subset of a larger body of standards and guidelines that exist; however, they are generally the most relevant for hospices within our boundaries. This document will assist you in navigating through these various documents including our own VCH standards and guidelines.





Useful Documents

The Province of British Columbia's 2009 *Residential Care Regulation* document provides requirements that must be met as part of the licensing process. There may be specifications within this document that may not be appropriate for some hospices – these should be discussed on an individual basis with Community Care Facilities Licensing Program.

WorkSafeBC/Occupational Health and Safety Regulation requirements should be considered during planning and development. Our *VCH Design Guidelines – Complex Residential Care Developments* document is specific to residential care facilities and the specific needs of the population they serve; however, it also applies as a useful resource for the planning and development of hospices.

While not considered mandatory (unless specified in the contract with VCH), the following documents provide information related to best practices in hospice palliative care:

- Canadian Hospice Palliative Care Association's (CHPCA) *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice.*
- CHPCA's *Hospice Palliative Care Nursing Standards of Practice.*
- CHPCA's *Applying A Model to Guide Hospice Palliative Care.*
- VCH's *Community Palliative Care Clinical Practice Guidelines.*
- British Columbia Hospice Palliative Care Association's *Volunteer Standards for Hospice Palliative Care in British Columbia.*
- Accreditation Canada's *Hospice, Palliative, and End-of-Life Services*.

The following provide background information relating to hospice palliative care in British Columbia specifically:

- VCH's *Regional Hospice Palliative End-of-Life Strategy, November 2005.*
- British Columbia's Ministry of Health Services' *A Provincial Framework for End-of-Life Care, May 2006.*

A summary grid which directs hospice service providers to the relevant standards and guidelines is included in Appendix I – Summary Grid.

Notes on Terminology

The terms "patient" and "resident" are used interchangeably throughout this document. Some hospice service providers prefer the use of the word "patient" while others prefer the use of "resident". The use of both terms in this document recognizes the uniqueness of each hospice service provider.

The term "family" is used throughout this document. It is meant to include both formal family members, as well as any person who has a close personal relationship with the individual.



Hospice Care in VCH

Hospice Palliative Care

The World Health Organization's (WHO) definition of palliative care is the following:

"*Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:*

- *Provides relief from pain and other distressing symptoms;*
- *Affirms life and regards dying as a normal process;*
- *Intends neither to hasten or postpone death;*
- *Integrates the psychological and spiritual aspects of patient care;*
- *Offers a support system to help individuals live as actively as possible until death;*
- *Offers a support system to help the family cope during the resident's illness and in their own bereavement;*
- *Uses a team approach to address the needs of residents and their families, including bereavement counselling, if indicated;*
- *Will enhance quality of life, and may also positively influence the course of illness;*
- *Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.*" (WHO, 2008)

The Canadian Hospice Palliative Care Association (CHPCA) broadened the definition of palliative care to incorporate, "the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with, or dying from, a progressive life-threatening illness, or are bereaved." (CHPCA, 1995) Within Canada, the term hospice palliative care is used to broadly describe the philosophy and services consistent with these definitions.

Hospice Care

While hospice palliative care relates to the philosophy of care described above, "hospice care", as used in this document, relates to the care provided within a residential hospice.

In VCH hospices, the focus is on quality of life and ensuring the comfort of residents and their families. While each hospice strives to create a homelike environment, they are staffed with a team of skilled care providers who are available to support the needs of the residents and their families. However, like a home, there are certain things hospices are not able to do, such as major diagnostic tests and complicated treatments.



History of Hospice Development in VCH

Unlike many of the health authorities that have developed hospice residence beds as part of a regional hospice palliative care strategy, hospices within what is now VCH were established prior to a standardized regional approach to hospice palliative care service development.

May's Place opened in 1990 as the first hospice in British Columbia. It was created by individuals in the community who realized the need for a more homelike environment for people at the end of their life and less of a hospital or institutional setting. They wanted the focus to be on comfort and quality of life, with a more holistic approach to care. Demand eventually outnumbered the availability of beds at May's Place, and a second Vancouver hospice, Cottage Hospice, was opened in 1999. Like May's Place, Cottage Hospice is operated and partially funded by St. James Community Service Society.

May's Place is targeted primarily as a resource for the Downtown Eastside and for patients from across the city with additional barriers and complex health care issues, including mental illness, addictions, social isolation and poverty.

The third hospice in Vancouver, Marion Hospice, was opened in November 2005 and is operated by Providence Health Care. Marion Hospice is currently located within a complex residential care facility.

Similar to Vancouver, Richmond's hospice development also arose from a need within the community. Opened in February 2006, Rotary Hospice House is owned and operated by The Salvation Army. It was developed as a community partnership between the Richmond Health Service Delivery Area (HSDA) and three community service groups: the Rotary Club of Richmond, the Richmond Hospice Association and The Salvation Army.

On the North Shore, a new hospice, the North Shore Hospice, opened in the fall of 2010. It was developed as a result of a partnership between the Lions Gate Hospice Society, Family Services of the North Shore and the Coastal Health Services Delivery Area, with fundraising led by the Lions Gate Hospital Foundation. Also in the Coastal HSDA, there are two designated hospice beds, operated by Coastal Health within a complex residential care setting in Sechelt (Shorncliffe) and supported by the Sunshine Coast Hospice Society and the Sunshine Coast Palliative Care Program.

VCH Regional Hospice Palliative End-of-Life Care Regional Strategy

In 2004, VCH initiated a regional hospice palliative end-of-life care planning process which developed a strategy that was accepted in principle by the VCH Senior Executive Team in November 2005. The overall themes of the strategy were to extend the number of people receiving hospice palliative care by expanding the patient population served to include more clients with non-cancer diagnoses, to increase community care capacity for more people in home or homelike

settings, and to have a coordinated continuum of care within each health service delivery area.

The strategy recognized the need for further development of hospice beds, reflecting concerns expressed in public consultation and by advocacy groups that people were spending their final days in acute care due to lack of access and supports in other care settings. The goal of increased access to end-of-life care in the home or homelike environments was also in line with the provincial government's directions. For example, the Ministry of Health Services' performance measures, established with each health authority, identified targets to shift the number of cancer and non-cancer deaths from acute care to community settings (home, hospice, residential care).

Development of a provincial policy framework for hospice is ongoing, as more hospice residence beds are being created within VCH and other health authorities. According to the British Columbia Vital Statistics Agency, from 2003 to 2008, the number of hospice deaths within British Columbia had increased from 776 to 2118.

The VCH regional strategy estimated the required number of hospice beds, based on benchmarking with other programs, at approximately 7 to 9.18 beds per 100,000 people in the population. When the regional palliative care team and the hospice working group began work in 2006, further work was done to refine the projected number of hospice beds required to meet the growing demand for hospice care, as well as to meet the anticipated provincial performance targets for shifting care to community settings. A model was created to project the number of required hospice beds from 2007 to 2015, for each HSDA. The model is based on:

- Increasing demand as the number of natural deaths across VCH goes up.
- Increasing demand as the proportion of clients, particularly those with cancer, die in a hospice setting rather than acute care.
- The current utilization of existing hospice beds, based on the average length of stay, occupancy levels and the waitlist for admissions to hospice.

This projection model is dynamic and will be reviewed annually. The required hospice bed numbers projected by this model for 2015 match the targets within the strategy and confirm the need for ongoing hospice bed development. The VCH strategy advocates for consistency in access, service standards and service levels within all hospice palliative care across VCH. In addition to hospice residence beds, the VCH strategy also recognizes the need to develop day hospice within the continuum of care.

Mission

The mission of hospices within VCH is to create a unique environment for quality living and dying as individuals approach the end of their life, where everyone involved in the journey – the individuals, their families and staff – are provided with the level of support and assistance that they need.



Values

The hospice palliative end-of-life care work carried out by VCH and our hospice service providers recognizes and supports the values of the Canadian Hospice Palliative Care Association, which are:

- The intrinsic value of each person as an autonomous and unique individual.
- The value of life, the natural process of death, and the fact that both provide opportunities for personal growth and self-actualization.
- The need to address residents' and families' suffering, expectations, needs, hopes and fears.
- The provision of care only when the resident and/or designated decision-maker is prepared to accept it.
- A model of care guided by quality of life as defined by the individual.
- A therapeutic relationship between caregivers and residents and families based on dignity and integrity.
- A unified response to suffering that strengthens communities.

Guiding Principles

The following principles were adapted from *VCH's Regional Hospice Palliative End-of-Life Care Strategy*. They provide guidance for the planning, development and operations of hospices within VCH, and help ensure that hospice palliative end-of-life efforts within VCH are aligned with our mission and values.

Death is a Natural Part of Life

The care services and support available in VCH's hospices will be provided in ways that recognize and respect death as a natural part of the life cycle. Because people are coming to hospice at the end of their life, the care provided extends beyond medical services typically available within the health care system and involves a more holistic approach that supports people with end-of-life closure. This includes loss, grief and bereavement, as well as caring, comfort and celebration.

Access Based on Need and Choice

Hospices are an option for people who meet hospice admission criteria, are unable or not wanting to remain at home at the end of their life, and who do not require the level of acute support provided in a hospital. Any person who needs and wants care in hospice will have appropriate and timely access to quality hospice care regardless of their ethnicity, language, culture, faith or socioeconomic background, or where they live within the VCH service area.



Resident and Family Centred
The main goal in the design and development of hospices is to create a warm, homelike environment that ensures the comfort, privacy and dignity of residents and their families. This resident- and family-centric philosophy extends to care provided in hospices, ensuring that individual and family preferences are known and respected, and that all members of the care team utilize this information in planning for and providing care.

High Quality Care
The care provided in our hospices is expected to meet clinical, cultural and ethical standards, and the spiritual needs of the individual; be consistent with individual and family wishes and needs; and ensure freedom from avoidable distress and suffering. The provision of high quality care is an ongoing process that requires continuous effort to ensure that the best available evidence- and opinion-based preferred practice guidelines are integrated into hospice policies and procedures.

Community Involvement
Along with the individual and the family, the voluntary sector and broader community are engaged as partners in the planning, development, provision and education for hospice care and services. Hospices should be integrated into the communities they serve and reflect the unique needs of these communities.

Partnerships and Collaboration
Hospices could not exist within VCH without partnerships between VCH, hospice service providers and hospice societies. This spirit of partnership and collaboration extends into the hospices, where all members of the care team, including residents and their families, have a role to play in the provision of care and support. Fundamental to the success of this collaborative relationship is a shared commitment to excellence, mutual respect and open communication.



Hospice Partnership Framework

Currently, hospice beds in VCH may be operated by a community-based organization, contracted service provider or within a facility owned and operated by VCH. It is expected that VCH and its hospice service providers work together during the planning phase of hospice development and during the ongoing operation of the hospice.

We work with hospice service providers that are interested in developing a respectful relationship and believe in the mission, values and principles stated in this document. Because VCH and its hospice service providers have a joint responsibility to ensure a high level of service to their patients and families, it is critical that they participate in a collaborative management model of service delivery. As each hospice service provider is unique, the manner in which the roles and responsibilities are shared will vary according to the strengths and needs of each.

Contractual Agreement

Because VCH provides operational funding and hospices are situated within the complex residential care sector, VCH does have a legal obligation and fiduciary responsibility to ensure an appropriate and consistent standard of excellence in hospice care. All hospice service providers must sign a contract with Vancouver Coastal Health Authority. Generally, these contracts specify services, payment, access to information and reporting, as well as some information relating to the standards that hospice service providers are expected to meet in consistency with the standards and guidelines outlined in this document.



Hospice Service Provider Models

The following table summarizes key components of the different hospice service provider models currently operating within our organization. These do not specify all of the possible hospice service provider models that may occur in the future. It is expected that, as more hospices are developed, new hospice service provider models will be created.

	VCH Owned and Operated	Hospice Service Provider Owned and Operated	Hospice Service Provider Leased and Operated
Building	VCH pays for all capital costs of building renovations and ongoing maintenance of building.	Hospice service provider pays for all capital costs of building renovations and ongoing maintenance of building.	Building owner pays for capital costs of building renovations. Ongoing maintenance may be paid for by building owner or hospice service provider.
Equipment/ Furnishings	VCH is responsible for the equipment and furnishings.	Hospice service provider is responsible for the equipment and furnishings.	Hospice service provider is responsible for the equipment and furnishings.
Basic Clinical and Operating Services and Standards of Care	VCH pays operating costs for basic staff, basic services, pharmacy and medical supplies. VCH establishes hospice standards, including admission criteria and process, clinical practice guidelines, educational requirements, etc.	VCH pays operating costs for basic staff, basic services, pharmacy and medical supplies. VCH establishes hospice standards, including admission criteria and process, clinical practice guidelines, educational requirements, etc.	VCH pays operating costs for basic staff, basic services, pharmacy and medical supplies. VCH establishes hospice standards, including admission criteria and process, clinical practice guidelines, educational requirements, etc.
Management of Staff	VCH manages both nursing and non-nursing staff.	Hospice service provider manages nursing and non-nursing staff. VCH may manage some of the non-nursing staff if they are from their hospice palliative care teams.	Hospice service providers manage both nursing and non-nursing staff. VCH may manage some of the non-nursing staff if they are from their hospice palliative care teams.
Additional Services and Comforts	Volunteers provided through community partners. VCH may provide other services such as rehabilitation therapies, etc.	Some combination of additional services, including volunteers provided by hospice service provider and VCH.	Some services are contracted out. Some combination of additional services, including volunteers provided by hospice service provider and VCH.



Partnership Role of VCH

Provide Operational Funding
In terms of funding, VCH is committed to providing basic operating funds for hospice beds, which includes core staffing and operations for hospice care. VCH does not have capital funding available for the construction of hospice facilities. Any new construction or capital funding requirements are the responsibility of the hospice service providers. In exceptional cases, some renovation work, as appropriate, may be funded through VCH. Community-based organizations and other partners have contributed generously to fundraising for equipment, furnishings and comforts for hospice residences and, in some cases, may provide a component of, or the full funding amount of capital required to build a hospice residence.

Manage Waitlisting and Admissions
Within each of the health service delivery areas, there is an established VCH infrastructure that provides central waitlisting and admission to hospice residences.

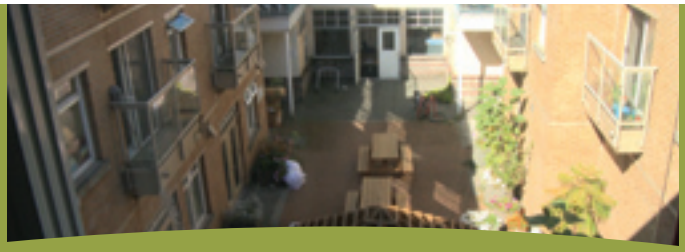
Establish Staffing Guidelines
VCH will be responsible for establishing guidelines pertaining to staff/resident ratios, staffing coverage, and required staff positions and qualifications.

Evaluate Hospice Design
At the design phase of any new hospice facility, VCH must have a role in reviewing and evaluating the design in order to ensure that it will provide an appropriate physical environment for staff safety, efficiency and comfort, and for resident privacy, comfort and safety.

Ensure Excellence in Delivery of Care and Services
The hospice palliative care teams operating in Vancouver, Richmond and Coastal are all committed to excellence in the delivery of care and services to residents and their families. They have incorporated national norms of practice, ethical principles and evidence-based practice into their standards and policies. They determine the expectations and requirements for a supportive and caring environment for residents, families, staff, volunteers and visitors in hospice. Finally, they ensure that standards outlined in the contracts between VCH and its hospice service providers are met, and work with their hospice service providers to overcome barriers to meeting these standards.

Facilitate Integration Between Hospice Service Providers and the VCH Health Care Community
Because VCH provides the entire community with a continuum of services, it has a perspective on the broader needs of the population and an understanding of how the different sectors interface with each other. VCH has a responsibility to ensure that its hospice service providers understand their role in the continuum and to facilitate the flow of information between the health authority and its hospice service providers, as well as amongst hospice service providers.

Provide Support to Hospice Service Providers
While VCH provides operational funding, it also provides support through other means such as access to resources, tools and education. VCH works to ensure that its hospice service providers are successful in providing high quality service to its residents and families.


Partnership Role of Hospice Service Provider

Work to Integrate into the Health Care System
VCH's hospice service providers cannot operate in isolation; they must work in partnership with VCH and be an integral part of the delivery of hospice services to the community. This may include participation in weekly clinical rounds, regular meetings with the VCH hospice palliative care teams, clinical education, partnering with the local hospice society, and implementation of *VCH's Hospice Standards and Guidelines*, policies, protocols, clinical pathways and symptom management guidelines as appropriate to the setting.

Deliver Quality Care
A hospice service provider is expected to contribute to the goals of excellence and quality of care within hospice by adopting *VCH's Hospice Standards and Guidelines*, participating in key educational and professional development activities, participating in hospice program evaluation, and by integrating quality improvement activities into all aspects of care. Quality care in hospice includes commitment to and advocacy for a caring environment within hospice.

Ensure Financial Responsibility
A hospice service provider is responsible for the administration of VCH allocated funds and for ensuring adequate funding for all other operating and capital costs including residents' payment of the minimum residential fee as determined by the Ministry of Health Services. Financial accountability, such as submission of an annual budget and quarterly financial statement to VCH, is required.

Lead Development and Design
It is the responsibility of potential and current hospice service providers to secure capital funding and to develop plans for the construction and/or provision of a hospice facility. Throughout the design phase, providers are expected to work with VCH's hospice palliative care staff to ensure that the hospice facility will meet established requirements.

Manage Day-to-Day Operations of the Hospice
While VCH and its hospice service providers work together to maintain a high level of service, the daily operations of the hospice are the responsibility of the hospice service provider. This includes hiring and retaining qualified staff, overseeing staff-related issues, creating a respectful workplace, ensuring residents and families feel supported, and providing a safe, functioning environment.



Admission to VCH Hospices

Each of the health service delivery areas in VCH manages their own admissions and waitlisting for hospices within their boundaries. Coordination is required between the HSDAs as well as with other health authorities. The goal is to ensure that those individuals requiring access to hospice who meet the admission criteria are placed as soon as an appropriate bed becomes available in a hospice.

Hospices in VCH provide palliative care to people who meet the following criteria:

- 19 years of age or older.
- Enrolled in the BC Palliative Care Benefits Program.
- Diagnosed with an end-stage illness with a life expectancy of three months or less.
- Cannot be supported in community or residential care.
- May need ongoing symptom management, but does not require acute care.
- Understands the philosophy of hospice care, e.g. relief of suffering, but not prolonging life; has a no Cardiopulmonary Resuscitation document (no CPR document) in place or equivalent (available on-line from the Ministry of Health Services website).
- Has a Palliative Performance Scale (PPS) rating of 40% or less.
- Is willing and able to move into the available hospice within 48 hours of notice.

Placement will also consider physical requirements of the individual, appropriateness of physical setting and their preferred location. If a waitlist exists, individuals will be placed in priority based on the urgency of their need for a hospice bed. Reassessments are performed in situations where a change in condition occurs, such as when an individual's condition improves in hospice and their life expectancy is extended beyond the three-month policy.

The intent of the policy relating to placement is to honour residents' preferred choice for hospice beds. However, where the resource is not available, the first available appropriate bed will be offered first, with the preferred choice offered when available.

In 2010, VCH created a DVD to help patients and their families understand and make decisions about hospice care. It provides a description of the hospice philosophy, answers to frequently asked questions about hospice care, and a virtual tour of different hospices within VCH. A link to the DVD's content is available on our corporate VCH website at www.vch.ca.

The following table provides a summary of the process for admissions and waitlisting. As part of the admissions process, the resident or family must sign a letter provided by VCH describing care provided in hospice.

Summary of the process for admissions and waitlisting

	North Shore	Sunshine Coast	Richmond	Vancouver
Admission Process and Documentation	For admission into hospice, the patient must be on the North Shore Palliative Care Program and have a completed referral form. If referred by the general physician (GP) or hospitalist, the palliative physician assesses referral. If in the community and on the palliative list, when the home nurse realizes something is changing, she contacts the patient's GP or palliative care on call physician (PCOC) if no GP is available. GP or PCOC will then arrange admission. When a bed becomes available, the patient is placed. If in acute and on the program, the patient will be moved to hospice, if appropriate, and when a bed is available. If under the care of a hospitalist, care must be handed over to the PCOC.	Referrals coordinated through palliative coordinator. Palliative coordinator discusses with involved parties (home and community nurse, GP, internist). Beds allocated on a needs basis. Criteria used to assist decision-making. Exceptions discussed with GP and home and community care manager.	Hospice referrals are coordinated through the Richmond Integrated Hospice Palliative Care Team (RIHPCT). If being referred from the home, the home care nurse contacts the RIHPCT and a decision is made whether or not hospice placement is appropriate. If being referred from hospital (including PCU), the RIHPCT is involved to discuss the patient and then a decision is made whether or not hospice placement is appropriate. Please see Appendix II – Request for Richmond Integrated Hospice Palliative Care Program.	Hospice referrals are coordinated through Vancouver Community Health Palliative Access Line (PAL). For details, go to Appendix III – Vancouver Hospice Consent Letter; Appendix IV – Vancouver Hospice Referral Form; Appendix V – Vancouver Healthcare Providers' Resource Guide for Prospective Hospice Care Residents and their Families; Appendix VI – Vancouver Hospice Referral Flow; Appendix VII – Process Flow for Urgent Admission to Hospice (after hours).
Waitlisting	Program has its own database, which includes list of palliative patients, diagnosis, GP, family members, etc. used for waitlisting. The process for waitlisting focuses on urgency of need.	Informal. Based on priority of need, urgency and personal choice.	Clients are waitlisted based on priority of need, urgency and personal choice.	Clients are waitlisted based on priority of need, urgency and personal choice. See Appendix VIII – Vancouver Hospice Guideline for Prioritizing Waitlisted Clients.
Respite Care	Respite care will be available for up to two weeks if a bed is available.	Respite care will be available for up to two weeks if a bed is available.	Available for persons meeting the criteria and requiring care to be admitted from the Richmond Community for up to two weeks, with an agreement that the person returns home following this period and that there are no people waitlisted.	Respite care will be available for up to two weeks if a bed is available. Please see Appendix IX – Vancouver Hospice Respite Process.
Day Centre	The day centre is available four days/week and open to anyone registered in the palliative program. It is staffed by a registered nurse and acute care aide. Clients can come for a full day (9-5) or ½ day. Services include bathing, salon and activities.	Currently not available.	Currently not available.	Currently not available.



Hospice Accommodation Fees

Hospice residents are charged a daily rate, up to a maximum per month. Rates are updated annually. Some hospices may charge additional fees for services such as telephone and cable. However, there is no financial barrier to living in hospice. If the resident cannot afford to pay this fee, VCH will help them complete the necessary paperwork to apply for a temporary rate reduction.

Policy Related to Holding Hospice Beds

If a hospice resident is transferred to acute and it is anticipated that they will come back to the hospice, VCH's policy is to hold the bed for up to 72 hours with an extension of up to 10 days upon the discretion of the manager and/or palliative care team. Hospice residents will be charged the per diem during this time.

If it is anticipated that a resident will not return within this time, their discharge will be discussed with the resident and family. They may be placed on the waitlist for a future bed if appropriate for their situation. This policy recognizes the scarcity of resources when it comes to hospice beds and the typically short-term nature of the occupancy of the beds.



Hospice Physical Environment Guidelines

VCH and its hospice service providers strive to provide a safe, homelike environment for our residents. Each hospice has a unique look and feel, reflecting the community that they serve. However, there are certain characteristics of the physical environment that should be consistent across all hospices, adhering to licensing requirements as well as to the guidelines established by VCH.

It is critical that, while designing and developing a new hospice, licensing staff be involved throughout the process. Designing and developing a hospice is a very complex process with many details that may be overlooked. By engaging the licensing staff throughout the process, the hospice service provider is less likely to run into a situation where their plans do not meet the licensing staff's requirements and workarounds have to be developed. Furthermore, there may be areas requiring negotiation between the licensing staff and hospice service provider, which are better addressed during the process rather than after the completion of the build.

While Appendix I – Summary Grid outlines some guidelines relating to the physical environment, most of these are generic to all residential care facilities. Because of the population they serve and their philosophy of care, hospices have unique design requirements.

The following table summarizes our expectations relating to the physical layout and environment. These requirements and additional desirable features have been adapted from the document *Fraser Health's Expectations/Requirements for Hospice Residences: Physical Environment,* but also reflect standards that have been developed based on VCH's and its hospice service providers' experiences and research into best practices.

Expectations/Requirements for Hospice Residences: Physical Environment

Physical Design	Expectations/Requirements	Additional Desirable Features
Hospice Size	• Minimum of 10 beds in order to accommodate an adequate and efficient staffing plan.	• Hospice has potential to expand if required to meet future needs.
General Design for All Areas (Resident Rooms, Hallways, and Public Areas)	• Use of materials, indirect lighting and layout that create a homelike quality for the residence that is distinct from an acute or institutional setting (e.g., wood-like materials for doors, frames and flooring; mouldings; sconces; incandescent ceiling fixtures; pot lights; lamps; accents; and millwork). • Furniture that is homelike rather than institutional; use of wood products and furniture wherever possible. • Homelike storage cupboards in hallways and other key areas to eliminate typical linen/supply carts and other equipment of an acute unit. • Create comfortable, calm and quiet setting (e.g., no overhead paging, quiet call bell system). • Internet access.	• Dimming ability of fixtures. • Incandescent fixtures (rather than fluorescent). • Call bells that are toned down and or a system that is not disturbing to the residents (e.g., wireless system using portable phones or pagers with vibrating mode). • Wire-in bed alarm system.
Resident Rooms	• Storage with either a locked drawer or cupboard for personal valuables. • Shelves and ledges for personal belongings and family pictures. • Private phone lines, cable and music system in each room. • Overnight sleeping accommodation for family members (e.g., sleeper chair, day bed or pull-out couch). • Building materials include wood-like products that create a homelike setting (e.g., headboards, cupboards, closets, shelves, storage and over bed tables). • Dimmable lighting or lamps and/or wall sconces. • Provision for safe transfer of residents (e.g., ceiling lift). • Extra electrical outlets (e.g., for TV, stereo, lamps, etc.). • Private room with toilet and sink.	• Internet access in each room. • Pullout couches. • Space for a television that residents can watch from their beds. • Track into resident bathroom; lift and wall charger stored in bathroom. • Consider XY Gantry for positioning of bed and client (see occupational therapist for information). • Ceiling lifts in each resident room (track colour may be changed to match ceiling colour). • Ensuite showers are not required; however, if they are present they must be designed to accommodate a wheelchair and safe transfer of residents by multiple caregivers.
Reception Area	• Reception area should be separated from nurses' station.	• Main reception central to main entrance.
Nurses' Station	• Nurses' station screened from view as much as possible in order to reduce "clinical environment". • Workspaces for unit clerk, nurses and other team members (e.g., one to six people at any given time). • Provides safe distance from families/residents and allows for staff to chart privately. • Nurse call station. • Medication area with locked medication cupboard, locked cupboard for resident valuables, medication preparation area, sink, small fridge for meds and security as required, (e.g., locked medication room vs. area in open station). • Space for storing two medication carts and paper supplies. • Computers (2), fax, photocopier, telephone. • Ergonomically correct computer workstations.	
Memorial Space	• Memorial space created to recognize past residents – located near entrance or other common area.	

Table continued...

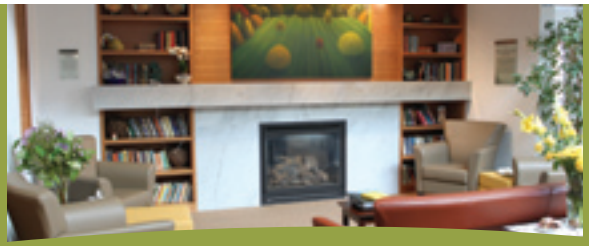
Expectations/Requirements for Hospice Residences: Physical Environment (Continued)

Physical Design	Expectations/Requirements	Additional Desirable Features
Family Lounge	• Separate sitting areas (groupings of furniture). • Telephone, TV/cable, VCR/DVD, music system. • Fireplaces in key lounge areas. • Bookshelves. • Materials and lighting that create homelike atmosphere.	• Dimming ability of fixtures. • Area to do puzzles or other quiet activities. • Visiting children's area. • Computers/printers for families' use.
Kitchen and Dining	• Main (working) kitchen area should include sink, commercial ice-maker, oven, fridge, commercial dishwasher, cupboard and counter space. • Kitchen area for family to prepare drinks and snacks including a small fridge, cupboards, sink and microwave. • Dining table and chairs to accommodate 8-10 people.	• Kitchen area wheelchair accessible (at least in part).
Family Room	• The family room and its furnishings should accommodate multiple functions including quiet time, counselling and complementary therapy treatments. • Telephone for private family calls. • Acoustical requirements for confidentiality.	• More than one room available.
Central Bathing Facilities	• "Spa-like" environment. • Adequate circulation space to ensure resident/staff safety. • Wheelchair accessible shower, therapeutic tub, sink, toilet. • Floor drain.	• Stretcher tub with lift preferred; consult with occupational therapist prior to purchase. • Should be located near residents' bedrooms.
Family Washroom/ Shower	• Separate from residents' rooms.	
Cigarette Smoking Area	• All VCH sites are smoke free; hospice residences that receive funding from VCH are strongly encouraged to develop similar smoke-free premise policies. • However, some hospice residents will smoke and, consistent with the hospice philosophy, efforts may be made to accommodate them. • In facilities that do allow smoking, the smoking area must meet all municipal bylaws, be located outside and far enough away from residents' windows and building ventilation intakes to ensure that second-hand smoke does not filter back into the facility.	• Additional ventilation support for the exterior smoking area may be required.
Access to Outdoors	• Must have centralized access to outdoor space. • In considering access to outdoors, there should be recognition of security issues and issues related to the population served. • Doors and ramps to outdoor area accommodate wheelchairs and reclining chairs. • Garden area has solid pathways for walkers and wheelchairs.	• Same floor access. • Garden can be accessed from patios from each individual room. • Doors and ramps accommodate beds. • Night lighting in garden area.
Staff/Volunteer Lounge and Washroom	• Locked space for personal belongings. • Space for coats and shoes. • Fridge for staff.	• Sink, counter, shower and cupboards.
Laundry Facilities	• Must have a working (commercial) laundry specifically for hospice and/or washer and dryer available for staff/family to use for resident's personal laundry. • Counter space, laundry sink and flushing sink required for soaking and rinsing soiled linens and garments. • Storage space is required for soiled laundry. • Laundry room is considered a "soiled" area and a clear functional flow of soiled to clean is required, with separation and storage of soiled and clean laundry.	• If working (commercial) laundry is located within the hospice, it should be centrally located (near residents' rooms/ bathing facilities) and appropriately equipped. Depending on numbers of residents, full size heavy-duty washers and full size heavy-duty dryers required; due to regulations, family use of working laundry not permitted.

Table continued...

Expectations/Requirements for Hospice Residences: Physical Environment (Continued)

Physical Design	Expectations/Requirements	Additional Desirable Features
Meeting Room and Office Space	• Meeting room should be able to accommodate multiple purposes such as family conferences, education sessions and team meetings; should have space for table and chairs for 8-10; acoustical requirements for confidentiality. • Adequate office space as required.	• Separate office available to support work of supervisor/other team leaders.
Storage	• Adequate storage for clean and dirty supplies, linen and equipment (including wheelchairs, walkers, commodes, etc.) in order to eliminate clutter in hallways, resident rooms, bathing areas, etc. • Storage rooms or cupboards with hidden doors; ability to lock these storage rooms/cupboards.	
Safety and Security	• Ability to prevent wandering residents from leaving unit/building and safely provide 24/7 access to visitors. • Security as required in each facility for staff safety. • Secure storage of medications and controlled substances. • Smoke detectors. • No injections of illicit drugs on the premises. • Emergency generator for provision of minimal service.	
Entrances	• Two entrances – one for visitors/one for funeral home personnel.	
Parking	• Safe and adequate parking for visitors and staff.	
Dirty Utility Space	• Janitorial area may be combined with dirty utility area. • Sink and counter space, floor drain, hopper. • Include sterilizer for bedpans/urinals. • Storage for dirty supplies and equipment, waste, etc.	
Clean Utility Space	• Shelves for clean medical supplies, linens, blankets, etc. • Include blanket warmer, sink.	


Hospice Staffing/Resource Guidelines

Meeting the complex and multi-dimensional needs of hospice residents and their families requires an interdisciplinary team of professionals. Currently, there are no national or provincial standards relating to staffing and it is expected that each hospice will have some variation. However, VCH has expectations relating to the minimum level of staffing and support resources, which are outlined below.

While VCH has not provided detailed expectations related to the number of hours that each role/function must work per week or staffing ratios (as this will vary from hospice to hospice) it has made an exception for nursing care given the critical nature of this role. Based on consultation with Fraser Health and our hospice service providers, the staffing levels within VCH's hospices must provide for total nursing direct care hours within the range of 5.0 and 6.0 hours per resident in a 24 period.

Total nursing direct care hours is defined as the direct care that is provided to residents by registered nurses (RN), licensed practical nurses (LPN) and care aides. This includes all activities relating to resident care – providing personal care to residents, treatments related to medical care, talking to families, answering calls related to the resident care and charting. It does not include time spent on non-resident care activities, such as housekeeping and food preparation. While it is recognized that these activities are undertaken by RNs, LPNs and care aides to varying levels within hospices, in order to ensure a high level of care, it should not be included in the calculation of total nursing direct care hours.

For a description of the duties, responsibilities and qualifications for a hospice RN, please see Appendix X – Sample Hospice RN Job Description.

The following table summarizes VCH's expectations relating to hospice staff and functions. These standards have been developed based on VCH's and its hospice service providers' experiences and research into best practices.

Expectations relating to hospice staff and functions

Role/Function	Expectations/Requirements	Additional Desirable Supports
Physicians	• Family physicians may follow their resident into hospice; otherwise, a designated hospice physician will be assigned to their care. • Must have access to/support of specialist hospice palliative care consultant where needed. • Access to a physician on a 24x7 basis.	
Nurse Practitioners (NPs)		• Some hospices may have NPs in roles similar to designated hospice physicians. • NP works within the interdisciplinary team autonomously and in collaboration with physicians to provide medical care to the hospice residents within the NP scope of practice.
Nursing (RNs/LPNs)	• Must have RNs onsite 24x7; however, there is recognition that occasionally there are short-term situations where this is not possible, e.g. nurse sick – in these situations, there must be 24x7 access to an RN. • It is expected that RNs have two years of recent, related medical nursing experience in an acute care facility or hospice palliative care environment, which includes one year of recent related hospice/palliative career experience. • Some hospices may have LPNs involved in providing direct resident care; while it is preferred that they have previous hospice palliative care experience, it is understood that, currently, few LPNs meet this standard. • Additional information on standards relating to the role of nurses in hospice palliative care is available in CHPCA's *Hospice Palliative Care Nursing Standard of Practice.*	• Nurses are encouraged to obtain the Canadian Nurses Association (CNA) certification for HPC – CHPCN(C).
Care Aides	• Care aides must be registered with the BC Care Aide and Community Health Worker Registry. • Care aides must have acute and/or palliative experience. • Care aides assist residents with their activities of daily living, provide medication assistance and help implement the care plans, as well as provide support for housekeeping and meal preparation.	
Management Function	• Each hospice should have a person functioning in a management capacity who will ensure appropriate care standards are in place, consult and collaborate with VCH, facilitate admission of residents in partnership with VCH, and report regularly to VCH on the quality activities of the hospice. • If the person provides this function to multiple facilities, it is expected that they will be on-site at each facility for a period of time each week.	
Clinical Nurse Lead/Patient Care Coordinator	• Nursing leadership must be provided in the hospice. • This person provides orientation and education for staff, works directly with residents and families, supports and mentors staff, and promotes decisions and actions that contribute to the environment in the hospice.	

Table continued...

Expectations relating to hospice staff and functions (Continued)

Role/Function	Expectations/Requirements	Additional Desirable Supports
Social Worker Function	• Hospices may have a social worker as part of their staff or access this function as a VCH resource; alternatively, they may have this function embedded in another role. • This person supports the care of and advocates for the residents and families. • Additional information on the competencies for this role are available in CHPCA's *Canadian Social Work Competencies for Hospice Palliative Care: A Framework to Guide Education and Practice at the Generalist and Specialist Levels.*	• Social worker on-staff.
Volunteers	• Volunteers play an important role in supporting hospice residents and their families, and are considered to be part of the care team. • In some hospices, volunteers may be coordinated directly by the hospice service provider; in others, volunteers may be coordinated by an external organization. • Regardless of the body that trains and coordinates the volunteers, their volunteers must adhere to the *Volunteer Standards for Hospice Palliative Care in British Columbia*.	• Some facilities may have volunteers with specific skills (e.g., therapeutic touch, art therapy, music therapy, spiritual support, etc.).
Pharmacy Function	• The distribution pharmacist must meet the requirements outlined in the College of Pharmacists of British Columbia's *Bylaw 7 - Residential Care Facilities and Homes.* • Sample of questions to ask when tendering for pharmacy services is available in Appendix XI – Sample of Questions to Ask When Tendering for Pharmacy Services. • In addition, they must be able to provide the following: - Daily Medication Administration Records and the ability to adjust medication times to suit resident's individual needs. - Individual medications and ward stock drugs on a mutually agreed upon schedule. - Frequent medication changes and admission orders during weekdays and regular business hours. - After hours and weekend/holiday pharmacy coverage for urgent medications. - Continuous infusions via cassette or mini-bag (to be given via portable pump). - Day pass/overnight pass medications with 24 hours notice or less if possible. - Process for ordering and delivery of medications. - System for transporting drugs and restocking medication cart drawers (e.g. Courier system, extra set of cassettes for easy transport and exchange). - Compounding services as needed, when covered under Plan P**. - Notification when there will be a delay in supplying medication. - Receive and be responsible for the destruction of expired or unusable medications (including narcotics).	

** Plan P refers to the BC Palliative Care Drug Program through PharmaCare. All hospice residents are on Plan P, which covers most medications required by hospice residents. Efforts should be made to use the Plan P formulary as much as possible. In situations where this is not possible, discussions with the resident and/or family regarding the fact that they will be financially responsible for these medications must occur. Accommodations will be made if they cannot afford these medications.

Table continued...

Expectations relating to hospice staff and functions (Continued)

Role/Function	Expectations/Requirements	Additional Desirable Supports
Spiritual Care Function	• Some facilities may have chaplains or other religious/spiritual leaders that provide spiritual care to residents and their families on a full-time or part-time basis, either as staff or as a volunteer; others bring in religious/spiritual support on an as-needed basis. • Regardless of the type of spiritual care provided, it is essential that residents and families are provided with religious/spiritual support when they request it.	
Bereavement Function	• Bereavement support for the resident, family and staff is a critical function. • There may be a dedicated person in this role or the function may be shared by volunteers, spiritual care personnel and/or other staff in the hospice; regardless of who provides this support, bereavement training must be provided.	
Occupational Therapist (OT)/ Physiotherapist (PT)	• Hospices may have an OT/PT as part of their staff or access this function on a consultation basis. • These people are responsible for providing diagnostic, consultative, and/or treatment services for residents with disorders that cause impaired functioning in activities of daily living.	
Nutritionist/ Dietitian	• Hospices may have a nutritionist/dietitian as part of their staff or access this function on a consultation basis. • This person ensures that the dietary and nutritional needs of residents are met.	
Complementary Therapy	• Residents and families should have access to complementary therapies (e.g., music, healing touch and/or art therapy). • This may be provided by paid staff, volunteers or people brought in by family/resident privately or by the community.	
Additional Community Clinical Specialist Services	• Additional community clinical specialist services may be utilized depending on the individual needs of the resident. • These may include wound clinicians, addiction support, mental health.	

Hospice Staff Orientation and Ongoing Education

Hospice service providers are expected to develop and provide orientation for new staff when hospice first opens and then as new staff is hired. VCH can assist with ensuring that the necessary topics are included in the orientation. However, generally, orientation should include information on: hospice philosophy; hospice palliative care clinical guidelines and tools; the hospice's mission, vision and values; collaborative practice; principles of death and dying; hospice facility policies and operations; expectations regarding performance; individual and team roles and responsibilities; goals and objectives; safe use of equipment, supplies and devices; and end of life care.

A sample of a palliative care orientation schedule is included in Appendix XII – Sample of Palliative Care Orientation.

Hospices are expected to support ongoing education, training and development for their staff, both formally and informally. This can include in-service education, formal or informal mentoring, conferences, education provided by VCH or another external organization, and other activities that promote lifelong learning.



Hospice Palliative Care Clinical Guidelines

This document does not establish hospice palliative care clinical guidelines, as several key documents relating to hospice palliative care clinical guidelines have already been developed and are in use within VCH. These are:

- *VCH Community Palliative Care Clinical Practice Guidelines.*
- *CHPCA: A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice.*
- *Accreditation Canada: Hospice, Palliative, and End-of-Life Services.*
- *Community Care and Assisted Living Act/Residential Care Regulation (Licensing).*

In situations where the guidelines appear contradictory, the VCH palliative care teams can assist the hospice service provider in determining the best course of action.

Patient Care Delivery

Care delivery, in the hospice setting, is provided by an interdisciplinary care team working collaboratively to ensure that all decisions and actions undertaken are resident-centred. The primary goal is to ensure continuity of care for residents and their families.

Samples of different forms and tools are available in the appendices:

- Appendix XIII – Sample History and Physical Examination.
- Appendix XIV – Sample End of Life Directives.
- Appendix XV – Sample of Care Map Kardex.
- Appendix XVI – Sample of Bereavement Record.
- Appendix XVII – Sample of Checklist for "When Someone Dies".
- Appendix XVIII – Sample of Medication Billing Form.

Patient Chart

The hospice patient chart is different in each of the facilities. However, there is an expectation that all charts contain the same basic information including details relating to medical history, pain and pain management, symptoms and symptom management, medications and non-drug treatments, and evaluation of each intervention.



Hospice Operational Guidelines

Each hospice will be expected to develop its own set of operational guidelines. These should include guidelines related to personnel, administration, safety and physical plant, among other areas. Licensing requirements should be incorporated into these guidelines. A sample of the table of contents for a hospice operational manual is included in Appendix XIX.

Hospice Indicators

VCH has established indicators for hospices operating within its boundaries. These include utilization indicators as well as quality indicators. The goal of collecting these indicators is to ensure a high level of service as well as to track trends in utilization.

The following are indicators that will be in place for tracking purposes in 2011. Other proposed quality-related indicators are currently being reviewed, with the goal of ensuring that they are integrated into the care process and based on Accreditation Canada's Qmentum Program 2010, Standards for Hospice, Palliative and End-of-Life Services.

- Average wait time for hospice.
- Number of admissions – cancer patients versus non-cancer patients.
- Hospice per diem rates (full rate, partial rate, no cost).
- Hospice length of stay (1-3 days, 4-21 days, 22-42 days, 43-90 days, 91-180 days, 180+) and average length of stay.
- Hospice utilization – male versus female.
- Hospice admitted from (acute, residential care, home, etc.).
- Hospice average age of clients.
- Hospice discharge to (death, acute, residential care, home, etc.).
- Number of patients placed in preferred location vs. placed in any location.
- Occupancy rate.

Appendices

Appendix I – Summary Grid

Item	Reference Document	Reference Page #
Applying for a licence, including details of process	*Residential Care Regulation (Licensing), March 2009*	7, 38, 39
Continuing duty to inform	*Residential Care Regulation (Licensing), March 2009*	7
Notice of change of operation	*Residential Care Regulation (Licensing), March 2009*	8
Liability insurance	*Residential Care Regulation (Licensing), March 2009*	8
Investigation or inspection	*Residential Care Regulation (Licensing), March 2009*	9
Building code considerations	*VCH Design Guidelines: Complex RC Developments, June 2007*	79-85
Facility Requirements: General Physical Requirements		
Directional assistance/wayfinding	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments, June 2007*	9 14, 26 (sec. 4.6 & 4.7)
Accessibility (e.g., mobility aid)	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	9 14
Windows	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	9 56-62
Temperature and lighting	*Residential Care Regulation (Licensing)*	9
Water temperature	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	10 64-65
Telephones	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	10 76
Monitoring, signalling and communication	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	10 74
Emergency equipment	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	10 27, 65, 75
Equipment and furnishings	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	11 55
Maintenance	*Residential Care Regulation (Licensing)*	11
Smoking	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	11 30
Weapons	*Residential Care Regulation (Licensing)*	11
Finishes	*VCH Design Guidelines: Complex RC Developments*	52-54
Electrical Services	*VCH Design Guidelines: Complex RC Developments*	68-73
Facility Requirements: Bedrooms		
Physical requirements of bedrooms	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	11-13 30-35
Facility Requirements: Bathroom Facilities		
Physical requirements of bathrooms	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	13 35-40

Table continued...

Appendix I – Summary Grid (Continued)

Item	Reference Document	Reference Page #
Facility Requirements: Common Areas and Work Areas		
Dining Areas	*Residential Care Regulation (Licensing)*	14
Lounges	*Residential Care Regulation (Licensing)*	14
Designated work areas	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	15 40-43
Outside activity areas	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	15 28-30
Staff		
Character and skill requirements, continuing health of employees, continuing monitoring of employees, management and supervisory staff, staffing coverage, employee trained in first aid, food services employees	*Residential Care Regulation (Licensing)*	15-17, 39
Investing in hospice palliative and end-of-life services, engaging prepared and proactive staff	*Hospice, Palliative, and End-of-Life Services; Accreditation Canada, Qmentum Program 2009*	1-9
Volunteers		
Standards	*Volunteer Standards for Hospice Palliative Care in British Columbia, 2008*	Entire document
Operations: Admission and Continuing Accommodation		
Prohibited service, admission screening, advice on admission, other requirements of admission, continuing accommodation	*Residential Care Regulation (Licensing)*	18
Operations: General Care Requirements		
Emergency preparations, harmful actions, privacy, general health and hygiene, program of activities, identifications of persons in care off-site, access to persons in care, release or removal of persons in care, family and resident council, dispute resolution, self-monitoring of community care facility	*Residential Care Regulation (Licensing)*	19-23
Clinical Practice Guidelines	*Clinical Practice Guidelines, Community Palliative Care, VCH, 2007*	Entire document
Clinical Practice Guidelines for Quality Palliative Care	*Clinical Practice Guidelines for Quality Palliative Care, National Consensus Project, 2009*	Entire document
Nursing Standards of Practice	*Hospice Palliative Care Nursing Standards of Practice, Canadian Hospice Palliative Care Association, February 2002*	Entire document
Providing safe and appropriate services, enhancing quality of life, monitoring quality and achieving positive outcomes	*Hospice, Palliative, and End-of-Life Services; Accreditation Canada, Qmentum Program 2009*	10-27, 29-32

Table continued...

Appendix I – Summary Grid (Continued)

Item	Reference Document	Reference Page #
Operations: Nutrition		
Menu planning, food preparation and service, food service schedule, participation by persons in care, individual nutrition needs, eating aids and supplements	*Residential Care Regulation (Licensing)*	23-25
Operations: Medication		
Medication safety and advisory committee, packaging and storage of medication, administration of medication, changes to directions for use of medication, return of medication to pharmacy	*Residential Care Regulation (Licensing)*	25-27
Operations: Use of Restraints		
Restrictions on use of restraints, when restraints may be used, reassessment	*Residential Care Regulation (Licensing)*	27,28
Operations: Matters That Must Be Reported		
Notification of illness or injury, reportable incidents	*Residential Care Regulation (Licensing)*	29, 40, 41
Records: Records for Each Person in Care		
Records for each person in care, records respecting money and valuables of persons in care, short term care plan on admission, care plan if more than 30 day stay, implementation of care plans, nutrition plan, use of restraints to be recorded in care plan	*Residential Care Regulation (Licensing)*	30-33
Maintaining accessible and efficient clinical information systems	*Hospice, Palliative, and End-of-Life Services; Accreditation Canada, Qmentum Program 2009*	28
Records: Additional Records		
Policies and procedures, records respecting employees, food services records, record of minor and reportable incidents, record of complaints and compliance, financial records and audits	*Residential Care Regulation (Licensing)*	33-35
Records: General Requirements Respecting Records		
Currency and availability of records, how long records must be kept, confidentiality	*Residential Care Regulation (Licensing)*	36

Appendix II –
Request for Richmond Integrated Hospice Palliative Care Program

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Richmond Integrated Hospice Palliative Care Program
Telephone: 604 278-3361
Fax: 604 278-4713

REQUEST FOR RICHMOND INTEGRATED HOSPICE PALLIATIVE CARE PROGRAM

DATE: _____

☐ Consultation by Palliative Care Team
☐ Home Care
☐ Hospice

☐ Urgent admission to PCU (within next 48 hours)
☐ Possible future admission ☐ PCU ☐ Hospice
☐ Volunteer

PATIENT'S NAME (PLEASE PRINT): _____ ☐ Male ☐ Female

PATIENT'S DATE OF BIRTH (dd/mm/yyyy): _____ PHN: _____

ADDRESS: _____

_____ PHONE: _____

CONTACT PERSON: _____

RELATIONSHIP: _____ PHONE: _____

DIAGNOSIS: _____

PATIENT AND FAMILY ACCEPTING OF PALLIATIVE CARE? ☐ Yes ☐ No

COMMENTS: _____

REASON FOR REFERRAL: _____

_____

_____

_____

LANGUAGE: _____

MOST RESPONSIBLE PHYSICIAN: _____ PHONE: _____

REFERRAL SOURCE: _____ PHONE: _____

NOTE: FORM MUST BE COMPLETED FOR REQUEST TO BE PROCESSED

Home Care Clerk: For consults and PCU referral, place form in PCT tray
For Home Care only, generate chart and forward to Home Care Team

FOR PALLIATIVE CARE TEAM USE ONLY

Accepted to Palliative Care

☐ Yes Date: _____ ☐ Faxed to Physician ☐ Bed control aware

☐ No Reason: _____

_____

Recommendations: _____

_____

_____

Palliative Care Benefits Program ☐ Yes ☐ No

VCH.RD.RH.0126 (Oct.2009)

Vancouver CoastalHealth

Appendix III – Vancouver Hospice Consent Letter

Vancouver Hospice Consent Letter

"'Hospice palliative care' is a philosophy of care that stresses the relief of suffering and improvement of the quality of living and dying. It helps patients and families to:

- *Address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears*
- *Prepare for and manage self-determined life closure and the dying process*
- *Cope with loss and grief during illness and bereavement."*

BC Provincial Framework for End-of-life Care – May 2006

Client and Family Discussion with Healthcare Provider:

(Healthcare Provider Name)_____, has shared and discussed the diagnosis ☐

the prognosis ☐ and the hospice philosophy with emphasis on comfort care only, including the 'no resuscitation' requirement ☐ with

(Client)_____, and/or Alternate Decision-maker

(Name)_____

The Client / Family agree with the philosophy and 'comfort care' emphasis of hospice. ☐ Yes ☐ No

Signature of Client/ Alternate Decision-maker: _____

Date of Discussion: _____

Financial:

Client/ Family agree to pay daily Standard User Fee (Rate Code A): ☐ Yes ☐ No

☐ Patient is on income assistance ☐ Yes ☐ No

Person responsible for payment: (in addition to Client) _____

Tel:_____

Address:_____

Signature of Client/Alternate Decision-maker: _____

If fee waiver is requested, two Rate Reduction forms; **LTC #6** and **Application for Temporary Rate Reduction of Client Rate** ***MUST*** be completed before Hospice admission.

Consent Letter completed by (print): _____ Title: _____ Date:_____

Client's PARIS # _____ or PHN # _____

2008/06 Vancouver Coastal Health Authority

Appendix IV – Vancouver Hospice Referral Form

Providence HEALTH CARE Vancouver Hospice Referral Form — Vancouver Coastal Health

☐ From Community: Complete & Fax to Palliative Access Line (PAL) @ 604-267-3419
☐ From Hospital: Complete form and forward with documents to TST Staff

DATE: (dd/mm/yy) _____ PHN #: _____ CC #: _____ PARIS #: _____

1 Referral source

	☐ New referral	☐ Re-referral
☐ St. Paul's Hospital PCU	☐ Three Bridges CHC	☐ RavenSong CHC
☐ Vancouver General PCU	☐ Pender St. CHC	☐ Home Hospice Consult
☐ St. Paul's Hospital Ward _____	☐ South CHC	☐ Fraser Health (FHA) Tel:_____
☐ Vancouver Acute Ward _____	☐ North CHC	☐ BCCA Unit: _____
☐ MSJ Hospital Ward _____	☐ Evergreen CHC	☐ G P Office (Name) _____
☐ UBC Hospital Ward _____	☐ Pacific Spirit CHC	Tel: _____
☐ Care Facility: _____ Tel: _____		Fax:_____

2 Healthcare Contact making referral:
Name:_____
Title: _____ Assessor # :_____
Has the Palliative Consult Service been involved? ☐ Yes ☐ No
Healthcare Contact for Hospice adm. when bed available:
Name:_____
Tel:_____ Pager:_____

3 Urgency of referral:
☐ Client otherwise requires ER admission in the next 24 hrs.
☐ Client is ready for hospice now (within 48 hrs. notice)
☐ Client is presently receiving Shiftcare Nursing at home
☐ Future care estimate: Probable adm. **less** than 1 month
☐ **Respite Care (1 wk) From:** _____ **To:** _____
Hospice Preferred: (1) _____
(2) _____

4 Client Name: (last) _____ (first) _____ (initial) _____
Date of birth dd/mm/yyyy: _____ Age: ____ male / female Marital Status: ☐ (S) ☐ (M) ☐ (D) ☐ (W) ☐ (Sep)
Permanent Address: (Apt.) _____ (Street) _____ (City) _____ Postal Code _____

Decision-maker if/when Client is unable to make decisions for Self:
☐ Next of Kin ☐ Power of Attorney (POA) ☐ Informal Decision-maker ☐ Legal Representative
Name: (last) _____ (first) _____
Address: (street) _____ (city/town) _____ (postal code) _____
Tel No: (home) _____ (work) _____ (cell) _____

5 Client Diagnosis: _____ Date Dx:_____
Prognosis: ☐ wks ☐ < 3 mos. ☐ > 3 mos. ☐ > 6 mos. Other illnesses: _____
_____
Allergies: _____ Present functional status: ☐ Independent ☐ 1 P assist ☐ 2 P assist ☐ Bed bound
Why does Client need hospice placement? _____
_____
_____ Palliative Performance Scale (PPS) % : _____
☐ Altered cognitive state ☐ Drug misuse ☐ Alcohol misuse ☐ Smoking ☐ Mental Illness ☐ Safety risk
If yes, explain: _____

6 Physician Coverage:
Family Physician (name):_____ Tel #: _____ Fax #: _____
Family MD will continue to provide primary care ☐ **YES** ☐ **NO** ☐Marion Hospice ☐Cottage Hospice ☐May's Place ☐Richmond Hospice

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Form continued...

Vancouver CoastalHealth

Providence HEALTH CARE

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Vancouver Hospice Referral Form

7 Communication:

Can Client express needs? ☐ Yes ☐ No Can Client comprehend? ☐ Yes ☐ No ☐ Unknown

English proficiency: ☐ None ☐ A few words ☐ Adequate ☐ Client unable to speak

Translator:_____ Translator relationship:_____ Tel:_____

Client Language(s): Spoken _____Preferred language:_____

8 Equipment to be ordered by Referral Source before admission: ☐ None

oxygen ☐ yes ☐ no	☐ Pleurx catheter supplies	☐ hypodermoclysis
Home Oxygen Program ☐ yes ☐ no	☐ CADD pump and tubing	☐ other_____
☐ oxygen tubing / prongs / mask / nebulizers	☐ feeding equipment	☐ enteral feeds_____
☐ trach supplies	☐ ostomy supplies	☐ specialized dressings

9 Client and Family Discussion with Healthcare Provider:

(Healthcare provider name)_____, have shared and discussed the diagnosis ☐, the prognosis ☐ and the hospice philosophy ☐, including no resuscitation with (client)_____, and/or Alternate Decision-maker (name)_____.

The Client / Family agree with the philosophy and comfort only care emphasis of hospice. ☐ Yes ☐ No

Date of discussion:_____

Comments:_____

10 Financial:

Client/ Family agree to pay daily Standard User Fee (Rate Code A): ☐ Yes ☐ No ☐ Patient is on social assistance

If fee waiver is requested, two Rate Reduction forms; **LTC # 6** and **Application for Temporary Rate Reduction** ***MUST*** be completed before Hospice acceptance.

Financial assessment completed by:_____ Title: _____ Date:_____

Person responsible for payment: (other than Client) _____ Tel:_____

Address:_____

11 *REQUIRED information to be sent at the time of referral:*

Medical History and Physical or Discharge Summary (within last 30 days)	☐ Sent
Copy of the B C Palliative Benefits Program application	☐ Sent ☐ Already in Program
Copy of the B C Provincial No CPR form	☐ Sent
Copy of the Palliative Care Consultation (if completed)	☐ Sent
Current list of medications OR MAR	☐ Sent

Date:_____ Client Signature: _____

Date:_____ Completed by:_____ Title:_____

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Appendix V – Vancouver Healthcare Providers' Resource Guide

Vancouver Healthcare Providers' Resource Guide For Prospective Hospice Care Residents and their Families

What is Hospice?	Hospice is a place of care for persons living with life-limiting illness in their last months of life. The focus of care at hospice is individualized for each resident and their family of choice. Hospice care focuses on controlling physical symptoms of illness, providing emotional care, supporting spiritual wishes and maximizing each person's quality of life.
When would a person be considered appropriate for hospice?	Persons in hospital or the community with an estimated disease prognosis of three months or less would be considered appropriate for hospice care. Please refer to the **Vancouver Hospice Admission Criteria** for further details.
What type of care is provided at hospice?	The emphasis in hospice is on comfort care. Symptom management and treatments to improve quality of life are provided. Some life-prolonging procedures and therapies that require monitoring and treating complications in a manner other than comfort-focused would not be appropriate for hospice; for example, surgical procedures or total parenteral nutrition (TPN).
How can a person check to find out if particular procedures, such as tracheostomy care, can be provided at hospice?	The palliative consult service, providing care in the community or in hospital can help you with answers. Generally, if a person meets the Hospice criteria, the goal of care is to accommodate him/her. However, a person with complex care needs may require a hospice to organize specific provisions such as, special ordering of equipment or staff training, before he/she can be admitted to hospice.
What staffing is provided in hospice?	All hospices are staffed with RNs and licensed care aides. A hospice doctor is available 24 hrs./day and will visit regularly. A resident's own doctor may still provide medical care in hospice if the physician and resident agree. Hospices have additional staff who provide meals, clean, and offer additional support, often with skilled volunteers.
Are there visiting hours like at the hospital?	There is no barrier to visiting hours. Staff will make every effort to accommodate an overnight stay too, especially at critical changes in the resident's condition.
Can a pet visit?	Yes. A pet is welcome if it is clean, safe and a responsible person will be able to look after its needs while visiting.
Can friends/family bring in special food?	If the resident is able to eat and drink, family and friends can bring in personal food. Unfortunately, hospices have limited space and facilities to store and heat food (microwave).
Can residents go out (E.g. shopping, to a restaurant)?	Yes. Just inform a staff member at hospice before leaving and an expected time of return.
Do hospices have computers? Internet?	Each hospice has internet capability. Check with a specific hospice about access and available equipment.
Are there telephones in resident's rooms?	There will either be a phone in a room or a portable phone can be brought to a room.
Is there a TV? CD player? DVD player?	Hospices all have cable TVs, CD players and DVD machines.

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Table continued...

Vancouver Healthcare Providers' Resource Guide For Prospective Hospice Care Residents and their Families

Is smoking allowed at hospice?	Smoking is allowed in special areas. At Marion Hospice, residents must be able to transport themselves downstairs (by elevator) and outside independently. The other hospices allow smoking in designated areas on the same floor level.
Is parking available?	Parking is available on site at Cottage Hospice and the shared Richmond Hospice. There is nearby parking available at Marion Hospice and metered parking at May's Place.
Can rooms be decorated with personal pictures and furniture?	The bedrooms at hospice are the resident's personal space. However, there is limited room for furniture and hospice furniture is particularly furnished for safety. A few items are welcome. Speak to hospice staff before moving personal items.
What happens to belongings after a person dies?	At the time of admission, it is very important to let staff know who will be responsible for any personal belongings. This person will be responsible for packing and returning any personal items to the family.
How much does Hospice cost?	There is no financial barrier to living in hospice. Hospice fees are set at a standard daily rate. If the hospice resident is unable to pay this fee, a healthcare provider will complete LTC # 6 and the Application for Temporary Reduction of Patient Rate and include these forms at the time of referral.
How does a person move into hospice? Can a person view the hospice before making a decision?	Hospice referrals are coordinated through Vancouver Community Health. Clients are waitlisted on priority of need, urgency and personal choice. Please refer to **Vancouver Hospice Referral** form and **Vancouver Hospice Transfer Checklist.** Respecting the need for peace and privacy at hospice, a visit to any hospice can be prearranged through the Hospice Coordinator.
Can a person be placed directly into hospice if there is a vacancy and the paperwork is sent as long as the hospice Coordinator agrees?	The only access to any hospice bed is through the single access system process in place in agreement with the Vancouver Hospice Palliative Care Consortium, TST, Social Work and the hospice coordinators. Please respect the process. Any concerns with the process or potential complex care issues can be directed to the acute or community palliative care consult teams.

Underpinning hospice care is a philosophy that takes as its starting point the affirmation of death as a natural part of life. Built on that bedrock are the values of respect, choice, empowerment, holistic care and compassion. Hospices care for the whole person aiming to meet all needs - physical, emotional, social and spiritual. Hospices care for the person who is dying and for those who love them.

The Canadian Virtual Hospice

For more information or to access Hospice care in Vancouver, call;
Palliative Access Line (PAL) @ (604) 263-7255

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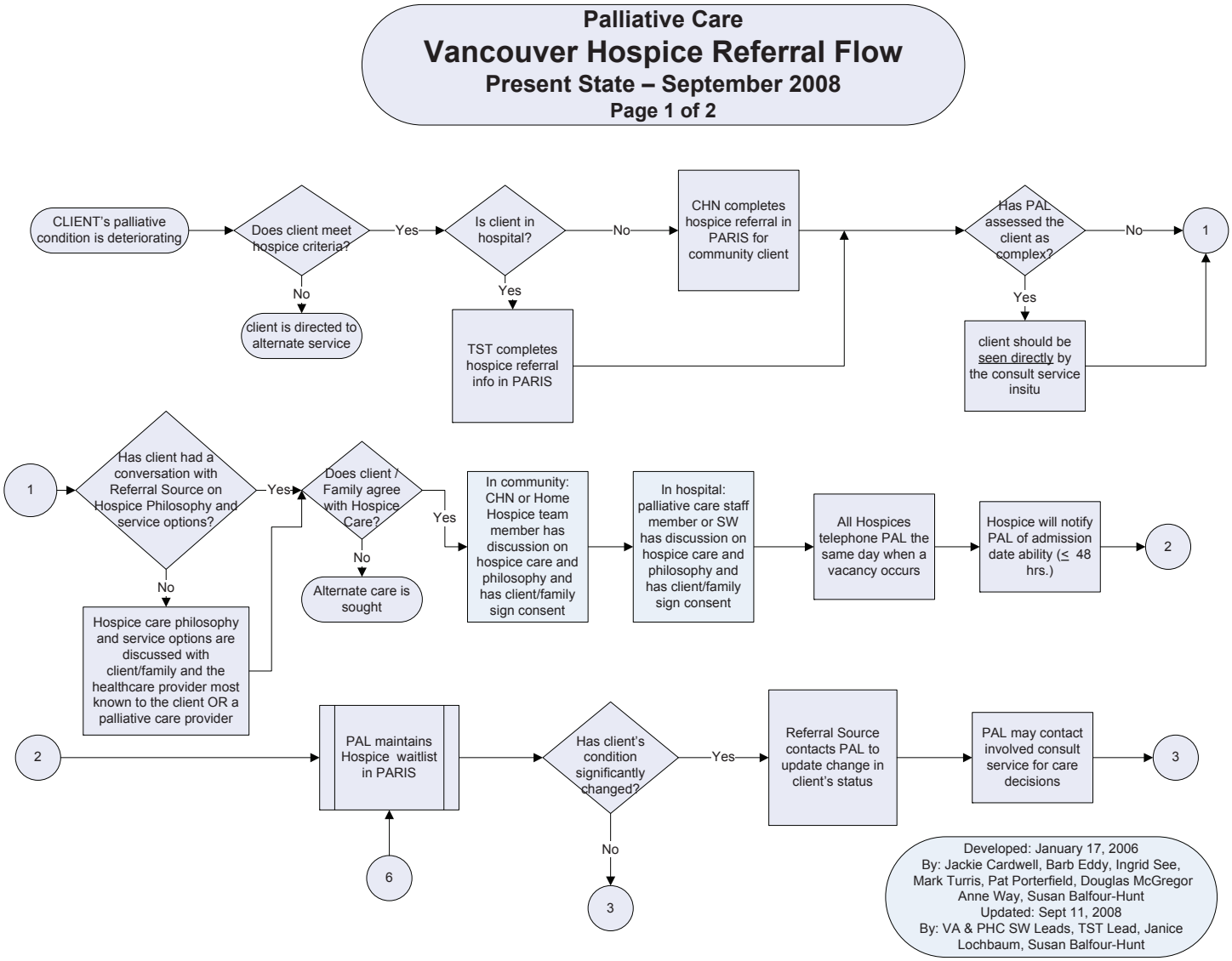
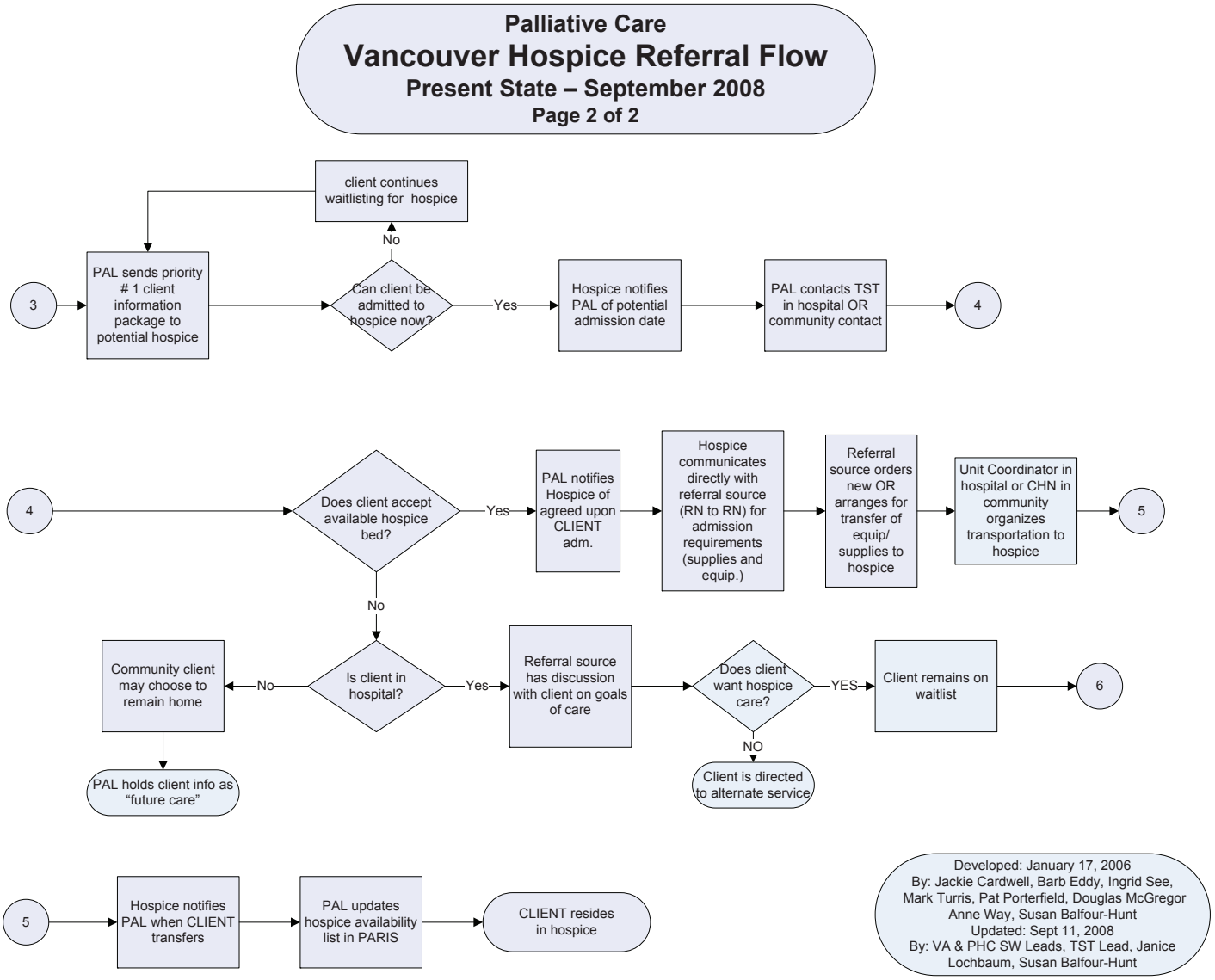
Appendix VI – Vancouver Hospice Referral Flow

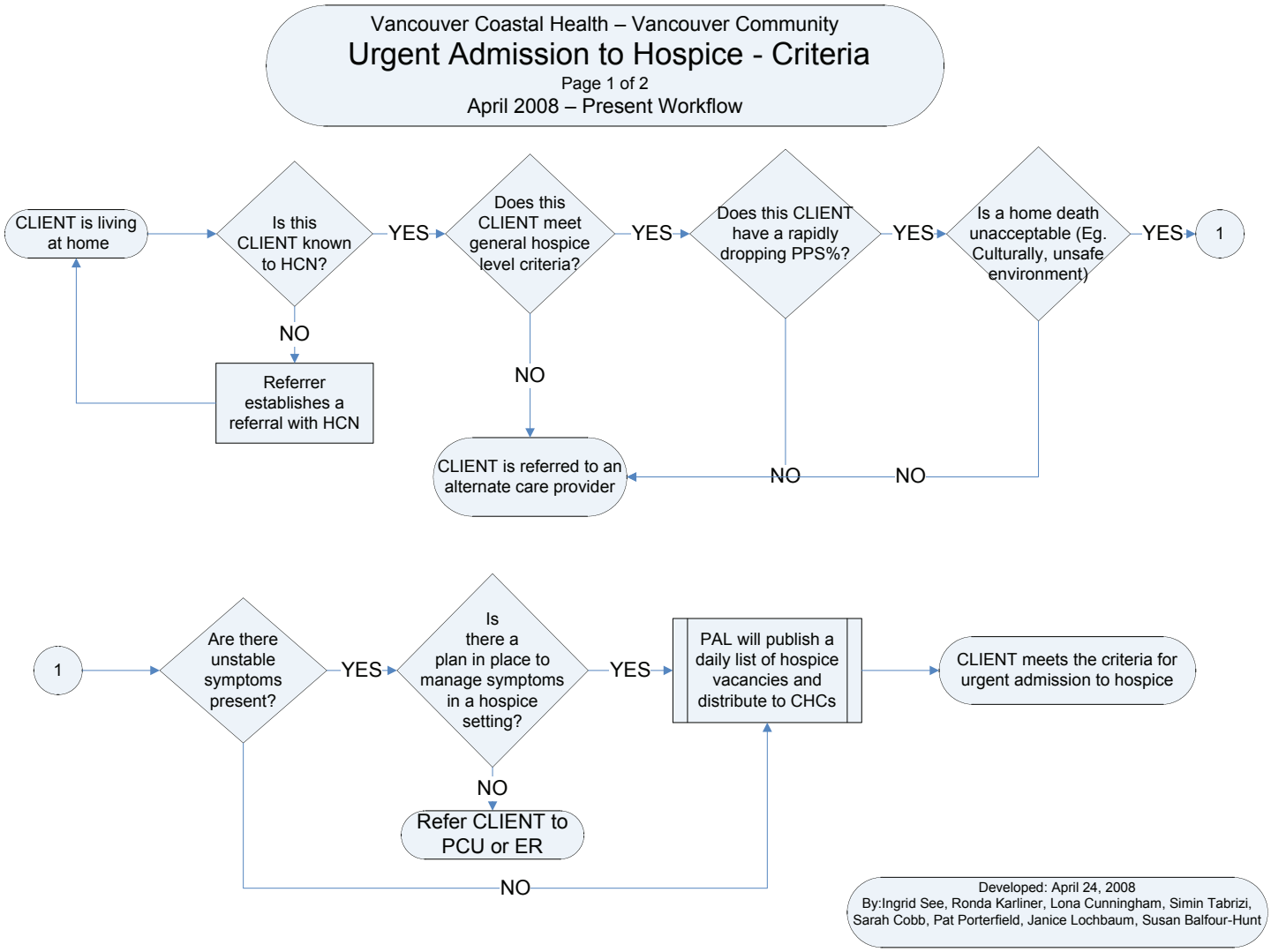


Flowchart continued...

Appendix VI – Vancouver Hospice Referral Flow (Continued)

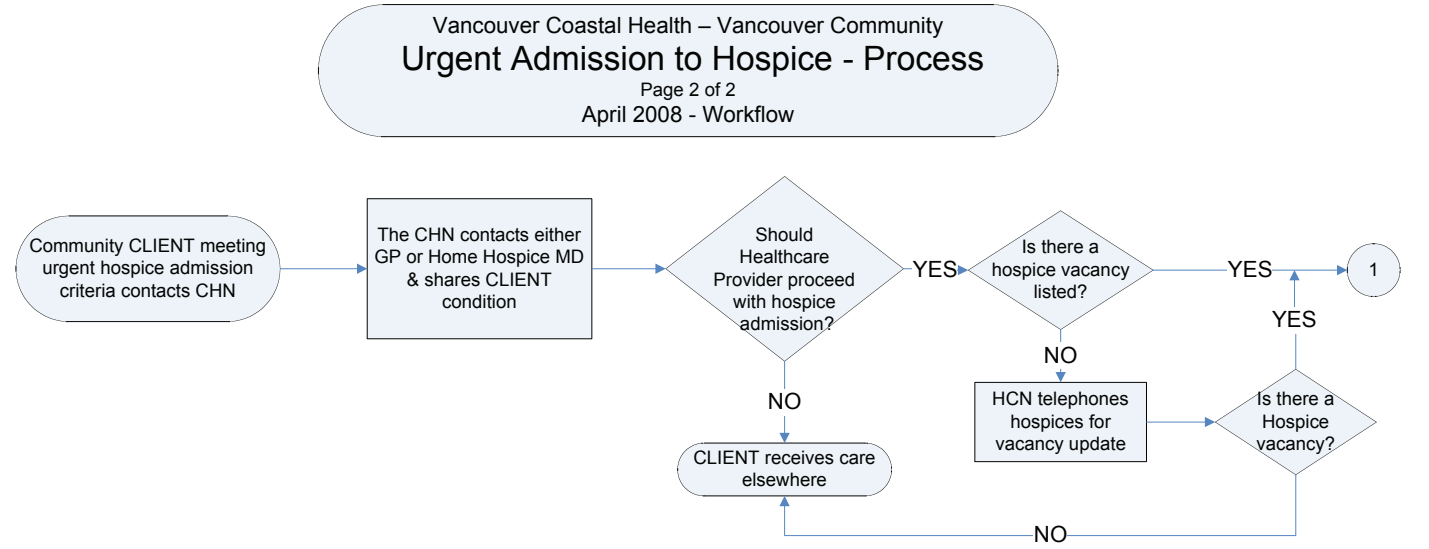


Appendix VII –
Process Flow for Urgent Admission to Hospice (after hours)



Flowchart continued...

Appendix VII – Process Flow for Urgent Admission to Hospice (after hours) (continued)



Developed: April 24, 2008
By:Ingrid See, Ronda Karliner, Lona Cunningham, Simin Tabrizi, Sarah Cobb, Pat Porterfield, Janice Lochbaum, Susan Balfour-Hunt

Appendix VIII –
Vancouver Hospice Guidelines for Prioritizing Waitlisted Clients

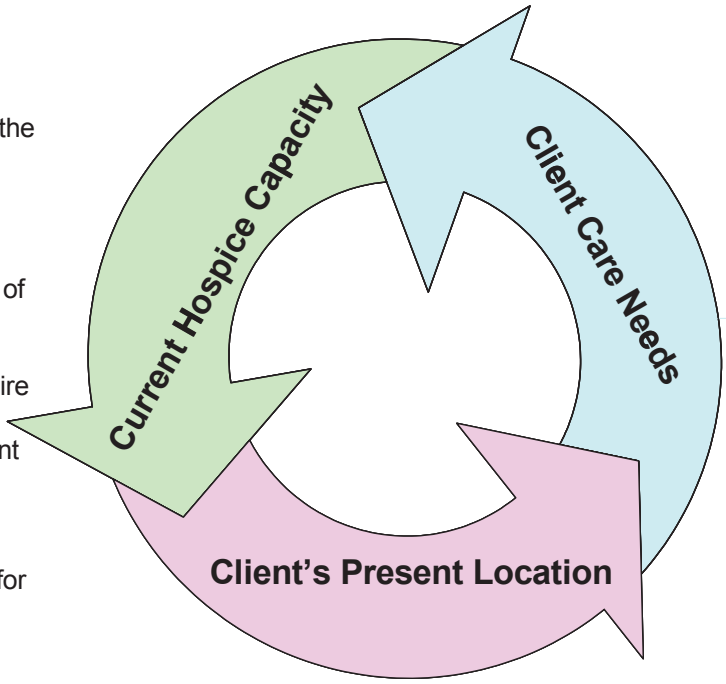
Vancouver Hospice Guideline for Prioritizing Waitlisted Clients

Hospice Profile

What is the present complexity of care within the hospice?
- ☐ Present hospice residents' care needs
- ☐ Staffing capability
- ☐ Environment / lifestyle of residents

Does this admission require a delay in admission for;
- ☐ Equipment procurement
- ☐ Staff education
- ☐ Care specialization

Geographic accessibility for closest family members



Client Profile: Social / Physical / Psychological

How many days has the client been waitlisted for hospice?

What is the client's EOL prognosis in days / weeks?

What is the rate of client's decline? PPS % decline?

Is the client presently receiving Shiftcare nursing at home?

Does the client have needs that require specific placement?

Would client accept an alternate hospice placement?

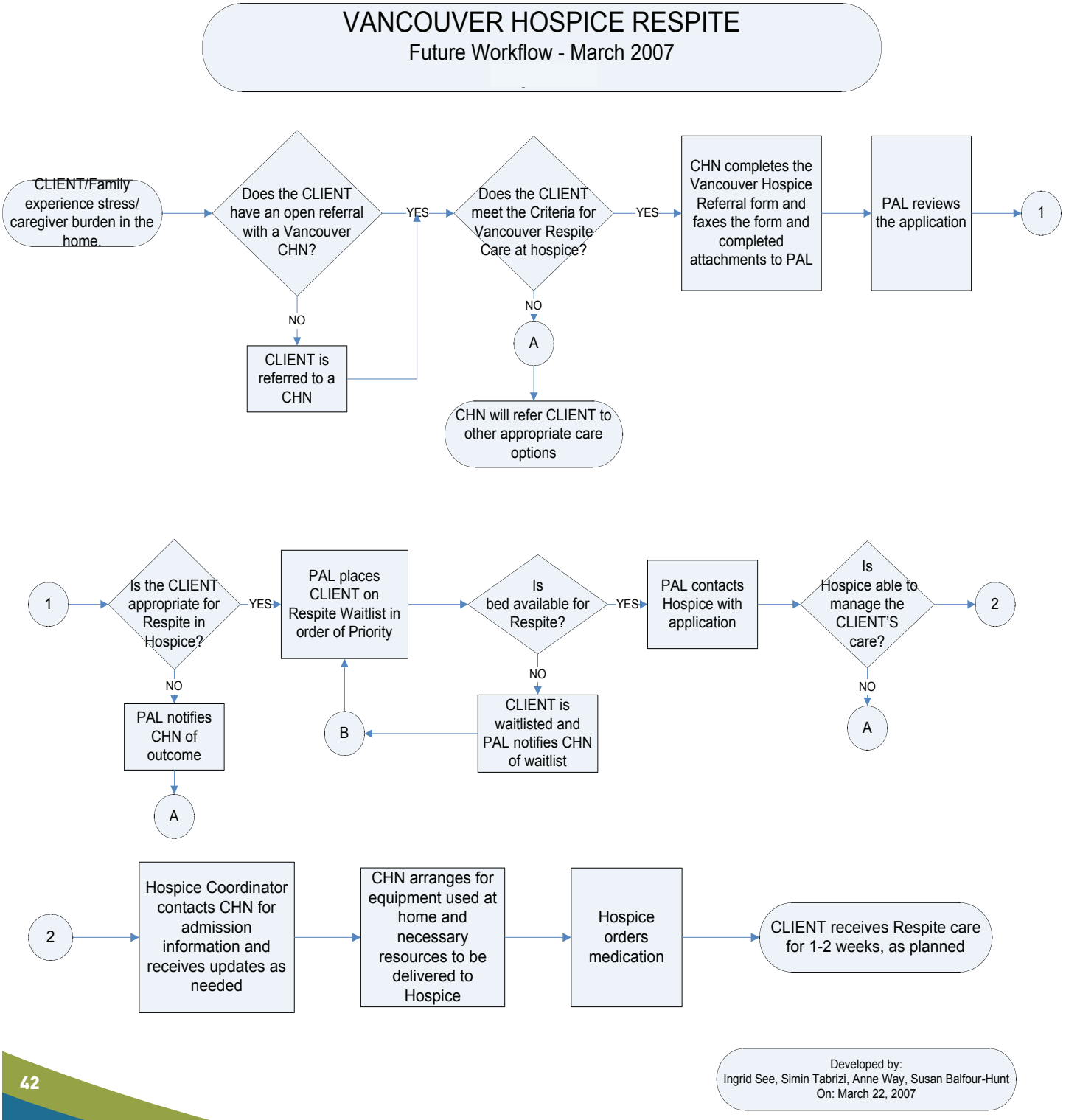
Site Assessment of Risk and Safety

What risk factors exist for the client in his/her present living placement?
- ☐ Physical setting is unsafe for client + / or caregivers
- ☐ Lack of caregivers / Caregiver burnout / Unsafe caregivers
- ☐ Threat from immediate environment
- ☐ Precarious family status

Can admission to hospice be delayed safely for the short-term with appropriate support?

Date: May 1, 2006
Developed by: Hospice Access Group

Appendix IX – Vancouver Hospice Respite Process



Developed by:
Ingrid See, Simin Tabrizi, Anne Way, Susan Balfour-Hunt
On: March 22, 2007

Vancouver CoastalHealth

Appendix X – Sample Hospice RN Job Description

This sample is provided courtesy of Fraser Health.

Position: Registered Nurse/Registered Psychiatric Nurse, Hospice Residence

Location:

Program/Service: Hospice Palliative Care

Reports To: Manager, Health Services

Bargaining Association: Nurses' Bargaining Association

Bargaining Unit:

Classification: Direct Care Level 1 (DC 1)

Job Description Number: N2224

Job Code: N_DC1

Job Summary: As a member of a multidisciplinary team, provides direct nursing care to patients of the Hospice Residence according to established policies and procedures including: assessing total physical, emotional, spiritual and psychosocial needs; planning, documenting and implementing care plans; evaluating effectiveness of care plans and making recommendations for changes where necessary.

Duties & Responsibilities:

1. Assesses, plans, implements and evaluates nursing care of assigned patients. Diagnoses actual or potential problems and strengths, plans and performs interventions and evaluates outcomes.
2. Collects information from a variety of sources using skills of observation, communication and physical assessment to enable the provision of appropriate nursing care.
3. Communicates and consults with members of the health care team about patient care. Participates in interdisciplinary conferences. Explains plan of care to patients and families.
4. Acts as an advocate to protect and promote the patient's rights to autonomy, respect, privacy, dignity and access to information.
5. Participates in quality improvement activities by identifying patient care issues and collecting data.

Continued

6. Writes timely and accurate reports of relevant observations including patient and family teaching and evaluation of nursing care.
7. Participates as an active member on nursing and hospital committees and councils for improvement of patient care and/or work environment.
8. Participates in the orientation and ongoing education of nursing staff and students by providing information and acting as a preceptor as appropriate. Identifies self-learning needs and attends educational programs to maintain and enhance clinical competency.
9. Participates in the evaluation of patient care programs, techniques, standards and procedures by providing feedback about effectiveness and patient care outcomes.
10. Maintains a safe environment for patients, families and staff by adhering to established safety and emergency practices Performs other related duties as required.

Qualifications:

Education, Training, and Experience:
Graduate of an approved school of nursing plus two years' recent, related medical nursing experience in an acute care facility or hospice palliative care environment, which includes one year's recent related hospice/palliative care experience.
Current practicing registration with the College of Registered Nurses' of British Columbia (CRNBC) and/or the College of Registered Psychiatric Nurses of British Columbia (CRNBC).

Skills and Abilities:

- Ability to communicate effectively both verbally and in writing.
- Ability to organize and prioritize work.
- Ability to operate related equipment.
- Physical ability to perform the duties of the position.
- Skill in conflict resolution.
- Interpersonal skills and ability to work with patients/families living with and dying from advanced illness.

Appendix XI –
Sample of Questions to Ask When Tendering for Pharmacy Services

- What is your understanding of hospice palliative care?
- What is your experience providing pharmacy services to hospices?
- Can you provide compounding?
- How do you accommodate frequent changes to resident's medication orders?
- Have any of your pharmacists taken the Victoria Hospice Medical Course?
- What is your understanding of Bylaw 7?
- What interests you about providing pharmacy service to the hospice?

Specific Pharmacy Deliverables

1. **Accessibility**
- How late in the day will your pharmacy accept physician's medication orders for same day delivery?
- What are your hours each day? How many days/ week are you open? What is your schedule on statutory holidays?

2. **Delivery**
- At what approximate time can we expect medication delivery?
- If medications are needed after your delivery service has left, what is your provision for delivery? What is the cost to hospice?

3. **Charges/Fees**
- Do you charge the standard dispensing fee for filling doctor's orders?
- What is your method of securing payment from residents for medications that are not covered under Plan P?
- Will you dispense medication pending payment?
- Do you charge the residuals back to the patients for the difference between what Pharmacare covers and the price you paid for the drug?
- What other charges or fees can the residents expect?
- What other charges or fees can the hospice expect?

4. **Education**
- Do you offer education sessions to staff? Is there a fee?

5. **Communication**
- If you require clarification regarding a medication order, who do you contact?
- If you receive new orders from a physician, how will you notify hospice?

Appendix XII – Sample of Palliative Care Orientation

This sample is provided courtesy of the Richmond Integrated Hospice Palliative Care Program.

Day One		
8:30 a.m. to 10:00 a.m.	Introduction to Hospice Palliative Care - Definition - Who - Our Program	Instructor
	Values and Beliefs - Hospice Palliative Care Values - Ours & Impact on Caring for Others - Self-Awareness and Self-Care	
	Communication	
10:00 a.m. to 10:30 a.m.	*Coffee Break*	
10:30 a.m. to 12:30 p.m.	Pain	Instructor
12:30 p.m. to 1:30 p.m.	*Lunch Break*	
1:30 p.m. to 4:30 p.m.	HPC Nursing Standards of Practice / Competency	Instructor
	The Illness Experience – Illness Trajectory Planning care – Goals of Care End of Life Care Case Study	
Day One finished		

Table continued...

Appendix XII – Sample of Palliative Care Orientation (Continued)

Day Two		
8:30 a.m. to 10:00 a.m.	Pain Assessment Tool, Pain Management Flowsheet Constipation Protocol, PPS Delirium Assessment Tool Palliative Emergencies Pre-printed Orders – Terminal Bleed/Dyspnea; EOL Orders Interdisciplinary Rounds – Tuesdays Discharge Planning – Home/Hospice Team Roles	Instructor
10:00 a.m. to 10:30 a.m.	*Coffee Break*	
10:30 am to 12:30 pm	Delirium Hypercalcemia Nausea & Vomiting, Constipation Dyspnea/Respiratory Congestion	Instructor
12:30 p.m. to 1:30 p.m.	*Lunch Break*	
1:30 p.m. to 4:30 p.m.	S/C – Intermittent, Continuous, Hypodermoclysis Pain Management: CSCI Low Dose Ketamine D/C Chemotherapy CADD Prism Pump – Continuous, PCA	Instructor
	Evaluations	

Appendix XIII – Sample History and Physical Examination

Appendix XIII – Sample History and Physical Examination

Providence HEALTH CARE

Marion Hospice

Patient Name: _____

Date of Birth: _____

PHN: _____

PALLIATIVE CARE UNIT
HISTORY AND PHYSICAL EXAMINATION (Part One)

MARITAL STATUS: **S** **M** **W** **D** **C/L**

RELIGIOUS AFFILIATION: _____

DIAGNOSIS

HISTORY OF TERMINAL ILLNESS

PAST MEDICAL HISTORY

Form continued...

Providence HEALTH CARE

Marion Hospice

Patient Name: _____

Date of Birth: _____

PHN: _____

PALLIATIVE CARE UNIT
HISTORY AND PHYSICAL EXAMINATION (Part One)

SOCIAL / FAMILY INFORMATION

EYE DONATION ☐ Yes ☐ No ☐ Unsure **Comments:** _____
If yes, complete consent form

FUNCTIONAL REVIEW

MEDICATIONS

ALLERGIES

HABITS (Smoking, Alcohol)

MOBILITY

SLEEP

BOWELS

BLADDER

SYMPTOMS: 0 = absent + = mild ++ = moderate +++ = severe

	0	+	++	+++
ANOREXIA				
NAUSEA				
VOMITING				
CONSTIPATION				
DYSPHAGIA				
WEIGHT LOSS				
BLEEDING				
COUGH				
DYSPNEA				
WEAKNESS				
PARALYSIS				
SORE MOUTH				
DRY MOUTH				
DROWSINESS				

Form continued...

Providence HEALTH CARE

Marion Hospice

Patient Name: _____

Date of Birth: _____

PHN: _____

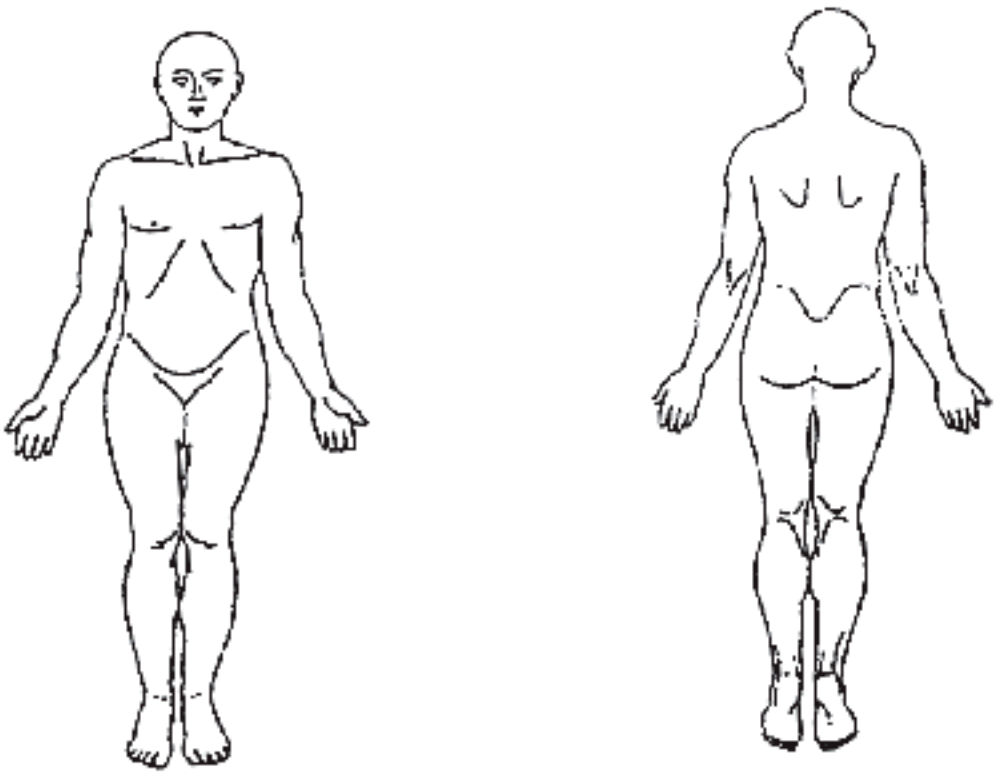
PALLIATIVE CARE UNIT
HISTORY AND PHYSICAL EXAMINATION (Part Two)

PAIN ASSESSMENT

Mark 0 - 5 in appropriate site(s) on Pain Chart(s)

0 = no pain
1 = mild
2 = discomforting
3 = distressing
4 = horrible
5 = excruciating

R **L** **L** **R**



Form continued...

Providence HEALTH CARE

Marion Hospice

Patient Name: _____

Date of Birth: _____

PHN: _____

PALLIATIVE CARE UNIT
HISTORY AND PHYSICAL EXAMINATION (Part Two)

PHYSICAL EXAMINATION

Vital signs: **T** _____ **P** _____ **R** _____ **B.P.** _____

Level of Consciousness:

SUMMARY (see also Problem List and Action Plan)

Form continued...

Appendix XIII – Sample History and Physical Examination (Continued)

Providence HEALTH CARE

Marion Hospice

PALLIATIVE CARE UNIT
HISTORY AND PHYSICAL EXAMINATION (Part Three)

Patient Name: _____

Date of Birth: _____

PHN: _____

PROBLEM LIST AND ACTION PLAN

PROBLEMS	PLANS
MEDICAL	
EMOTIONAL	
FAMILY / SOCIAL	
FINANCIAL / LEGAL	
SPIRITUAL	
OTHER	
INSIGHT OF PATIENT AND FAMILY	
PATIENT'S GOALS	

_____ _____ _____
PHYSICIAN SIGNATURE **PRINTED NAME** **DATE**

Appendix XIV – Sample End of Life Directives

Providence HEALTH CARE

PRESCRIBER'S ORDERS

NO DRUG WILL BE DISPENSED OR ADMINISTERED WITHOUT A COMPLETED
CAUTION SHEET
ALLERGY/INTOLERANCE STATUS FORM (PHC-PH047)

DRAFT
May 20, 2010

DATE AND TIME

MARION HOSPICE END OF LIFE DIRECTIVES

(items with check boxes must be selected to be ordered) Page 1 of 1

The "Hospice End of Life Directives" will apply to all admitted patients.

CODE STATUS: Do Not Attempt Resuscitation (DNAR) – refer to completed Orders (PHC-PH254).

DIET: Diet as tolerated.

ACTIVITY: Day/overnight pass PRN.

MONITORING: Notify physician if temperature above 38.5 C°.

TREATMENTS: May insert Foley catheter for patient comfort (try to avoid).
O_2 via NP 2-4LPM PRN for comfort.
RN may pronounce death. MD to be notified within 12 hours.
If unable to swallow, may insert subcutaneous butterfly.
Oral, eye and skin care per PHC guidelines.

MEDICATIONS: **Symptom alleviation:** The following orders will be carried out for each episode until re-assessed by the physician within 12 hours.

Anxiety: ☐ lorazepam 0.5 to 1 mg sublingual or subcutaneous Q6H PRN

Confusion/delirium: ☐ haloperidol 0.5mg to 1mg PO or subcutaneous Q4H PRN

Fever: ☐ acetaminophen 650 mg PO or rectal Q4H PRN for fever above 37.5 C°

Nausea/vomiting: ☐ haloperidol 0.5 to 1 mg PO or subcutaneous Q12H PRN
☐ metoclopramide 10 mg PO or subcutaneous QID PRN

Bowel Protocol: ☐ fruitlax or prunes PO BID ∗**OR**∗ ☐ fruitlax or prunes PO BID PRN
☐ sennosides 17.2 mg PO at 08:00 and 17:00 ∗**OR**∗
☐ sennosides 17.2 mg PO at 08:00 and 17:00 PRN
If no bowel movement after 48 hours give milk of magnesia with cascara 5 mL at HS x1
If no bowel movement after 72 hours give bisaCODYL 10 mg suppository rectally x 1
∗**and**∗ glycerine suppository rectally x1
∗**OR**∗ sodium phosphates enema rectally x1

Restlessness/agitation: ☐ methotrimeprazine 2.5 to 5 mg PO or subcutaneous Q3H PRN

Myoclonus: ☐ lorazepam 0.5 to 1mg sublingual or subcutaneous Q6H PRN

Seizures: ☐ lorazepam 1 to 2mg subcutaneous STAT, may repeat Q15MIN x 2
Contact physician

Respiratory congestion: ☐ scopolamine HYDRObromide 0.4 to 0.6 mg subcutaneous Q2H PRN

Thrush: ☐ nystatin 500,000 units PO QID x 5 days then reassess

HS sedation: ☐ methotrimeprazine 2.5 to 5 mg PO or subcutaneous HS PRN

Crisis management: **ACUTE RESPIRATORY DISTRESS, TERMINAL BLEED**
☐ HYDROmorphone _____ mg subcutaneous Q10MIN PRN
☐ midazolam _____mg subcutaneous Q10MIN PRN
Other:

I agree with the implementation of the Hospice End of Life Directives for this patient.

Printed Name _____ Signature _____ College ID _____ Pager _____

Vancouver CoastalHealth

Appendix XV – Sample of Care Map Kardex

Diagnosis and reason for admission

Understanding of illness/prognosis	Palliative Performance Scale Score
☐ Yes	Score and date on admission:
☐ No	Current score and date:
☐ In transition	

DNAR & Options for Care Level	MRSA/VRE Screening	Precautions
	☐ Admission screening done Date Completed:	☐ Airborne ☐ Droplet/Contact ☐ Droplet ☐ Contact ☐ Protective

Contact Information (Family, friends, next of kin, POA…)			Patient Care Conference	
Name	Relationship	Phone numbers	Date last care conference:	Date next care conference:
☐ Call in the night to report changes			Summary of last care conference:	
☐ Call in the night to report changes				
☐ Call in the night to report changes				

What you need to know about me: Hopes & Fears – Likes & Dislikes – Complementary Therapies – Personal Story – Cultural Beliefs – Spiritual Beliefs		
Prefers to be called:		

Plans/hopes for time of death & after death	Cornea & Tissue Donation	Funeral Arrangements
	Conversation date:	
	Consent obtained:	
	☐ Yes ☐ No	

Form continued...

Appendix XV – Sample of Care Map Kardex (continued)

Day Routine	Night Routine

Date	Pain	Date	Other Symptoms	Date	Neurological & Mood

Date	Mobility & ADLs	Date	CV & Respiratory	Date	Genitourinary

Date	Diet & Appetite	Date	Skin	Date	Gastrointestinal & BPS
					Last BM:

Date	SC Butterflies	Date	IVs/Infusions/Transfusions & Epidurals

Pertinent Treatment History

☐ Chemotherapy	☐ Radiation Site:	Other
Date last given:	Date last treatment:	
Next chemotherapy date/time:	Next radiation date/time:	
Ambulance booked:	Ambulance booked:	

Procedures – Tests – Specimens – *still to be completed*

When	What

Appendix XVI – Sample of Bereavement Record

Marion Hospice
Bereavement Record

Patient's Name:
_____

Sex: M /F Age:_____ Diagnosis: _____

Date of Admission _____ Date of Death _____
D/M/Y D/M/Y

People to Be Contacted:

1. Name: _____ Sex M / F
   Relationship to Patient _____
   Telephone # _____
   E-mail address _____
   Address _____
   _____

❑ **Card**

❑ **Memorial Invite**

---

2. Name: _____ Sex M / F
   Relationship to Patient _____
   Telephone # _____
   E-mail address _____
   Address _____
   _____

❑ **Card**

❑ **Memorial Invite**

Follow Up Notes:

Appendix XVII – Sample of Checklist for "When Someone Dies"

This sample is provided courtesy of Marion Hospice

Notify

- ☐ Family Members.
- ☐ Consider Eye Bank donation (< 75 years of age).
- ☐ Hospice Physician 0800-1700.
- ☐ Patient Placement Coordinator @ Providence Health-604 806-9271.
- ☐ Finance Department (Gordon Manning) 604 806-8614.
- ☐ Palliative Access Line 604-263-7255.
  Leave message stating patient's name (spell name) with date & time of death.
- ☐ Fax note to pharmacy advising of death.
- ☐ Notify funeral home. Determine transport time. Avoid Windermere meal times.

Must Do But Can Wait

- ☐ Change Diet Sheet/Change Patient Assignment Sheet.
- ☐ Notify Housekeeping at Windermere 604-737-5478. Clearly give room # and priority for room cleaning. i.e. urgent or routine).
- ☐ Notify front desk at Windermere of death and transport time 604-736-8676.
- ☐ Notify Family Physician – usually located on the Record of Admission form.
- ☐ Gather all loaned equipment and place in storage room. Ensure patient's name is on all equipment prior to storage.
- ☐ Notify Loan companies for equipment pick-up.
  - ☐ Vitalaire 604 881-0214.
  - ☐ KCI: 1-800-668-5403: Hospice Acct#32882.
- ☐ Notify referring sources and/or involved clinicians.
- ☐ Cancel any booked appointments.

PRN Only

- ☐ Notify Organ Donor Program immediately if person an organ donor 1-877-366-6722.

Document

- ☐ Pronouncement of Death in Progress Notes and Release of Body Form.
- ☐ Release of Body Form: signatures required for removal of body and valuables.
- ☐ Bereavement Referral Sheet.
- ☐ Remembrance Card and Communication Book.

Medical Certificate of Death

Certificates are in the Forms Drawer. Fill in correctly, i.e.:

- Ensure full and correct name from Admission Record.
- Place of death refers to Marion Hospice at 900 W. 12th, Vancouver, V5Z 1N3.
- Phone number refers to the Funeral Home.

Attending Physician completes Medical Certificate of Death.

- ☐ **Three** extra copies must go on Patient's Chart.
- ☐ Fax a completed copy to the Funeral Home ASAP; note Funeral Home can pick up body with a promise of a FAX.
- ☐ Original is sent to the Funeral Home by CNL/ designate.

Appendix XVIII – Sample of Medication Billing Form

Marion Hospice
9th Floor, 900 West 12th Ave
Vancouver, BC V5Z 1N3
604 731-5947

Many medications prescribed for patients at Marion Hospice are covered under the Palliative Care Benefits Plan of the BC Ministry of Health. However there are medications that are not covered and the patient or the family will be required to pay for the cost of these medications.

The following information is required in order to facilitate the timely administration of medications for the patient. We will securely destroy this form once it is received by the pharmacy. If you are not comfortable with providing credit card information, please discuss your concern with the Clinical Nurse Leader to establish other payment options.

Responsible Party Billing Address

Name: _____

Relationship to Patient: _____

Address: _____

Postal Code: _____

Phone Numbers: _____(Day) _____ (Cell)

Patient's Extended Health Plan: _____

Group #: _____ ID#: _____Carrier ID#: _____

Patient or Responsible party's Credit Card #: _____ ¬¬¬¬_____

Credit Card Expiry Date: _____

Appendix XIX – Sample of Table of Contents for Operational Manual