Hospice Halifax

Eligibility and Requests for Assessment

In Effect from March 2019

TABLE OF CONTENTS

PREAMBLE

1. Hospice residences are home-like community settings where palliative care is provided for eligible individuals.
2. It is important to have clear eligibility criteria for hospices to provide safe, equitable, sustainable, high-quality hospice-level care for those with limited life-expectancy.
3. All hospice residence policies are guided by the Nova Scotia Community Hospice Residence Standards.

1. HOSPICE HALIFAX ELIGIBILITY

1.1. POLICY STATEMENTS:

1.1.1. In order to be **eligible for hospice**, patients must:

- Have a predicted life expectancy of 3 months or less.
- Have a Palliative Performance Scale (PPS) score of 50% or less (See Palliative Performance Scale Version 2 (PPSv2))
- Be 16 years of age or older. Younger patients may be considered on a case-by-case basis with the IWK Hospital to determine if the setting is appropriate to meet the care needs of the child.

1.1.2. Patients or their Substitute Decision Maker (SDM) must:

- Be aware of the patient's diagnosis and life-expectancy, with no further plans for diagnostic tests or monitoring.
- Confirm their understanding that resuscitation and other life-prolonging interventions are not provided in hospice.
- Have explored all appropriate and available community supports but can no longer be supported at home, or have confirmed that a home death is not desirable.
- Agree to a transfer of care if the patient no longer meets the eligibility criteria described in this policy.

1.2. **GUIDELINES:**

Specific Eligibility Considerations

1.2.1. Hospice Care is not appropriate for:

- Mobile patients with wandering or aggressive behaviors that threaten their safety or the safety of other patients and staff.
- Patients with stable frailty who meet the eligibility criteria for long-term care.
- Patients who wish to come to hospice for the sole purpose of receiving Medical Assistance in Dying (MAiD).
- Patients who are actively dying and are admitted in another care facility (death is anticipated within 24 hours.)
- Patients who require planned and regularly scheduled transportation to off-site medical appointments.

1.2.2. Also, some patients require interventions or management strategies that are **not** provided in hospice. Examples include, but are not limited to:

- Patients who are ventilator-dependent.
- Patients receiving dialysis.
- Patients requiring ongoing platelet or whole blood transfusions.
- Patients requiring or requesting the ongoing use of intravenous lines (peripheral or central) for any medications (including chemotherapy, antibiotics) or fluid.
- Patients with active, infectious diarrhea (eg. Clostridium difficile).
- Patients with active airborne disease (eg. measles, tuberculosis, herpes disseminated zoster).
- Patients with active Implanted Cardiac Defibrillators (ICDs).
    - Deactivation prior to admission (or a plan to deactivate it as soon as possible after admission) is required.

1.2.3. Certain interventions or devices will not necessarily exclude a patient from hospice, but do require discussion with the hospice care team to determine if the patient's needs can be safely met. Examples include, but are not limited to:

- High-flow oxygen (more than 15L/min)
- Negative pressure wound therapy (NPWT)

- Bi-Level Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP)
- Enteral feeding
- Antineoplastic therapies including hormonal/oral agents
    - A discussion with the treating specialist about stopping oral agents is recommended prior to admission.
- Procedures for symptom management that require ongoing transportation to an acute-care facility (eg. thoracentesis, paracentesis, palliative radiation therapy)
- Peripherally inserted central catheters (PICCs) or central venous catheters (CVCs)
    - PICCs and CVCs are removed before or shortly after admission to hospice.
    - If they cannot be removed, PICCs and CVCs will not be used or maintained in hospice. Dressings will be changed according to local protocols.

2. REQUESTS FOR ASSESSMENT

2.1. **POLICY STATEMENTS:**

2.1.1. If the patient's **most responsible healthcare professional** believes that the patient is appropriate for hospice based on the eligibility criteria outlined above, a request for assessment for hospice is made. Any special care needs or circumstances such as those listed in section 1.2.3 above must be discussed with the hospice at this time.

- Requests must come from the patient's most responsible healthcare professional.
- If the professional making the request is not the patient's **primary care provider**, the person or team making the request must inform them that it has been made.
- Requests are not accepted directly from patients or family members.

2.2. **GUIDELINES:**

2.2.1. *Requests* are reviewed and prioritized by the hospice assessor or their delegate according to the identified care needs and acuity of the patients.

2.2.2. *Admission priorities* are determined by the individual hospice Medical Directors and/or Nurse Managers through a collaborative triage process with care partners; eligible patients' care needs and acuity will be the primary factors in considering priority for admission.

2.2.3. Admission decisions will also be guided by patients' place of care. People living at home or those who are precariously housed, whose care needs exceed what they can manage safely or comfortably with the

resources available to them, will receive first priority. People accessing care in a hospital or other care institution will receive next priority.

Admission to hospice is not considered emergent, and patients are not generally accepted in direct transfer from emergency departments or other facilities without an in-person assessment.

2.3. **PROCESS:**

2.3.1. If appropriate, based on the information provided in the request for assessment, it is the responsibility of the hospice team or its delegate to complete an in-person standardized assessment of the patient.

At their discretion, the hospice may waive the in-person assessment when it is clear from consultation with the requesting party that the patient meets the eligibility criteria.

2.3.2. Based on the information received in the request for assessment and/or from the in-person assessment, if a patient does not meet the eligibility criteria, the hospice communicates the reason(s) for not admitting the patient to the requesting party.

- This decision is clearly documented.
- It is the responsibility of the requesting party to inform the patient/family of the decision.

2.3.3. Based on the in-person assessment, at the discretion of the hospice, if a patient is a) predicted to meet the eligibility criteria in the near future, or b) meets the criteria but is not ready for admission, the hospice keeps the patient information accessible for a period of 3 months.

- Within 3 months, the requesting party must initiate contact with the hospice for the patient to be considered again for hospice and must send any new pertinent information to the hospice.
- After 3 months, a new request must be made.

2.3.4. It is the responsibility of the hospice assessor or their delegate to include in their in-person assessment, as appropriate, the following:

- A standardized assessment, and/or a review of the content of the request for assessment, and any supporting information as required.
- An explanation and review of the hospice philosophy of care and the hospice's admission agreement (if applicable) with the patient or substitute decision maker.
    - Once the patient or SDM has a chance to review the hospice's admission agreement, they are asked to sign it.
- A description of the hospice facility and its amenities.

2.3.5. It is the responsibility of the hospice assessor or their delegate to confirm that the patient has a signed Do-Not-Resuscitate/Allow a Natural Death document.

2.3.6. Once all of the above are confirmed by the hospice assessor or their delegate, the patient is placed on the list for admission to hospice.

3. ONGOING ELIGIBILITY

3.1. **POLICY STATEMENTS**

3.1.1. It is the responsibility of the interdisciplinary hospice care team members to assess a patient's continued appropriateness for hospice on an ongoing basis as part of their regular assessment.

3.1.2. Based on this ongoing assessment and discussion with the patient/substitute decision maker, the most appropriate place of future care is determined.

3.1.3. Patients are discharged when:

- They and their families express the wish to return home, or
- It has been determined that the course of the illness and/or goals of care have changed and would be more appropriately addressed in either an acute care or long term care setting.

3.1.4. The attending hospice physician makes decisions about discharge in consultation with the hospice care team, patient, and family.

3.1.5. Each hospice site will have a discharge process or policy based on local resources and patient flow procedures.

4. REFERENCES

LEGISLATIVE ACTS/REFERENCES

"Policy framework for the establishment of Hospice as a setting of care in Nova Scotia." Nova Scotia Department of Health and Wellness. March 2017.

"An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)". Government of Canada. (S.C. 2016, c. 3). Accessed on February 21, 2018. http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html

OTHER

Nova Scotia Community Hospice Residence Standards. Nova Scotia Health Authority. March 2017.

"Personal Directives Act – Information for Health Care Providers." https://novascotia.ca/just/pda/_docs/PDA_Web_Info_Health%20Care%20providers.pdf

5. RELATED DOCUMENTS

POLICIES

Medical Assistance in Dying (MAiD) – NSHA policy pending

Nova Scotia Department of Health and Wellness, Service Eligibility Policy, effective February 28, 2015: https://novascotia.ca/dhw/ccs/policies/policyManual/Service_Eligibility_Policy.pdf

6. DEFINITIONS

Frailty	Frailty is a stage of life that is the result of the cumulative effects of health and functional deficits over the life course. When this accumulation of deficits depletes the physiologic reserve to the point that day-to-day activity is affected, a person is said to be "frail".
Hospice	A term that encompasses both a *setting* of care and a *type* of care for those near the end of life, focused on comfort rather than acute care. Hospice as a *setting* can include stand-alone facilities or designated hospice beds in other locations. In this policy, "hospice" will refer to a Hospice Residence.
Hospice delegate (for assessment purposes)	A healthcare professional with training in hospice palliative care whos is authorized by hospice leadership to assess patients for admission.
Hospice-level care:	Care provided in the last weeks of life for those who cannot or do not wish to die at home. Hospice is for those who are relatively stable but require monitoring and interventions that are unavailable in their home setting for a variety of reasons.
Medical Assistance in Dying	In accordance with federal legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: administers a substance that causes an individual's death; or prescribes a substance for an individual to self-administer to cause their own death.
Most responsible healthcare professional	The healthcare professional who has the overall responsibility for directing and coordinating the care and management of a patient *at a specific point in time*.
Palliative Care	Care that improves the quality of life of patients/families facing life-threatening illness, through the prevention and relief of suffering by

	means of early identification, impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. Includes *end of life care* offered to dying persons and a *palliative approach* to care integrating key aspects at appropriate times for those with advanced illness at *increased risk of dying.*
Palliative Performance Scale	The Victoria Hospice Palliative Performance Scale (PPS, version 2) is an 11-point scale designed to measure patients' performance status in 10% decrements from 100% (healthy) to 0% (death) based on five observable parameters: ambulation, ability to do activities, self-care, food/fluid intake, and consciousness level. It is designed to provide a snapshot of functional assessment at the time of assessment.
Personal Directive	A legal document that allows a person to name a substitute decision maker to make health and personal care decisions on behalf of the individual, if they are not mentally capable. A Personal Directive includes decisions about health care, nutrition and hydration; where the person would like to live and die and comfort measures; it needs to be written, dated, signed by the person and witnessed by an adult.
Primary Care	The day-to-day healthcare usually provided by a family physician or a Nurse Practitioner. Typically, primary care providers act as the first contact and principal point of care for patients within a healthcare system, and they facilitate access to other specialist care that a patient may need.
Substitute Decision Maker (SDM):	The person named in a Personal Directive to make decisions on behalf of the author of the directive when that person can no longer speak for themselves, also called a delegate or substitute decision maker.