Feedback from Survey - Hospice/ EOL Care program Acute Care Setting Oct 2019

In relation to the care delivery and the management of clients/families within the Rural Hospice Palliative Care Co-Location Suite within your community hospital:

1. What are the <u>strengths</u>?

- Staffing ratio is adequate
- Access to 24/7 pharmacy support
- Core group of nurses are trained in palliative care
- Positive feedback from families regarding the care, and compassion provided
- Residents of North East Region do not have to drive more than 1 hour to access a hospice bed.
- Hospice Suite Coordinator role can be absorbed within an existing position, typically a Nurse Manager who oversees & liaises with the floor nurses on a daily basis. (this can also present a challenge)
- Access is coordinated; bed is dedicated for Hospice / EOL Care
- Model endorsed by NE LHIN, MOHLTC and 17 hospitals have received funding for one bed hospice = $105,000 / annualized
- Model has been used to create 4 bed co-located unit within hospital
- Model used aligns with early identification & HPCO Residential Hospice Standards
- Intended to be not just room where patient is admitted to die but rather philosophy of Hospice care for patients & families
- Hospital able to provide in-kind support for space and utilities, education & training.
- Patient stays in home community
- Smooth transitions from acute / ER departments to Hospice Care
- Model calls for Integration of care from within the community – multiple partners identifying potential clients
- Meditech – facilitates ID of clients in community that are interested in being admitted to Hospice Care at some point during the end of their illness “waitlist”
- Lends itself to community rounds with other providers

- Creates discussions for integrated care if providers meet to provide an update on these clients who have made a referral to Hospice Care
- If bed is filled it is known that the Hospice or EOL Care will be provided elsewhere in the acute care area - HPC is improved throughout the hospital
- Also if bed is empty it could potentially be used for Pain & Symptom Mgmt and the patient discharged back home (in order to ensure area is being utilized and patients become familiar with it)
- Personalized approach is needed as the patient is usually known within the community
- In kind contributions from community partners; e.g. FHT in one small area that does not have NP for palliative care works in community to liaise with hospital
- PPS has been created in Meditech as an intervention which provides opportunity for early identification of clients who would benefit from a palliative approach to care
- Provides access to professional staff 24/7 and back up coverage. The RN can be somewhere else on the unit to qualify as accessible to the hospice suite 24/7. Standard statement A6.1 (Care Delivery) states that the Community Residential Hospice provides care delivery from professional staff 24 hours a day, 7 days a week to meet the residents' needs in accordance with each resident's plan of care/treatment plan. HPCO will allow alternate models for nursing support for smaller facilities (3 beds or less), provided that admissions are risk managed and a solid plan is in place to ensure prompt on-call and back up RN coverage. The RN can be somewhere else on the unit. In Kirkland, there is an RPN usually assigned to the hospice suite. The RN must be easily accessible.
- Hospitals might have access to Palliative Pain and Symptom Management Consultants depending on the location and FTE accessible for case consults, education, a monthly newsletter and mentorship. Consultations are available in person, by telephone, videoconference and e-mail.
- First Nation cultural values, practices, beliefs and customs are accommodated. Some Hospitals have designed the ventilation in the room to allow smudging.

- Kirkland and District Hospital, has worked closely with the IT department of Health Sciences North, and Victoria Hospice in British Columbia to develop the PPS as an intervention in Meditech, and secured permission for the NE hospitals and agencies associated with NEON to also incorporate and utilize the PPS within Meditech.
- Hospitals have developed processes for **direct admission from home**.
- Hospital manages its own admission list.
- Some hospitals have expanded a portion of their weekly multi-disciplinary rounds to include
- H&CC staff, hospice volunteers and other community providers and discuss condition of individuals in the community or hospital, who may benefit from an admission into the hospice suite.
- Most family physicians in the rural communities are hospitalists and are aware of the hospice suite.
- The space is great for families to spend quality time with their loved one.
- Area is in a quieter part of the unit.
- Ability for the patient to have 24 hour care in comfortable space.
- Local sites for family & friends
- Layout, calm, quiet
- Support for patient and family thru staff and volunteers
- the family feels supported and comfortable in a home like setting
- If patients come in through the ED who have become palliative in the ED due to their condition eg. Catastrophic stroke and the Hospice suite is available we will admit patients from the ED directly into this room. Positive feedback from families on the last days, hours they were able to have in this type of environment especially when their family member's death was unexpected.

- The communication between the Espanola FHT and the Acute Care unit on patients who are in the community and on the Hospice/Palliative Care waitlist. Weekly Meditech reports to both departments so all designated providers are aware who is on the waitlist. The Hospice/Palliative Care waitlist is reviewed weekly by FHT palliative nurse, Acute Care Charge RN, Acute Care Clinical Manager and the NELHIN local care coordinators, updates are provided on how patient/family is managing in the community.
- Perhaps flexibility around how the $105 / year is deployed

2. What have you found to be a <u>challenging</u>?

- Sometimes Acute Care focus
- ACP conversations and early identifications not always happening soon enough
- Word palliative still an issue if the concept / approach is not being utilized
- Should be talking palliative approach and EOL Care
- Some providers think it is merely a "Room in which to Die" in last days of life
- RN / RPN have acute and palliative care assignments concurrently which makes time for caring for Hospice / EOL difficult
- Multiple patients needing the suite at same time and there is only one room
- Limited resources in community
- Lack of full team in communities
- Decrease LOS and # of patients admitted (utilization questioned / risk of losing funding
- Suggest track # of days other patients occupy an acute care bed elsewhere in the hospital once designated Hospice / EOL Care
- Sometimes have to relocate patients if they improve and others are waiting for the bed
- Lack of community resources – does not provide individuals the opportunity to stay at home
- Some hospitals do not have direct admit
- Physicians, nurses in acute care setting do not always have time to be with patient/family
- Nurses experience "Burn Out"
- Creative; innovators have still NOT received funding ($105,000/annum)
- LOS – patients are often admitted from community at PPS 30 but have no primary care giver so they are admitted to these beds and have increased LOS
- Due to these beds residing within the hospital, often utilized for overflow and not palliative patients **

- Some discontinuity with hospitalist care (need for staff person to coordinate)
- Navigator role within community integrated within agencies that
- Significant learning curve to develop a clear understanding that Hospice Palliative Care is a type of care that can be provided to support individuals and families at any stage of a life-limiting illness and expands beyond the hospice suite and into acute and medical care, and with community partners
- Providers unclear about Palliative Approach to Care and when EOL Care presents
- PPS often 10 – 20% / Length of Stay is often only 1 or 2 days which presents difficulty in meeting some expectations for client/family and caregivers at EOL
- sometimes difficult to move beyond active care treatment sooner because of the focus on acute care within the hospital setting
- Nurse feels she has no time to spend with the client & family
- Patients sometimes have to go through ER department, at EOL when precious moments could be best spent in the Hospice Suite area where respect, dignity, compassion and comfort come foremost.
- 99% of admissions are coming to hospice suite from inpatients eliminating experience of early and direct admission from home (? What is the % of admissions from home and hospital to free standing hospices in NE)
- Recognized that rural areas are much different than urban who have greater resources and can maintain patients at home
- Need to get the community to know that room is available for use from home; this has improved with the help of our local HCC Case Manager.
- Residents who live at LTCH are generally transitioned back to the home for EOL care; it would be nice to have an EOL care suite in each LTC facility as well which could better accommodate family & friends at EOL because of shared rooms with other residents.

- Two important domains in the CHPCA Model of Care are social and practical. Where a hospital does not have a Social Worker on staff, they have had to collaborate with local partners, such as the Hospice Volunteer Visiting program, or the partners who have Social Workers *i.e.*: CCAC, Family Health Team or Centre de santé communautaire to provide this type of support.
- The suites have not yet been used for admitting children. There are presently no designated pediatric palliative or pediatric respite beds in Northern Ontario. Children in need of these services must travel to Toronto or Ottawa to access them. Adult residential hospices do not typically co-mingle population groups. The province is developing a capacity planning formula but it is not yet released. The Kirkland suite is not used for children. Most often, they would return to CHEO or Toronto and are supported by the facility where they received active treatment, or sometimes be cared for at home. The Residential Hospices in Sudbury and Sault Ste. Marie have piloted services to one child and one youth. They are hoping to be funded to expand their operations. Pediatric hospice care requires a focus not only on the patient but also on the parents, siblings and extended family. Staff can be hesitant if did not "sign up" for this population group. Additional education is needed for staff to prepare them for a pediatric admission.
- At times, a hospice patient improves and no longer meets the admission criteria. The care that is delivered in hospice is more one-on-one and preferred by families. It is important to have the conversation early about transferring out. Social worker or a chaplain can be involved in the process.
- A procedure is required for admissions on weekends and after hours.
- It is important to market the hospice suite so that individuals can benefit earlier in their trajectory.
- Nurse Practitioners must be credentialed to admit their patients to hospice suite.
- Potential for duplication with H&CC when conducting assessment for admission.

- Hospice Suite Coordinator role can be absorbed within an existing position, typically a Nurse Manager who oversees & liaises with the floor nurses on a daily basis. (this can also present a challenge)
- Demand for 2 rooms on many occasions
- Lack of funding for hospice bed in Kirkland Lake and Englehart has created discussion around sustainability, equity and accessibility
- Frequently patients are admitted to the acute care setting who have a life limiting illness but no plans have been put in place for EOL care therefore we find we are doing acute care medicine and when these treatments are not effective then they become palliative but we are actually initiating EOL care which sometimes is only a matter of days.
- The word palliative has a stigma to it where the public and some healthcare workers feel that this is nothing more to be done except comfort measures. We are trying to change that messaging and use EOL care when PPS is 30% or less but it has been difficult.
- When patients have not been added to our Hospice/Palliative Care waitlist and we get urgent calls for an admission to the Hospice suite, this transition is not as smooth as we would like it to be as there has to be primary care provider to our Hospitalist handoff, these patients sometimes will end up going through our ED for admission because the primary care provider cannot be reached and we require the patient to have a physician assessment. Our ED physicians will sometimes allow a direct admission to the Hospice and they will assess the patient there but again this is a case by case determination.
- Evaluation of experience – Voices caregiver survey is to be used to demonstrate experience of patient and family in hospice care but the survey does not lend itself to identifying specific details around this particular EOL care.

- Our utilization was down and there was a risk of losing some of the funding dollars. We made some adjustments internally on moving in-patients to the Hospice room sooner as we were trying to leave this available in case there was someone from the community who may require it. At one point we had someone in the Hospice suite for greater than 10 days but there were 3 other patients who were on the Hospice waitlist who were admitted to the acute care setting and passed away during this time (outside the Hospice), so it is difficult to sometimes predict utilization of the Hospice suite.

3. SUMMARY - THEMES IDENTIFIED / What improvements can be made?

- **FUNDING & SUSTAINABILIY**:
  - Call for funding equity for Hospice Beds in Kirkland Lake and Englehart
  - Some of larger centers like the idea of having a 4 bed residential hospice
- **EDUCATION & SUPPORT**:
  - Increase staff education programs to increase comfort
  - More Fundamentals, CAPCE, LEAP education
  - Education sessions for families and caregivers while their loved ones are in the palliative suites
  - Community grief support for families
  - Resources in community
- **EARLY IDENTICATION STRATEGIES (OF PERSONS WHO WOULD BENEFIT FROM A PALLIATIVE APPROACH TO CARE**
- **DEVELOP COMMUNITY INTEGRATED TEAM APPROACH**
  - This would help to ensure bed availability, and awareness of clients functional ability at home / need for bed
  - Dedicated physicians for the Hospice suite to provide expertise In EOL/palliative care
  - Integration from primary care – home care – acute / hospice care adapting palliative approach to care