Hospice Palliative Care (HPC) is receiving heightened attention as the Canadian population ages and an increasing number of individuals are living with progressive, life-threatening illness. National and local studies have documented that patient preference is to die at home if appropriate supports are available, yet the majority of natural deaths in BC in 2005 (54%) took place in hospital, as reported by the Department of Vital Statistics. To support individuals to die at home, or in a home-like environment when death at home is not possible, increased resources are required in the community.

In 2002, the Fraser Health HPC Clinical Service Group strongly supported the need to move to a community based service delivery model which would allow for the reduction of deaths within acute care, while improving quality and access to specialized palliative care resources. Hospice beds were seen as creating a more appropriate care setting for patients who are dying, as well as providing the favourable economics that occur when a shift is made away from acute care.

In the 2000-2003 Fraser Health Directional Plan, the reallocation of acute care beds to hospice beds throughout the region was noted as a strategic priority. Prior to the implementation of the plan, several palliative care units were in place in hospitals throughout Fraser Health. This plan required the re-allotment of a portion of the funding for palliative care units to Hospice Residences. In addition, a Tertiary Palliative Care Unit was established at Burnaby Hospital, with plans for two additional tertiary units to be opened over the next few years.

Currently, there are a total of 78 hospice beds in seven Hospice Residences operating in Fraser Health. The first of these beds were established in May 2002. In 2007 Fraser Health committed to providing funds for 30 additional hospice beds. The goal is to open 10 Hospice Residences, providing an estimated 120 beds across the region to serve a population of 1.5 million people. Fraser Health is committed to developing hospice beds in each community in order to provide local access to this specialized type of care.

The development of such a comprehensive, population based approach to HPC in a large integrated health authority has been a significant challenge. This manual is an opportunity to share the knowledge gained over the past five years with other healthcare providers across Canada and make explicit the standards, principles and operational learning that have been realized in Fraser Health as the result of our experience.

Hospice Residences have been welcomed in all communities and are providing a caring, cost effective and patient/family centred approach to care at end of life. This is a testament to partnership and realizes the dreams of many dedicated providers and public citizens to enhance care for the dying.

Elizabeth (Betty) Ann Busse
Acting President & Chief Executive Officer
August, 2007
Acknowledgements

Authors

Kathy Bodell, RN, BSN, MSN, CHPCN (C), Clinical Nurse Specialist, Hospice - Fraser Health
Carolyn Tayler, RN, BN, MSA, CON(C), Director, Hospice Palliative and End of Life Care, Fraser Health

The authors would like to acknowledge the contributors to the document, “Creating a Hospice Residence: Hospice Beds in the Fraser Health Authority – Guidelines for Planning” (2002), which provided the foundation for this document.

Fraser Health Leaders

The authors would like to thank the following Fraser Health leaders who have championed and supported the vision of hospice residences at the executive level:

Keith Anderson
Past Acting President and Chief Executive Officer, Fraser Health

Elizabeth (Betty) Ann Busse
Acting President and Chief Executive Officer, Fraser Health

Maureen Wood
Executive Director, Home Health and End of Life Care

With special thanks to
Dr. Doris Barwich, Medical Director, Hospice Palliative and End of Life Care, Fraser Health, for her commitment and leadership in developing hospice residences.

Reviewers

Fraser Health Hospice Palliative Care Hospice Residences Committee
Fraser Health Hospice Societies Advisory Committee
Fraser Health Hospice Residence Managers Committee
Fraser Health Hospice Palliative Care Clinical Services Planning and Delivery Team

Photographs

We would also like to thank Ruth Scott, RN at Queens Park Hospice and Photographer, who provided several of the photographs for this manual.
## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>page ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>page iii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>page iv</td>
</tr>
<tr>
<td>Introduction</td>
<td>page v</td>
</tr>
<tr>
<td><strong>Section 1: Background</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Hospice Palliative Care (HPC) - Overview</td>
<td>page 1-1 to 1-2</td>
</tr>
<tr>
<td>1.2 About Fraser Health</td>
<td>page 1-3</td>
</tr>
<tr>
<td>1.3 Hospice Development Within An Integrated Program</td>
<td>page 1-3 to 1-10</td>
</tr>
<tr>
<td><strong>Section 2: Development Of Hospice Residences</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Hospice Residences In Fraser Health</td>
<td>page 2-1 to 2-2</td>
</tr>
<tr>
<td>2.2 Estimation Of Number Of Hospice Beds Required</td>
<td>page 2-2 to 2-4</td>
</tr>
<tr>
<td>2.3 Hospice Planning Principles</td>
<td>page 2-5</td>
</tr>
<tr>
<td>2.4 Hospice Partnership Framework</td>
<td>page 2-6 to 2-9</td>
</tr>
<tr>
<td>2.5 Hospice Operational Model</td>
<td>page 2-9 to 2-16</td>
</tr>
<tr>
<td>2.6 Hospice Environment</td>
<td>page 2-16 to 2-24</td>
</tr>
<tr>
<td>2.7 System And Clinical Standards</td>
<td>page 2-24 to 2-30</td>
</tr>
<tr>
<td><strong>Section 3: Implementation</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Work Plan For Start-Up Of Hospice Residence</td>
<td>page 3-1 to 3-9</td>
</tr>
<tr>
<td><strong>Section 4: Current Challenges and Future Directions</strong></td>
<td></td>
</tr>
<tr>
<td>4.1 Planning Challenges</td>
<td>page 4-1</td>
</tr>
<tr>
<td>4.2 Admission Challenges</td>
<td>page 4-2 to 4-3</td>
</tr>
<tr>
<td>4.3 Staffing Challenges</td>
<td>page 4-3</td>
</tr>
<tr>
<td>4.4 Transition Challenges</td>
<td>page 4-4</td>
</tr>
<tr>
<td>4.5 Future Directions</td>
<td>page 4-4 to 4-5</td>
</tr>
<tr>
<td>Conclusion</td>
<td>page vi</td>
</tr>
</tbody>
</table>
Hospice, as a location for care, is defined as a home-like setting for individuals who have end-stage illnesses that require holistic care, including regular assessment of symptoms and changes in treatment and care plans, and who are unable or do not wish to remain at home to die. The goal of Fraser Health is to foster partnerships with hospice service providers and provide high quality care within these hospices.

Presently there are no national or provincial standards on the staffing, licensing or environmental requirements for Hospice Residences.

The “Creating a Hospice Residence”\(^{(1)}\) document provided a discussion of guidelines for planning hospice beds in Fraser Health. This manual builds on that foundation by summarizing the outcomes of hospice development in Fraser Health, based on five years of planning experience and the successful opening of seven Hospice Residences. It includes the Fraser Health vision for Hospice Residences, the process of establishing hospices within an integrated HPC program, and rationale for processes and standards. Detailed operational documents and resources used by all hospices across Fraser Health are available on the Fraser Health website at www.fraserhealth.ca.

The purpose of this document is to:

- Describe the vision and purposeful development of Fraser Health Hospice Residences as healing and caring environments for patients, their families, staff and volunteers.
- Provide clarity of expectations for service providers interested in delivering Hospice Residence care in Fraser Health.
- Share the Fraser Health experience and learning with other care providers and leaders in healthcare, in order to assist those individuals and groups in planning for hospice beds.
- Share established requirements, processes and practices developed for Fraser Health Hospice Residences, to promote discussion about provincial and national standards.
- Highlight the various challenges faced within HPC as we strive to support patient choice for preferred location of care.
- Postulate on future directions that may evolve related to Hospice Residences.

References

\(^{(1)}\) Fraser Health Hospice Palliative Care Service. Creating a Hospice Residence: Guidelines for Planning Hospice Beds in the Fraser Health Authority. Surrey: Fraser Health Authority; 2002.
Fraser Health Hospice Residences
Creating a healing & caring environment at the end of life

Section 1: Background

1.1 Hospice Palliative Care (HPC) - Overview
1.2 About Fraser Health
1.3 Hospice Development Within An Integrated Program
Section 1: Background

1.1 Hospice Palliative Care (HPC) - Overview

The Canadian HPC Association’s Model to Guide Hospice Palliative Care, which is based on national principles and norms, was adopted as a framework for the Fraser Health HPC Program.

In Canada, the terms “hospice” and “palliative care” are often used interchangeably to denote a philosophy of care. In fact the term “hospice palliative care” has been adopted by the Canadian HPC Association and utilized to indicate the integration of care throughout a variety of settings. In addition, the word “hospice” may refer to a place of care. In this paper, the word “hospice” is used to identify a place outside the acute care environment where quality HPC is provided for a specified group of patients who do not require hospitalization in an acute care setting, but cannot be managed safely or comfortably at home.

The Senate report on Quality Care at the End-of-Life,\(^2\) which was tabled in 2000, noted that while many Canadians state they wish to die at home, over 75% of deaths take place in hospitals and long term care facilities. The provision of hospice beds creates a supportive setting for individuals who are reaching the end of their lives. An interdisciplinary team provides clinical skills to address pain and symptom management issues in an environment of sensitivity to the emotional, psychological and spiritual needs of the patients and their families.

In 2006 the British Columbia Ministry of Health Services (MOHS) released a document entitled, “A Provincial Framework for End-of-Life Care”\(^3\) that committed the government to establishing high quality end-of-life care as an integral component of our provincial healthcare system. The MOHS has set performance targets that direct Health Authorities to support and increase deaths to occur outside of acute care settings. The Fraser Health plan to develop hospice bed capacity in all communities is a major strategy that is enabling Fraser Health to meet its targets.

Definition of Hospice Palliative Care (HPC)\(^4\)

HPC aims to relieve suffering and improve the quality of living and dying.

HPC strives to help patients and families:
- 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 the illness and bereavement

HPC aims to:
- treat all active issues
- prevent new issues from occurring
- promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization

"Improve the quality of living and dying"
Section 1: Background

1.1 Hospice Palliative Care (HPC) - Overview

In this document, family refers to “Those closest to the patient in knowledge, care and affection. [Family] may include: the biological family, the family of acquisition (related by marriage/contract), the family of choice and friends (including pets). The patient defines who will be involved in his/her care and/or present at the bedside.” (5)

HPC is appropriate for any patient living with, or at risk of developing a life threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care.

HPC may complement and enhance disease-modifying therapy or it may become the total focus of care. HPC is most effectively delivered by an interdisciplinary team of healthcare providers who are both knowledgeable and skilled in all aspects of the caring process related to their discipline of practice. Schools or organizations that are governed by educational standards typically train these providers. Once licensed, providers are accountable to standards of professional conduct that are set by licensing bodies and/or professional associations.

“Hospice is a place of meeting. Physical and spiritual, doing and accepting, giving and receiving, all have to be brought together... the dying need the community, its help and fellowship... the community needs the dying to make it think of eternal issues and to make it listen... we are debtors to those who can make us learn such things as to be gentle and to approach others with true attention and respect.” (6)

Dame Cicely Saunders MD
(Founder of the modern hospice movement)
1.2 About Fraser Health

Fraser Health is the largest health authority in British Columbia, comprising 35% of the current B.C. population. Fraser Health also has the fastest growing population. In 2005 Fraser Health served a total population of 1.5 million. It is projected that the population will increase to 1.65 million by 2011. This means that over half of the population growth in B.C. during this time frame will occur within Fraser Health.

Fraser Health is comprised of the following communities: Abbotsford, Agassiz, Burnaby, Chilliwack, Delta, Harrison, Hope, Langley, Maple Ridge-Pitt Meadows, Mission, New Westminster, Surrey, Tri-Cities (Coquitlam, Port Coquitlam and Port Moody), and White Rock/South Surrey. Fraser Health oversees the operation of 12 acute care hospitals (about 2,000 beds), 7,000 residential complex care beds and 1,176 assisted living units.

1.3 Hospice Development Within An Integrated Program

Background

Prior to 2002, HPC services in Fraser Health focused on access to acute care services and beds, and support in the community provided by Hospice Societies and Home and Community Care Services. Prior to 2002 Fraser Health had the following designated palliative care beds: Peace Arch Hospital (7), Surrey Memorial Hospital (10), Burnaby Hospital (13), St. Mary’s Hospital (12), and Eagle Ridge Hospital (10). Throughout the region, acute care hospitals were admitting a growing number of dying patients who could be cared for more appropriately at home (if resources were available), or in a hospice (if beds were available).

The plan early in 2002 was to build upon the existing community based model developed in the former Simon Fraser Health Region. The model aimed to address physical, psychological, social, and spiritual and practical expectations and needs of patients and families. The model also addresses loss, grief and bereavement issues, and preparation for and management of the dying process. The model shifts service delivery to four settings along the care continuum: hospice, home, acute/tertiary care and residential care. In order to provide HPC team consultation...
Section 1: Background

1.3 Hospice Development Within An Integrated Program

In smaller communities, some smaller communities were grouped with larger communities. This resulted in eleven (11) community groupings for the HPC program. Interdisciplinary HPC teams were to be implemented in each of ten (10) Fraser Health community groupings (hereafter referred to as communities), to provide education and consultation in all four settings, integrating services across this continuum. The eleventh community, Hope, is a small geographically remote community of about 9,000 people. It is linked to the Fraser Health HPC Program via the Clinical Nurse Specialist for the Chilliwack/Agassiz/Harrison HPC Team. In addition, a local interdisciplinary team supports Hope HPC patients, their families and staff.

The FHA Clinical Services Directional Plan and the Budget Recovery Plan (2002) also supported the desired model. The model was successfully introduced through budget reinvestments, the changing roles of some hospitals and residential care facilities to provide sub-acute care (e.g. hospice), and increasing the ability of the community to support the desired increase in home based deaths. The right resource in the right place at the right time applies to this objective. This ‘rightness’ in the system requires flexibility beyond what we had experienced in the community to provide access to services 24 hours a day and seven days a week. However, over the past three years additional investments have been made to provide operational funds for hospice, increase the number of consultation team members, make equipment available for home patients, and provide an after hours service linked to the BC NurseLine.

Fraser Health HPC Program Mission

The mission of the Fraser Health HPC Program is to ensure the provision of high quality, integrated HPC services to people and their families who are living with a life threatening illness throughout the duration of both the illness and bereavement.

Working in collaboration with the Fraser Health HPC community, the program plans and provides services that are:

- Appropriate and timely
- Evidence based
- Equitable throughout the region
- Culturally sensitive
- Inclusive of primary care providers and supported by expert palliative care teams
- Responsive to the fluctuating needs and wishes of individuals and their families

Integral elements of the Program include:

- Planning and strategic development
- On-going monitoring and evaluation
- Public and professional education
- Active participation in community based HPC research
- Advocacy at local, provincial and national levels
- Care provider support
Section 1: Background

1.3 Hospice Development Within An Integrated Program

Fraser Health HPC Program Goals

The goals of Fraser Health HPC Program include:

- Continuity of care across all settings (home, acute care, residential care and hospice), and among all care providers
- A consistent and appropriate standard of HPC in all communities and settings
- Provision of a range of HPC resources to individuals and families
- Timely assessment and placement of palliative individuals to meet their care needs in the most appropriate and cost-effective environment

Fraser Health HPC Model

The following pictorial diagram illustrates the service delivery model which is based on a regional approach to planning, standard setting and consultation, in order to support and enable the local delivery of HPC by primary providers.

Fraser Health HPC Services

The provision of HPC in Fraser Health is based on a model of comprehensive and integrated service delivery, and on partnerships between service providers in the community and in the health authority.
Section 1: Background

1.3 Hospice Development Within An Integrated Program

Current services include:

- Home care nursing and home support to individuals dying at home
- Designated palliative care beds (31) in three hospitals for palliative patients with acute and complex care requirements (including 11 tertiary HPC beds)
- Community based HPC consultation teams (10) that provide specialized clinical and educational support to Fraser Health staff in all locations of care, to contracted service providers such as residential care, and in some limited direct services to individuals
- Hospice beds (78)
- Coordination and planning of HPC service delivery across the health authority
- Community hospice organizations (11) that provide a wide range of resources, including volunteer support to dying individuals and their families, and bereavement support
- Patient and family access to HPC specialists 24/7 via BC NurseLine

Settings of Care for HPC Patients

Each Fraser Health community has an HPC interdisciplinary consultation team consisting of an HPC physician, clinical nurse specialist, clinical resource nurse, social worker, volunteer coordinator and access to an HPC clinical pharmacist. The consult teams are a key factor in working towards seamless transitions and care for patients and their families, as they move from one sector to another in the healthcare system. They make decisions with patients and families about the best location of care at a given time in the illness trajectory. Consult team members often act as a bridge to communicate patient and family needs to team members in other settings. The following diagram further illustrates the role of the consultation teams in supporting patients at all locations of care.
Section 1: Background

1.3 Hospice Development Within An Integrated Program

Settings of care include:

1. **Home/Residential Care** - Many patients will be able to be safely and comfortably supported at home or in residential care with family and professional caregivers and additional resources.

2. **Hospice Residences** - Another group of patients will be unable to remain at home due to care needs, pain management, lack of caregiver support, or other reasons, and will require a sub-acute level of care and symptom management for the last days and weeks of life.

3. **Tertiary HPC Unit** - A third group of patients have complex and unstable pain management and symptom control issues or emotional distress, and will require a tertiary level of care in a hospital palliative care unit. These patients require specialized, frequent, and skilled assessments and interventions over a short period of time and/or require diagnostic tests, complex treatments or invasive procedures.

**Current Registered HPC Patient Distribution across Sectors and Targets**

In Fraser Health in 2006, patient referrals to the HPC Program came from acute care (51%), home (45%) and residential care (2%). For those in acute care the majority (79%) have a malignant disease. Approximately 3400 patients are referred annually, with the majority having malignant disease (71%). The main reasons for referrals to HPC are routine assessment and support (38%), a team consult (32%), pain and symptom management (10%), or Hospice Residence assessment (14%). Forty-eight per cent of referred patients die in acute care, 30% in a Hospice Residence, 17% at home and 3% in residential care.

Within Fraser Health, HPC is provided in every acute care facility and in all communities by physicians and other primary healthcare providers supported by HPC consultants. It is anticipated that by 2009, tertiary HPC will be centralized in three acute care hospitals in Fraser Health and provide care for complex and difficult to manage patients/families when their needs can not be met in their own community.

Fraser Health HPC Program targets for registered HPC patients include: 30% home deaths, 20% dying in acute care beds, 10% dying in Tertiary HPC Units, 35% dying in Hospice Residences and 5% dying in residential care facilities.

In addition, the British Columbia Ministry of Health Services (MOHS) monitors location of death for all natural deaths in B.C. The MOHS has set targets to increase the number of patients dying outside of acute care facilities. Each year the health authorities are expected to decrease the number of cancer and non cancer deaths occurring in acute care. The 2006/07 target for cancer deaths is a decrease in 3% from the previous year. The Fraser Health MOH target for non cancer deaths is a decrease of 2%. Fraser Health is expected to exceed its target for cancer deaths outside of acute care in 2006.
Section 1: Background

1.3 Hospice Development Within An Integrated Program

Central Leadership and Committee Structure for HPC

Leadership for the HPC Program is provided by the Director of Hospice Palliative and End of Life Care, and the Medical Director for Hospice Palliative and End of Life Care. A comprehensive and strong committee structure is in place to support the leaders and interdisciplinary decision-making related to current and future policies, standards and clinical practice. The following diagram shows the committee structure within the HPC Program.

Hospice Palliative Care Program Committee Structure: July 2007

<table>
<thead>
<tr>
<th>Committee Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary Hospice Palliative Care Unit (THPCU) Committee</td>
</tr>
<tr>
<td>HPC Physician Committee</td>
</tr>
<tr>
<td>HPC Practice Advisory Council: Education &amp; Research Work Groups</td>
</tr>
<tr>
<td>Local HPC Committees: Burnaby, Chilliwack/Agassiz/Harrison, Delta/Ladner, Hope, Langley, Maple Ridge/Pitt Meadows, Mission/Abbotsford, New Westminster, Surrey, Tri-Cities and White Rock/South Surrey</td>
</tr>
<tr>
<td>Hospice Societies Advisory Committee</td>
</tr>
<tr>
<td>Hospice Residence Managers Committee</td>
</tr>
<tr>
<td>Hospice Residences Committee</td>
</tr>
<tr>
<td>Social Work/Counselor Consultant Committee</td>
</tr>
<tr>
<td>Clinical Nurse Specialist Committee</td>
</tr>
</tbody>
</table>

The Fraser Health HPC Clinical Services Planning and Delivery Team (CSPD) creates the strategic plan for the Fraser Health HPC Program. The Director of Hospice Palliative and End of Life Care, and the Medical Director for Hospice Palliative and End of Life Care co-chair this committee. The committee is supported by an Executive Sponsor who reports the program plan at the Fraser Health Executive level. The CSPD sets the yearly targets for service, indicators and performance measures for the HPC Program, and assigns tasks to other HPC committees. All the other HPC committees report into this committee.

The Fraser Health HPC Program Practice Advisory Council’s mandate is to provide interdisciplinary leadership in patient care, clinical decision making and quality of care for hospice palliative patients in all sectors of care throughout Fraser Health. Work is based on the Canadian Hospice Palliative Care Association (CHPCA) A Model to Guide HPC: Based on National Principles and Norms of Practice (March 2002) and by the performance indicators as determined by Fraser Health HPC CSPD, Canadian Council on Health Services Accreditation (CCHSA) and B.C. Ministry of Health. There are HPC Education and Research work groups within this committee. The Education Work Group plans and evaluates educational activities on a yearly basis.

Each of the eleven (11) Fraser Health communities has a local HPC Program Committee composed of stakeholders from all sectors of that community. This committee provides leadership in the development, implementation and evaluation of a comprehensive integrated delivery system for HPC patients and their families within the local service delivery area. Membership typically includes: Acute Care Director, Home Health Director, HPC Clinical Nurse Specialist, HPC physician, Hospice Society representative, consumer representative, family physician, spiritual care representative, other HPC team members, and representatives from acute care, home health, home support, and residential care.
Section 1: Background

1.3 Hospice Development Within An Integrated Program

The Hospice Residences Committee is an interdisciplinary committee established to provide a forum for discussion of issues, and collaboration and coordination of clinical activities. This committee makes decisions or recommendations to other committees in order to establish and maintain consistency of structure, processes, education and practice across hospice settings in Fraser Health. Several Hospice Residences have also formed a Leadership Team to meet regularly to discuss and make decisions about day to day hospice needs and issues. These teams include administrative, medical, volunteer and front line staff representation.

The Hospice Managers Committee provides a forum for discussion, collaboration, recommendations and decision-making regarding operational, human resources, management and administrative issues that arise within Hospice Residences in order to maintain consistency of structure within hospice settings in Fraser Health.

All discipline specific committees (physician, CNS, social worker) discuss the details of initiatives and issues requiring their expertise in decision-making and implementation.

The Hospice Societies Advisory committee includes representation from all Hospice Societies, the Executive Director of Home Health and End of Life Care, the Director of End of Life and HPC and the Home Health directors. This advisory committee provides a vehicle for discussion of issues and events.

Central Coordination of Hospices

In addition, central coordination and development of the hospices was accomplished by establishing a regional Clinical Nurse Specialist position responsible specifically for clinical aspects of planning and opening hospice beds. The roles and responsibilities of this position evolved over time, according to need. They now include establishing and maintaining standards across all Fraser Health Hospice Residences.

Once decisions were made regarding funding of beds in a particular community, there was intense pressure to get construction done and beds open quickly. Allowing time for community input into planning, development of standards and thoughtful hiring and orientation of staff was often challenging. As each new hospice opened, a new piece of development work was accomplished, that could be used by all other hospices. Since 2002 when the first hospice opened, many additional standards have been developed, implemented, and evaluated.

Each new community presents a unique combination of history of practice, population demographics, culture and individual personalities, requiring flexibility and time to collaborate and encourage buy-in to the new vision and practice implications. Having a consistent person in this leadership position is crucial to the successful opening and ongoing operations of each new hospice since the local hospice manager and director are usually responsible for many other units and often do not have expertise in the area of HPC. The CNS also knows the history of the hospice development, what has worked and what has not worked well, so helps communities adapt and move forward more quickly with planning.
Section 1: Background

references

2 Senate of Canada; Subcommittee of the Standing Senate Committee on Social Affairs, Science and Technology. Quality End-of-Life Care: The Right of Every Canadian; 2000 June.


Section 2: Development of Hospice Residences

2.1 Hospice Residences In Fraser Health
2.2 Estimation Of Number Of Hospice Beds Required
2.3 Hospice Planning Principles
2.4 Hospice Partnership Framework
2.5 Hospice Operational Model
2.6 Hospice Environment
2.7 System And Clinical Standards
There are currently seven Hospice Residences in Fraser Health, plus two hospice suites in Fraser Canyon Hospital in Hope. It has been the Fraser Health experience that ten beds is the smallest size possible to provide efficient and effective staffing for a dedicated hospice residence. In small communities, such as Hope, that do not have the population and/or resources to establish a dedicated Hospice Residence, designated hospice beds have been established, with modified requirements, to provide a specialized environment for HPC patients within an acute facility.

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Community</th>
<th>Number of Beds</th>
<th>Date of Opening</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Michael’s Centre</td>
<td>Burnaby</td>
<td>16</td>
<td>May 2002</td>
<td>Residential Care Facility</td>
</tr>
<tr>
<td>Crossroads Inlet Centre</td>
<td>Port Moody</td>
<td>10</td>
<td>Sept. 2003</td>
<td>Seniors Housing Building</td>
</tr>
<tr>
<td>Queens Park</td>
<td>New Westminster</td>
<td>10</td>
<td>Jan. 2004</td>
<td>Mixed Use Healthcare Facility</td>
</tr>
<tr>
<td>Surrey</td>
<td>Surrey</td>
<td>10</td>
<td>April 2005</td>
<td>Residential Care Facility (temporary location)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td></td>
<td>Mixed Use Healthcare Facility</td>
</tr>
<tr>
<td>Langley</td>
<td>Langley</td>
<td>10</td>
<td>June 2005</td>
<td>Residential Care Facility (temporary location)</td>
</tr>
<tr>
<td>Christine Morrison</td>
<td>Mission</td>
<td>10</td>
<td>July 2005</td>
<td>Acute Care - Separate Floor</td>
</tr>
<tr>
<td>McKenney Creek</td>
<td>Maple Ridge</td>
<td>10</td>
<td>Oct. 2006</td>
<td>Mixed Use Healthcare Facility</td>
</tr>
<tr>
<td>Fraser Canyon</td>
<td>Hope</td>
<td>2</td>
<td>2003</td>
<td>* Designated Beds in Acute Unit</td>
</tr>
<tr>
<td>Cascade</td>
<td>Chilliwack</td>
<td>10</td>
<td>Winter 2008</td>
<td>Mixed Use Healthcare Facility</td>
</tr>
<tr>
<td>Delta</td>
<td>Delta</td>
<td>10</td>
<td>Summer 2009</td>
<td>Mixed Use Delta Hospice Society Operations and Supportive Care Centre</td>
</tr>
</tbody>
</table>

* Fraser Health Authority Plan for Hospice Beds in Locations other than a Hospice Residence (February, 2003)
Section 2: Development of Hospice Residences

2.1 Hospice Residences in Fraser Health

Level of Care: Target population for Hospices Residences

In Canada and the United States, Hospice Residences have been developed to provide care to patients with varied levels of acuity and complexity. Some hospices provide longer term residential care, while others provide shorter term sub-acute care. In addition, some provide short term respite care for caregiver relief.

In Fraser Health, Hospice Residences are resourced to accommodate a sub-acute level of care. This level of care is aimed at patients who require frequent adjustments to medications for symptom management, and psycho-social-spiritual care of patients and their family during the final days and weeks of life. Patients admitted to Hospice Residences require longer stays, with less intensive levels of medical and nursing care than in a hospital setting. They generally do not require acute care investigations and treatments. They require more specialized care than individuals in residential care and do not benefit from the activity programs that are offered in residential care facilities. Hospice beds are not residential beds; they are not intended for long-term admissions or for patients needing care at less than a sub-acute level. Hospice patients that require treatments for symptom management (for example, blood transfusions, radiation treatments, paracentesis, thoracentesis, IV bisphosphonates) are transported to a hospital Ambulatory Care unit for treatment.

The characteristics of patients in Fraser Health Hospice Residences:

- At end stage of disease, with less than 3 months of life
- Mostly cancer patients (84%)
- Younger population than residential care (Approximately 36% of patients are 20-69 years)
- Less likely to have caregiver support
- Most patients are admitted from hospital (66%)
- Most patients stay in hospice less than 3 weeks (1-3 days - 28%; 4-21 days - 46%)

Categories of patients requiring care in Fraser Health Hospice Residences:

- Patients whose care is being managed in the community but whose needs are outstripping the family resources available to them in the community or whose caregivers are unable to continue providing care
- Patients whose care is being managed at home but are actively dying (days to live) and the patient/family preference is to die in hospital/hospice
- Patients in hospital wards or Palliative Care Units who cannot return home and are not appropriate for residential care but who do not require an acute bed
- Patients whose care is being managed in residential care but whose needs are outstripping the resources available to them in residential care
- Patients who require a short term stay for symptom management, when acute care resources are not required for investigation and treatment
- In situations where admission is required to provide caregiver relief and symptom management, thus preventing an emergency admission, an HPC team member may arrange for a short term admission to the next available hospice bed. (Pre-booked respite is not provided in Hospice Residences.)
Section 2: Development of Hospice Residences

2.2 Estimation of Number of Hospice Beds Required

In 2001, prior to opening any hospices, acute care hospitals throughout Fraser Health were admitting a growing number of dying patients who could be cared for more appropriately at home (if resources were available) or in a hospice, if one were available. The number of cancer deaths within the health authority in 2001 was 2,483. The anticipated number of HPC patients (cancer deaths plus 10% non-cancer) was 2,731 individual deaths. The estimate that cancer deaths would increase by almost 40% over the next 10 years made it evident that the need for hospice care was becoming crucial, given that these individuals would be accessing costly healthcare services via emergency departments and acute care services.

Data from the Edmonton Regional Palliative Care Program was used to guide Fraser Health planning. The Edmonton program, which has been in operation since 1995, found that it was able to attain rates of more than 30% of all palliative deaths in hospice. The Fraser Health HPC Statistics for 2006 show that Fraser Health communities with an established hospice have 30-40% of all HPC deaths occur in the hospice.

Fraser Health began to open hospice beds in 2002. At that time the estimation of the total number of beds needed for hospice in the Fraser Health was determined using the projected population of the Fraser Health, cancer deaths plus 10%, and the experience of the Capital Health Region in Edmonton (see Table 1 below).

Table 1 – Population and Hospice Bed Requirements (2002)

<table>
<thead>
<tr>
<th>Local Health Area</th>
<th>Population 2001</th>
<th># of Cancer Deaths 2001 (Vital Statistics BC)</th>
<th># of HPC* Cases Based on Cancer Deaths plus 10%</th>
<th>Projected # of Hospice Beds Needed to Meet Needs for 2001**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chilliwack, Agassiz, Harrison</td>
<td>81,014</td>
<td>199</td>
<td>218.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Abbotsford</td>
<td>120,126</td>
<td>230</td>
<td>253</td>
<td>10.3</td>
</tr>
<tr>
<td>Hope</td>
<td>8250</td>
<td>16</td>
<td>17.6</td>
<td>0.72</td>
</tr>
<tr>
<td>Mission</td>
<td>38,044</td>
<td>62</td>
<td>68</td>
<td>2.7</td>
</tr>
<tr>
<td>Maple Ridge</td>
<td>80,451</td>
<td>154</td>
<td>170</td>
<td>6.9</td>
</tr>
<tr>
<td>Langley</td>
<td>116,660</td>
<td>237</td>
<td>260</td>
<td>10.6</td>
</tr>
<tr>
<td>Tri-Cities</td>
<td>191,757</td>
<td>274</td>
<td>301</td>
<td>12.2</td>
</tr>
<tr>
<td>New Westminster</td>
<td>56,456</td>
<td>145</td>
<td>160</td>
<td>6.5</td>
</tr>
<tr>
<td>Burnaby</td>
<td>197,292</td>
<td>385</td>
<td>424</td>
<td>17.2</td>
</tr>
<tr>
<td>Delta</td>
<td>102,943</td>
<td>161</td>
<td>177</td>
<td>7.2</td>
</tr>
<tr>
<td>Surrey and White Rock</td>
<td>367,574</td>
<td>620</td>
<td>682</td>
<td>27.7</td>
</tr>
<tr>
<td>Total:</td>
<td>1,362 Million</td>
<td>2483</td>
<td>2735</td>
<td>111</td>
</tr>
</tbody>
</table>

* Hospice Palliative Care
** Figures based on calculation of hospice beds accommodating 33% of total HPC caseload, with an average length of stay of 45 days
Section 2: Development of Hospice Residences

2.2 Estimation of Number of Hospice Beds Required

When planning for hospice beds, it was estimated that approximately one third of patients registered on the HPC program would die in hospice, when a hospice is available. In 2006, this goal had already been met. The number of beds required for hospice is currently estimated at 7 beds /100,000 population. This estimate allows for expected population growth and an increasing mortality due to the aging population. Hospice bed planning must also consider the need for acute care beds. The model adopted within Fraser Health called for the establishment of 30 tertiary beds which results in a ratio of 1 bed per 50,000 population. Further forecasting was done as part of the Fraser Health Acute Care Capacity Initiative (ACCI) which predicted needs for all acute care beds until 2020 (available on Fraser Health website).

In 2006, the average length of stay for Fraser Health hospice patients was 19 days. The length of stay is shorter than was anticipated in 2002, when the plan was developed using an average length of stay of 45 days. The average wait time for admission is less than 1.5 days. The goal for occupancy is 90%. The actual occupancy rate varies from about 75% to 90%. If this trend continues, the planned bed capacity will meet future needs for hospice beds for some time beyond original predictions.

Factors that are thought to contribute to lower occupancy or short length of stay in Fraser Health hospices include the following:

- Some patients and/or physicians are reluctant to let go of acute treatment, resulting in admission to hospice late in trajectory or no admission to hospice
- The move from acute care to hospice requires discussion of goals of care prior to the move. Staying in hospital makes it possible to avoid these discussions even when goals and resultant care have changed to supportive comfort care
- Patients and families are supported to stay at home by expertise within the home health program as well as the HPC consultation teams, and often only come into hospice for the last few days. This may occur because the patient or family do not wish the death to occur in the home, or they become exhausted with the care demands and/or find it difficult to manage symptoms in the home setting
- A culture change is required with the addition of hospice as a new category of care. In each community where a hospice opens, healthcare administrators, healthcare professionals and the public require education about Hospice Residence care. There must be strong leadership to help change perspectives and patterns of referral. The Fraser Health experience shows there is a tendency for low number of referrals at time of opening with the demand growing as the community becomes aware of the new setting and its benefits
Section 2: Development of Hospice Residences

2.3 Hospice Planning Principles

The following principles were established in 2002 by the sub-acute task force to guide the planning efforts, and remain important principles.

- **Alternative to Acute Care** - The provision of hospice beds is intended to provide an alternative that meets the needs of hospice palliative patients who are unable to remain at home, but who do not require the acute care support of a hospital. Those who can die at home will continue to be supported to do so, and those who require complex palliative care will be accommodated in tertiary facilities. Patients who require short-term symptom management (and do not require acute care investigations or treatment) may also be cared for in hospice.

- **Community Needs** - It is anticipated that each hospice will be unique because in each community there will be differences in the need for hospice beds, potential partnerships, and development opportunities. It is recognized that each community may want to modify hospice according to its own culture, tradition, demographics and geography.

- **Hospice Environment** - The location of a Hospice Residence may be varied; within a residential facility, as part of a housing project or assisted living project, within a sub-acute facility, or as a separate building. All hospice facilities should provide a warm, comfortable and home-like environment while also ensuring that the functional requirements of patients and staff are met. Hospice beds may be operated by a contracted service provider or within a facility leased or owned and operated by Fraser Health. Fraser Health supports only those operational models that provide some level of shared services which are required for the economic viability of small units of ten beds.

- **Operational Funding** - Fraser Health is committed to providing basic operating funds for hospice beds; these funds are allocated as part of the re-organization of acute care services or the result of new funding allotments.

- **Capital Funding** - Fraser Health does not have capital funding available for construction of hospice beds. Any new construction or capital funding requirements are the responsibility of the project partners. Some renovation work as appropriate may be funded through Fraser Health. Fraser Health also leases purpose-built space within buildings housing other programs such as complex care, assisted living, etc. Hospice Societies have contributed generously to fundraising for equipment, furnishings and comforts for Hospice Residences and in some cases may provide a component or the full funding amount of capital required to build a Hospice Residence.

- **Partnerships** - Fraser Health seeks partnerships with contracted service providers who wish to become an integral part of the HPC Program and to proactively participate in a joint management model of service delivery.

- **Policies and Standards** - The Fraser Health HPC Program establishes the policies, practices and standards for all hospice facilities.

- **Admission Policy** - The Fraser Health HPC Program will manage a coordinated and standardized procedure for assessment, wait-listing and admission of hospice patients.
Section 2: Development of Hospice Residences

2.4 Hospice Partnership Framework

Regardless of the hospice model adopted by the community, Fraser Health, in providing operating funds, will require that specific terms of a funding partnership be met in order to ensure an appropriate and consistent standard of excellence in HPC. Fraser Health, the Fraser Health HPC Program, the Hospice Societies and the contracted service providers have specific roles and responsibilities that must be fulfilled.

Partnership Role of Fraser Health

1. Provide Operational Funding - Fraser Health is responsible for allocating operating funds based on the established staffing model and a budget developed jointly with the contracted service provider and approved by the Director, Hospice Palliative and End of Life Care. Fraser Health funding will be limited to core staffing and operations for hospice care. Added-value items, activities and positions may be provided by the service provider or hospice society.

2. Provide HPC Program Delivery Infrastructure - Fraser Health, through the HPC Program, will be responsible for maintaining a system-wide infrastructure that supports hospice operations, including the community consultation teams, the development and delivery of resources, evaluation tools, and the provision of professional development opportunities.

Partnership Role of the Fraser Health Hospice Palliative Care Program

1. Commitment to Excellence - The Fraser Health HPC Program is committed to excellence in the delivery of care and services to patients and their families. The Fraser Health HPC Program has incorporated national norms of practice, ethical principles and evidence-based practice into its standards and policies. In addition, the Fraser Health HPC Program determines the expectations and requirements for a healing and caring environment for patients, families, staff, volunteers and visitors in hospice.

2. Define Standards and Policies - The Fraser Health HPC Program is responsible for developing standards and policies pertaining to clinical practice, standards of service delivery, records and information management, financial accountability, and other standards and policies that contribute to a consistent and integrated system of HPC service delivery across Fraser Health. The nurse manager of each hospice is required to attend monthly Hospice Managers Committee meetings. It is also desirable to have the nurse manager attend the Hospice Residences Committee meetings.

3. Manage Waitlist and Admissions - There is an established Fraser Health infrastructure that provides central wait-listing and admission to Hospice Residences in Fraser Health. The Fraser Health HPC consultation team members screen patients and determine priorities for admission into hospice. The Hospice Access Coordinator reviews all patients wait-listed and urgency of admission, then allocates available hospice beds. The community consult team will work closely with client coordinators, discharge planning personnel, home care and hospital nurses and family physicians as to the need of a patient for admission to hospice. The hospice manager determines whether admission needs to be delayed to allow time to acquire resources or provide education for staff in certain circumstances. The HPC social worker assesses patients...
Section 2: Development of Hospice Residences

2.4 Hospice Partnership Framework

who may have difficulty paying the per diem charge for the hospice room and any resultant reduction in charges is forwarded to the Finance/Billing department.

4. Establish Minimum Staffing Requirements - The Director, Hospice Palliative and End of Life Care, will be responsible for establishing standards pertaining to staff/patient ratios, staffing coverage, and required staff positions and qualifications.

5. Evaluate Hospice Design - At the design phase of any new hospice facilities, Fraser Health 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 the privacy, comfort and safety of patients.

Partnership Role of Hospice Society

A Hospice Society is a community-based, non-profit charitable organization that provides compassionate support to people and their families who are facing terminal illness, death and bereavement. A hospice society offers a variety of services that focus on helping people understand and manage their situation. A key component of the hospice society mandate is to provide volunteers to support patients at home and in a variety of healthcare settings, such as hospital, Hospice Residence, and residential care facility. Hospice societies provide training for their volunteers, as well as ongoing supervision, support and education. Programs may include: bereavement support for children, adults and teens, public education, access to resource materials and seasonal memorial services.

The Hospice Societies in all Fraser Health communities have a contract with Fraser Health to provide volunteer services in HPC settings, including Hospice Residences. The Hospice Societies have provided a strong voice and unrelenting advocacy in pushing for Hospice Residences in Fraser Health. From a community perspective, they have identified the need, educated the public and approached local and provincial politicians for support. They provided grassroots impetus for change and have worked diligently alongside Fraser Health to provide funds and services to complement and strengthen that which the healthcare system can provide.

1. Emotional and Practical Support - The Hospice Society provides volunteers to support the Hospice Residence for several scheduled hours every day of the week. These volunteers are an integral part of the HPC team, contributing greatly to the healing and caring environment within Hospice Residences.

2. Bereavement - The Hospice Society offers a comprehensive variety of bereavement services to family members during the patient’s stay in hospice, and for at least a year following the death of a patient.

3. Fundraising - The local Hospice Society plays an important role in fundraising for equipment, furnishings and comfort items for Hospice Residences. The extent of the fundraising role is determined by the management model and the capacity and/or desire of the local Hospice Society to raise funds.

4. Non-medical perspective - The local Hospice Society collaborates with Fraser Health staff to provide input into the interior furnishings and decoration of the Fraser Health operated hospices. In all hospices, the memorial space is set up in
Section 2: Development of Hospice Residences

2.4 Hospice Partnership Framework

collaboration with representatives of the Hospice Society. Hospice society staff and volunteers provide ongoing input from a lay perspective, to support the needs of patients and their family members.

Partnership Role of Contracted Service Providers

1. Integration into System - A contracted service provider must be an integral part of the Fraser Health HPC Program. This specifically includes participation in weekly clinical rounds, regular meetings with the HPC consultation team, partnering with the local Hospice Society, and implementation of all HPC Program policies, protocols, standards, clinical pathways and symptom management guidelines as appropriate to the setting.

2. Deliver Quality Care - A contracted service provider is expected to contribute to the goals of excellence and quality of care within hospice by adopting Fraser Health Hospice Residence standards of practice, participating in key educational and professional development activities, participating in HPC Program evaluation, and by integrating quality improvement activities into all aspects of care. Quality care in hospice includes commitment to and advocacy for a healing and caring environment within hospice, as described later in this document.

3. Financial Responsibility - A contracted service provider is responsible for the administration of Fraser Health allocated funds and for ensuring adequate funding for all other operating and capital costs including patients’ payment of the minimum residential fee as determined by the Ministry of Health. Financial accountability, such as submission of an annual budget to Fraser Health as well as a quarterly financial statement is required.

4. Development and Design - It is the responsibility of potential and contracted service providers to secure capital funding and to develop plans for the construction or provision of a hospice facility. Throughout the design phase providers are expected to work with HPC Program staff to ensure that the hospice facility will meet established requirements.

Shared Roles of HPC Program and Contracted Service Provider

Partnership implies shared roles and responsibilities, both during the planning phase of hospice development and the ongoing operation of the hospice. The way that roles and responsibilities are shared will vary according to the strengths and needs and desires of the contracted service provider.

1. Hospice Culture - The Fraser Health HPC Program and the contracted service provider will co-create a hospice that meets the needs of the local patient population, accommodates the culture of the contracted service provider, and utilizes the HPC Program values, standards, policies and system-wide infrastructure.
Section 2: Development of Hospice Residences

2.4 Hospice Partnership Framework

2. Joint Management - Shared responsibilities during planning and start-up of the hospice include: making decisions regarding adaptation of possible HPC resources and activities to fit the culture of the service provider/ local patient population; provision of human resources to carry out tasks for planning and implementation; organization of meetings; and provision of orientation for hospice staff. It is highly desirable that the panel for hiring the clinical manager for a new Hospice Residence should include a Fraser Health HPC CNS. An HPC CNS is also available to participate in the initial hiring of staff in locations that have not previously provided Hospice Residence care. Fraser Health job descriptions and interview questions are provided to the contracted service provider, indicating standards related to qualifications and competencies required for nursing staff.

Shared responsibilities related to the ongoing operation of the hospice include: on-going adjustment of unit routines, policies and structure to meet standards; resolution of system/process problems; orientation of new staff, and provision of education for staff.

2.5 Hospice Operational Model

Hospice Management Models

While in some cases Fraser Health directly operates hospice beds, a number of Hospice Residences are operated as partnerships with contracted service providers. Hospice Societies are encouraged to consider their role as it relates to the Hospice Residence in their community. This willingness to accommodate a variety of Hospice Residence management models has made it possible to plan and open eight Hospice Residences in a 5 year period.

There are four (4) management models currently in existence in Fraser Health: Fraser Health owned and operated, Fraser Health Leased, Contracted Service Provider, and Hospice Society/Fraser Health shared management. Each management model has required different parameters in relation to the building, equipment and furnishings, management of staff and additional services and comforts. Basic clinical services and standards of care are managed consistently across all settings.
# Section 2: Development of Hospice Residences

## 2.5 Hospice Operational Model

The chart below summarizes the key components of these models.

<table>
<thead>
<tr>
<th>Fraser Health Owned and Operated</th>
<th>Fraser Health Leased and Operated</th>
<th>Contracted Service Provider (CSP)</th>
<th>Hospice Society/ Fraser Health Shared Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Building</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraser Health pays for all capital costs of building renovations and ongoing maintenance of building</td>
<td>Building owner pays for all capital costs of building and ongoing maintenance of building</td>
<td>CSP pays for all capital costs of building/renovations and ongoing maintenance of building</td>
<td>Hospice Society (plus Greater Vancouver Housing Corporation at Crossroads Hospice) pay for building costs and ongoing maintenance of building</td>
</tr>
<tr>
<td><strong>Equipment and Furnishings</strong></td>
<td>Hospice Society (and other donors) pay for a portion of costs of equipment and furnishings</td>
<td>Hospice Society (and other donors) pay for a portion of costs of equipment and furnishings</td>
<td>Hospice Society (and other donors) pay for capital costs of equipment and furnishings</td>
</tr>
<tr>
<td><strong>Basic Clinical Services and Standards of Care</strong></td>
<td>Fraser Health pays operating costs for basic staff, basic services, pharmacy and medical supplies</td>
<td>Fraser Health determines hospice standards, admissions, clinical practice, education, etc.</td>
<td>Hospice Society provides Meditech connections and computers for hospice clinical staff</td>
</tr>
<tr>
<td><strong>Management of Staff</strong></td>
<td>Fraser Health manages both nursing and non-nursing staff</td>
<td>Fraser Health manages both nursing and non-nursing staff</td>
<td>CSP manages both nursing and non-nursing staff</td>
</tr>
<tr>
<td><strong>Additional Services and Comforts</strong></td>
<td>Hospice Society provides volunteers and complementary therapies</td>
<td>Hospice Society (or other donors) provide operating costs for television/internet cable, telephones for patients/families</td>
<td>Hospice Society manages non-clinical staff (housekeeping, laundry, food services)</td>
</tr>
</tbody>
</table>

Fraser Health determines hospice standards.
2.5 Hospice Operational Model

**Hospice Clinical Operational Model**

Meeting the complex and multi-dimensional needs of hospice patients and their families requires an interdisciplinary team of professionals. The integrated HPC Program allows for a combination of dedicated staff within hospice, supported by a variety of disciplines from outside the Hospice Residence. The staffing and support for patients and their families in hospice come from the following resources:

- Hospice clinical staff (nursing and administrative support)
- Family physicians and designated hospice physicians
- Hospice Society volunteers
- HPC consultation team (clinical nurse specialist/clinical resource nurse, physician, social worker/counsellor, clinical pharmacist, Hospice Society Coordinator of volunteers)
- Access to other disciplines on a one-off basis (i.e. occupational therapist, nutritionist/dietician)
- Access to other disciplines as negotiated by contracted service provider and the HPC Program (i.e. spiritual care practitioner, music therapist)

**Clinical Staffing Requirements**

Presently in Canada, no standards exist around staffing in hospice and while it may be valuable to benchmark to other settings, a danger exists in not fully considering the total care environment and the level of acuity of hospice patients. In some cases hospice care has been most closely aligned with long term residential palliative care or “respite care” – this model is not consistent with the levels of acuity in Fraser Health.

In Fraser Health we have determined that the acuity, complexity and care needs of hospice patients and families require that a Registered Nurse (RN) be on site at all times, supported by a Licenced Practical Nurse (LPN) working at full-scope.
### Section 2: Development of Hospice Residences

#### 2.5 Hospice Operational Model

The following table provides rationale for the chosen staffing model:

<table>
<thead>
<tr>
<th>Nursing Requirement</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to provide all aspects of physical and emotional care – all shifts</td>
<td>Hospice philosophy focuses on the needs and goals of patient/family rather than nursing routines, therefore it is not expected or desired that the majority of physical care be completed on day shift. Most patients are awake at frequent intervals during the night.</td>
</tr>
<tr>
<td>Ability to deal with acuity and complexity– all shifts</td>
<td>Regular changes in condition and symptoms requiring assessment, decision-making and changes in medications or dosage of medications and treatment. For example, malignant wounds, tracheotomy, etc.</td>
</tr>
<tr>
<td>Ability to consult another nurse for decision-making – all shifts</td>
<td>Patients and families have specialized needs at end of life including psychosocial, spiritual and educational needs</td>
</tr>
<tr>
<td>Ability to provide prompt and frequent assessment, anticipatory planning, problem-solving, decision-making, medications and other interventions to patients in emergent and urgent situation while simultaneously providing teaching and support to family members – all shifts</td>
<td>Major bleed, seizures, pain crisis, spinal cord compression, etc.</td>
</tr>
<tr>
<td>Ability to get help to deal with urgent situation and call doctor for orders simultaneously – all shifts</td>
<td>Some hospices do not have security on site. Some hospices do not have adjacent nursing staff/other staff to call upon for assistance.</td>
</tr>
<tr>
<td>Ability to deal with aggressive patients or family members, including calling physician or police while managing situation – all shifts</td>
<td></td>
</tr>
</tbody>
</table>

Actual FTE requirements will depend on the number of patients, but must provide for total nursing direct care hours of 4.4 hours per 24 hour period. Additional workload may be required at times, depending on circumstances within the hospice. In most Fraser Health hospices, staff work 12 hour shifts. Nursing staff generally prefer 12 hour shifts because having several consecutive days off provides a good break from the intense physical and emotional workload, and allows time for self-care.

The Fraser Health standard specifies that each hospice should have a manager who will: ensure appropriate care standards are in place, collaborate with the HPC consultation team, facilitate admission of patients into hospice as recommended by the consultation team, report regularly to the HPC Program on quality activities of the hospice, and participate in Fraser Health HPC activities.

Many Fraser Health hospices have a manager covering hospice in addition to several other units and a part-time patient care coordinator (PCC) dedicated to the Hospice Residence. The PCC provides on-site management of the hospice staff under the supervision of the manager. The PCC provides orientation and education for staff in...
2.5 Hospice Operational Model

collaboration with the local Clinical Nurse Specialist. The PCC also works directly with patients and families. It is important that there be a clinical manager or PCC with HPC expertise regularly on site to support and mentor staff, and promote decisions and actions that contribute to a healing environment in Hospice Residence. Ideally, the minimal requirement for the PCC position is .56 FTE.

Hospices have part time unit clerk support (.5 FTE) during weekdays.

**Patient Care Delivery Model**

The optimal model of care delivery in the hospice setting is a patient-centred assignment system. In this system one person performs all the care tasks for a particular patient, regardless of the skill level of the task, within the limits set by the person’s job description. The rationale for this model is continuity of care. Daily patient assignments determine which caregiver will care for each patient on any given day, thus matching patient needs with the abilities of the caregiver. Continuity of care is more important than geographical assignment of patients.

The RN and LPN work together as a team to care for all the patients, while each takes responsibility for the care, medications, treatments and charting on his/her assigned patients. Nurses work collaboratively in planning, implementing and evaluating patient and family care. The patient assignment is determined according to acuity, complexity and variability in patient condition and complexity of family dynamics and needs. The level of experience and expertise of the individual nurse is also considered. The RN is assigned patients and families that exceed the LPN scope of practice; therefore RNs are responsible for the most acutely ill patients. In hospice these patients would include those with unstable pain / symptoms, difficult psychosocial situations (such as conflict among patient’s family members), and treatments that require daily assessment and frequent changes in care plan.

As hospice is a specialized setting of care, the Canadian HPC Association (CHPCA) Nurses’ Model for HPC nursing, standards and competencies have been adopted for the Hospice Residences. The qualifications required for nursing staff reflect that level of specialization. Qualifications for RNs include two years recent, related medical nursing experience in an acute care facility or HPC environment, which includes one year’s recent related hospice/palliative care experience. Many of the nurses working in hospice residences have obtained Canadian Nurses Association (CNA) certification for HPC - CHPCN(C).

Licensed Practical Nurses (LPN’s) that have previous HPC experience are preferred in hospice, but at this time there are very few LPN’s with this experience. LPN’s must be educated and mentored to take on skills and decision-making that fall within their scope of practice, but which they have not previously had an opportunity to practice. In Fraser Health we have developed a comprehensive team orientation program prior to start-up of a new hospice and a structured ongoing orientation program for nurses new to HPC (See System and Clinical Standards section for details.)

To assist in hiring the most suitable nurses for available positions, detailed interview tools and a medication quiz have been developed to help assess knowledge, attitude and communication skills of prospective staff. These tools have been very helpful, not only in determining the most qualified applicants, but also helping applicants without...
Section 2: Development of Hospice Residences

2.5 Hospice Operational Model

the required attributes and skills to better understand the reality of hospice nursing and determine when it is not the right place for them. These tools are available to interested managers, on request.

Physician Roles and Coverage

Physician support for the Hospice Residences comes from three sources:

Family physicians that choose to follow their own patients - Ongoing support and continuity of care from family physicians is encouraged. Two patient visits per week and after-hours availability through a call group is the minimum standard of care. Physicians are expected to be available for ongoing care with frequency of visits adjusted according to the needs of the patient/family. Physician’s bill fee-for-service for the work they do.

Designated Hospice Physicians - Designated physicians with some additional training in HPC will take on the care of the patients in hospice who do not have an attending family physician. Ideally a physician will attend the unit on a daily basis (Monday to Friday), be available for nursing concerns and attend weekly patient rounds. These physicians may be contracted with Fraser Health or bill fee-for-service and are compensated for their attendance at patient care rounds. Staffing for physician coverage is calculated as one hour of physician time per bed per week plus attendance at weekly patient care rounds. Evening and weekend call availability for Hospice Residences is currently covered through a contract with the Fraser Health.

HPC Physician Consultants - Consultants are physicians with extra skills and training in HPC. The consultant will be available to assist in the management of complex cases and to assist in the education and support of primary providers. There is always a designated HPC physician consultant on call as backup to the primary care physician on first call.

Hospice Society Volunteers

Hospice Society volunteers are an integral part of our Hospice Residence support system. There is a contractual relationship between Fraser Health and the eleven community Hospice Societies to provide a wide range of resources, including volunteer support for dying individuals and their families, and bereavement support in home, hospital, residential care and hospice. Hospice societies provide about 30 hours of specialized training for their volunteers, as well as ongoing supervision and support groups.

In Hospice Residences, the volunteers have an expanded role in providing emotional and practical support to patients and their families. The volunteer role is complementary to paid healthcare providers. For patients, volunteers provide the caring presence that a knowledgeable and skilled family member would provide (if they were present) and also support family members at this difficult time. Volunteers who have previously been visiting HPC patients in other locations follow the patient and family into hospice, providing continuity of support. Other volunteers commit to being at hospice at scheduled times of the day, in order to be available to any patients and families requiring emotional or practical support.
Section 2: Development of Hospice Residences

2.5 Hospice Operational Model

Volunteers are also available, as part of the team, to provide practical support for general hospice tasks, such as orienting family members to the hospice environment, decorating for special occasions, and helping with specific tasks. Some hospice society members have taken further training to provide additional comforts such as: energy-based therapies, companionship and assistance at meals, vigil support, tea cart service, life review, or art care activities. Volunteers are considered part of the hospice team and are included in education sessions and team events.

Another group of hospice society volunteers provides bereavement support to families during the first year after the patient’s death. When requested, volunteers provide resources by mail and emotional support either by phone or in person. Programs offered vary from community to community. In addition to the supports mentioned above, programs offered may include: memorial services, drop in sessions, walking groups, grief support groups specifically for adults, teens or children, seasonal events and bereavement education workshops.

Complementary Therapy Volunteers

Hospice Society volunteers who have the required qualifications may provide Therapeutic Touch, Healing Touch, Reiki or Integrative Energy Healing treatments to patients, family members or staff within the hospice. The availability of these energy-based therapies is consistent with the holistic HPC philosophy, enhancing the quality of living and dying in hospice by providing comfort and relaxation. Detailed guidelines have been developed for complementary therapies, including qualifications, interview tool, policies, and communication with staff (available on the Fraser Health website). Pet visitors and art care activities are also available to patients in most hospices.

Spiritual Care Volunteers

Spiritual Care volunteers are a part of the team in most hospices. All spiritual care volunteers have received training for the provision of spiritual care in healthcare and are supervised by the Coordinator of Spiritual Care for each hospice. In many settings these volunteers have also received the volunteer training provided by the Hospice Society. Some spiritual care volunteers who have been trained and are working in other healthcare settings have received additional training and orientation specific to Hospice Residence. All spiritual care is provided from a broad spectrum, multi-faith perspective. The schedule of availability for these volunteers is variable.

HPC Consultation Team

The HPC consultation team generally includes an HPC physician, social worker/ counsellor, clinical nurse specialist (CNS) / clinical resource nurse (CRN), and Hospice Society Coordinator of volunteers in each community. In addition, there are three Fraser Health HPC clinical pharmacists, who are shared across the teams. The consult team members are available during weekdays. They determine which patients are admitted to hospice, attend weekly Patient Care Rounds and are available by phone to staff for expert clinical consultation. Team members have limited direct patient care or support roles with patients or families. Such support is provided when patient and family complexity and needs require expert assessment, decision-making,
Section 2: Development of Hospice Residences

2.5 Hospice Operational Model

Communication skills and time beyond what the nurses can provide. During evenings and weekends both an HPC physician and an HPC Clinical Nurse Specialist are available to hospice nurses through an on-call rotation.

Other Disciplines on the Team

Our experience has been that the need for occupational therapy and nutritionist/dietician services in hospice is infrequent. These services have been provided when needed, by accessing community or adjacent program services. Payment for services is on a case by case basis.

Hiring of other disciplines is negotiated by the contracted service provider and the HPC Program. Most hospices have a part-time Spiritual Care Coordinator and a part-time music therapist.

2.6 Hospice Environment

Introduction

In a Hospice Residence there is an opportunity to create an environment that is separate and distinct from healthcare settings driven by the medical model. Building on HPC principles and values by adding conscious application of healing concepts, provides a framework for creating a culture and environment that provides a safe, respectful and supportive place for the work of the dying and their families.

Definition: Healing

“A cure is an externally applied medical intervention that removes all evidence of the diagnosed disease. Healing is an internal process of recovery that takes place on the physical, emotional, mental, or spiritual level and results in the person’s having a sense of being complete, in balance or in harmony with self and surroundings. Because the two need not and may not occur together, it is possible for a patient to feel healed even when cure is no longer possible and to be cured but not healed.”

Creating a Healing Environment

In Fraser Health hospices, the vision is to create a healing environment for patients, their families, healthcare providers and volunteers. A healing environment is “the surroundings (including physical, social, emotional, mental, cultural and spiritual characteristics) that support each individual’s inner processes, to promote a sense of wholeness, balance or harmony.” This inner shift is often described in terms of psychological or spiritual awareness or growth. The Hospice Residence provides a calm, quiet and unrushed setting with a home-like character. It should be the private domain of patients and their families, and the staff who support them. It is not appropriate to combine other spaces or programs with the Hospice Residence.

The healing environment of hospice is created by attention to physical, psychological, social and spiritual elements of the environment, as well as the physical setting of...
Section 2: Development of Hospice Residences

2.6 Hospice Environment

hospice. Leaders in Hospice Residence must expect and nurture attitudes, values and beliefs that support a healing environment. Team members (staff, physicians and volunteers) play an important part in creating a healing and caring environment by contributing who they are as individuals, how they enact their beliefs and values, and the extent of their ability to be present for patients, families and each other. Team members must be willing to give power to patients and families, as they accompany them during their final days. Those team members that are committed to and fully engaged in the hospice philosophy and service to dying patients and their families, find themselves engaged in their own journeys of self-awareness, discovery, personal growth and healing.

In this section, the characteristics of the hospice environment will be discussed, followed by a detailed description of the physical setting that supports these characteristics.

Physical Characteristics

Physical aspects of the environment include considerations that contribute to the patient and family’s feeling of safety and comfort. They include privacy, practical assistance, choice of activities and food, and opportunities for complementary therapies treatments. For team members it includes having opportunities for breaks, getting help when needed, and comfortable spaces for work and breaks.

Psychological, Cultural and Social Characteristics

The psychosocial aspects of the hospice include a variety of attitudes, actions and ‘ways of being’ that demonstrate a focus on living while supporting dying. This is a place where laughter and tears are both embraced. It is essential to create a safe and calm space where the patient has privacy, dignity, control, freedom and choice; a place where everyone feels respected, heard, understood and cared about. A sense of connection, relationship and community should be evident to all who enter the hospice space. The non-judgmental, caring and positive attitude for patients and families is also extended to other team members. Flexibility and open communication are encouraged and supported. Visiting hours are unrestricted. Patients may have their pets with them during the day and overnight if family are present to care for the pet.

Spiritual Characteristics

At end of life, patients, families and team members are faced with situations that require attention to their own values, beliefs and spiritual practice. Providing access to religious leaders, spiritual discussion (as determined by the patient or family), symbols, rituals, traditions and music of the patient’s choice are common ways we address spiritual needs in HPC. The practice of mindfulness and being truly present with a person in-the-moment creates a sacred space where individuals can explore personal meaning or feel unconditionally loved. Patients, families and team members benefit greatly from reflection, self-awareness, intention and an attitude of gratitude. Being outdoors, amid living things is very powerful for some people and important to accommodate, particularly for those who rely on nature for a sense of connection beyond themselves.
Section 2: Development of Hospice Residences

2.6 Hospice Environment

Physical Setting

The goal of hospice is to provide as “home-like” an atmosphere as possible, while meeting the physical, spiritual and psychosocial needs of the patient and family. Therefore, every effort must be made to avoid an “institutional” atmosphere. Hospice should present a feeling of warmth, openness and calm, taking advantage of natural light, high ceilings, home-like furniture and use of materials and finishes that are home-like in nature. Public areas and private should be available to patients and families for discussion, counselling, and family events. Patients should be able to personalize their own bedroom, by bringing in their own pictures, favourite objects or small pieces of furniture. Ideally patients and families will have access to outdoor gardens and patios. Since it is a desired outcome that very few patients will require transfer to acute care, the environment must be also have medical equipment, supplies and other practical considerations available in order to provide high quality medical care. The equipment and supplies should be stored out of view except when in use; hallways and public areas should be uncluttered.

Creating pleasant surroundings also includes auditory and olfactory aspects of the environment. Loud, repetitive or unpleasant noise should be avoided when possible. Overhead paging should occur only in case of emergency (for example, fire or disaster). Noise related to movement of equipment should be minimized. The nurse call system should be silent or have a quiet, pleasant tone. Patients should have private rooms so they can listen to music or television of their choice or have quiet if they prefer. Prevention or elimination of unpleasant smells requires attention in hospice. In addition, opportunities can be provided to create comforting smells by providing space and appliances to bake such things as cookies, muffins and bread.

Hospice Design Criteria

The design of the Hospice Residence directly impacts on the operations, specifically in relation to the design capacity to meet the functional requirements of patients and staff. The patient and family needs and activities provide the basis for space planning. This section broadly describes the Fraser Health minimum standards for design and construction, including the rationale on which they are based. A chart showing detailed requirements and additional desirable features, and a sample hospice layout are available on the Fraser Health website.

Standard of Design and Construction

While the hospice should have a home-like character, the standard of design and construction should be that of a residential care facility in terms of practical space planning and safety. Elements such as floor finishes, ventilation and air handling capacity, individual room thermostats, door widths, circulation space, and clearances at toilets and bathing facilities should all be consistent with residential care facility standards. In addition, consideration should be given to sound-proofing of rooms, choice of call bell system and security options in hospice.

Fraser Health Hospice Residences always exist within a multi-purpose building to provide efficiencies related to required services. The design must include clear boundaries between the Hospice Residence space and the rest of the building and staff. This enables the hospice to build its own milieu and limits disruption for patients.
Section 2: Development of Hospice Residences

2.6 Hospice Environment

and families. This is important because different populations have different goals of care. For example, in residential care there is emphasis on planning group programs and providing opportunities for stimulation and socialization. In hospice, patients typically prefer to spend their limited time and energy with close family and friends. Family need space for grieving and counselling, and space to be away from patients without being disturbed.

Hospice Size

A minimum of ten beds at any one site should be included in hospice planning in order to accommodate an adequate and efficient staffing plan. A maximum of 20 beds still allows for the more intimate, home-like atmosphere.

Access to Hospice

Efficient, secure and appropriate access to the hospice is functionally critical. If the hospice is in a building shared with other programs (such as housing or long term care), access to the hospice should be carefully planned to meet several objectives including:

- The hospice should be located relatively close to an acute care facility, physician offices and the HPC consultation team
- Separate entrance for hospice, to allow for privacy and to minimize disruption to others
- A second separate access for funeral home and ambulance services
- Facilitation of convenient, comfortable ambulance access for patient transfers
- Wheelchair and stretcher accessible, convenient drop-off area
- Adequate, accessible parking including parking that is close and safe for access to hospice during the night

Memorial Space

Each hospice should have a sacred space allocated for Memorial purposes. This space should be near the entrance or a public area and should have a table with space for items chosen to recognize and honour individuals who have died recently in the hospice.

Reception Area/Staff Workspace

The reception area/office must be separate from staff workspace used by other programs or resident populations. It should be located close to the entrance of the hospice so that visitors can readily identify where to make enquiries. This will avoid visitors looking into patient rooms trying to find their loved one/friend. The office should include an enclosed work area with two computer workstations and a small meeting area for direct care staff. The medication room should be adjacent to this work area.
Section 2: Development of Hospice Residences

2.6 Hospice Environment

The office area must provide flexibility of use, security of records, information and confidential discussions, and provision of adequate work and storage space for staff. Adequate space should be allocated for a conference room for clinical rounds and education. Space should also be provided for consultant staff and administrative staff. A secured area or areas for office supplies, equipment, file and record storage is required. One unisex staff washroom is required.

Adequate separate space should be provided for volunteers to work so that confidentiality of patient information can be maintained within reception/office workspace.

Nurse Call System

There must be a nurse call system specifically for the hospice patients. This system should be quiet or silent, to avoid disruption to the calm, home-like environment. Over head paging should be avoided except for emergency situations.

Medication Storage

Appropriately located and stored medications are critical to staff efficiency and compliance with regulatory requirements. A separate and secure area for the storage and preparation of medications is required. This space should include a refrigerator, double locked cupboards, and a counter with a sink. There must be adequate space for all medication carts. Depending on the source of medications and delivery system, there may be additional requirements.

Circulation Space and Access

All circulation space and access must be generous to allow for efficient and comfortable movement of patients and reduced risk of staff injury in moving patients. Patient movement will involve wheelchairs, as well as the bathing stretcher and beds. Corridors, doorways, and corners must be sufficiently wide to accommodate movement of beds and wheelchairs. All areas must be wheelchair accessible. All doorways should accommodate the width of a patient bed. Lift systems will be required, including portable lifts and ceiling track lifts.

Patient Rooms

A private room for each patient is recommended. Patient rooms should be sufficiently large to enable staff to work efficiently and comfortably and to allow families to comfortably spend time with their loved one. Each room must have a self-contained wheelchair accessible washroom with clearance at both sides of the toilet and pull-down grab bars. The recommended size is 22.0 m² including the washroom; this provides enough room for family to stay with the patient overnight if desired. Additional space may be required depending on the room shape. The shape and layout of the room should allow the patient bed to be located closer to the door than the family sleeping accommodation. This enables the nurse to provide patient assessment and care during the night with less disruption to family members. It also provides better access to the patient in an emergency situation such as fire or disaster.
Section 2: Development of Hospice Residences

2.6 Hospice Environment

**Bathing**
Most patients will require assistance with bathing. Bathing areas should be designed to provide a “spa-like” environment, to maximize the potential for a relaxed, attractive and therapeutic experience for patients. A central bathing area must be provided, and should include both a therapeutic tub and a wheelchair accessible shower. A sink and toilet should also be provided. Adequate circulation space is required for the tub stretcher, staff assistance at both sides of the tub, and for the movement of the shower commode chair, to ensure patient and staff safety. A floor drain is required. Patients may move between their bed and the bath on the tub stretcher. The bathing area should be located near the bedrooms to facilitate privacy when patients are transferred between their rooms and the bathing area.

**Access to Outdoor Space**
Direct access to outdoor space, on the same floor as the hospice, is required as part of the objectives of the model of care and the hospice philosophy. Patients will be too frail to travel any distance to outdoor space, which is a greatly appreciated amenity and central to the home-like and non-institutional environment. The provision of outdoor space should be as generous as possible, as it provides an important retreat for both patients and families. There should be provision for a covered area outside, for protection during inclement weather. If it is compatible with the design, small balconies/patios in patient rooms should be considered. Outdoor spaces should be accessible by wheelchair, reclining chair and bed.

**Oxygen and Suction**
The provision of oxygen and suction is a significant design and capital cost consideration, and needs to be based on functional requirements. Based on the increase in non-cancer patients being admitted to hospice, there is more need for oxygen than in the past. Piped in oxygen has the advantage of being quiet and readily accessible, although there is the temptation to use oxygen too quickly (before exploring more suitable alternatives such as fans and medications). Portable concentrators are suitable for hospice, and are usually housed in the bathroom during use, to cut down on the noise for the patient. Oral suction and gastric suction are rarely used. However, both types of suction must be available when required. Patient needs can be managed adequately with portable machines.

**Smoking**
Many hospice patients will smoke and should be accommodated comfortably, as this is consistent with the hospice philosophy. WCB regulations prohibit staff from providing care in the smoking setting. For this reason, staff surveillance of this space from outside the room is critical for safety. The smoking area should be located outside and meet LEED requirements. LEED stands for Leadership in Energy and Environmental Design Green Building Rating System. It is a system for new construction and major renovation that has been tailored for Canadian climates, construction practices and regulations. One of the five principle categories is indoor environmental quality.
Section 2: Development of Hospice Residences

2.6 Hospice Environment

Security

Security for the hospice is very important, both to ensure privacy for patients and families and to ensure staff safety. This is a particular concern with the medications, including controlled substances that will be on site. Security provisions should include:

- Controlled access points at the building entrance and at the Hospice Residence entrance, including the capacity to visually check before admitting anyone
- An alarm system for patients who may be confused and at risk of wandering
- Secure storage of medications and controlled substances
- Controlled access for visitors 24/7
- Plan for staff security or police response

Kitchen

Food may be supplied from a central kitchen via tray or dining room service, or from a working kitchen within the Hospice Residence. When there is a working kitchen, it should be as home-like as possible while also providing adequate storage and workspace for the provision of three meals daily. Equipment must meet all food safety and food handling guidelines. The kitchen will be used only by food services staff, to comply with licensing and regulatory standards. The preferred method of food delivery is dining room type service, where patients may choose types and amounts of food at time of meal service. In hospice, this service should be available in the dining area and in patient rooms. If meals are being prepared on site, a separate kitchen or servery type area should also be made available for family and visitor use.

Dining/Living

Private home style dining and living areas should be provided. Wheelchair accessibility is required. It is expected that not all patients will be using the dining room for meals but an adequate dining space is important to allow families to join in at some meals or on special occasions.

Quiet Room

One or two small rooms should be available to be used for families to have quiet and private time away from the bedside, for counselling, or to meet privately with others. These rooms may also be used for provision of complementary therapy treatments to family members, or as a place for prayer or meditation.

Visitor Bathroom

A single occupancy bathroom, with a shower stall or a tub with a shower, should be provided for visitors’ use and mobile patients. Many visitors will sleep in the hospice overnight and will need a place to wash up in the evening and morning. A small percentage of patients will be mobile enough to shower or bath independently so will need to use this bathroom.
Section 2: Development of Hospice Residences

2.6 Hospice Environment

Laundry

Many hospices will share a central laundry facility with the rest of the building or send laundry to another facility for cleaning. Where there is no laundry on site allowances should be made, where possible, for the provision of personal laundry.

If there is a working laundry specifically for the Hospice Residence, it should be centrally located (near patient rooms and bathing facilities) and appropriately equipped, as there will be a significant laundry workload. Depending on numbers of patients, full size heavy-duty washers and full size heavy-duty dryers will be required. Counter space, a laundry sink and a flushing sink will be required for soaking and rinsing soiled linens and garments. Storage space is required for soiled laundry. The laundry room should be considered a “soiled” area and a clear functional flow of soiled to clean is required, with separation and appropriate storage of soiled and clean laundry.

Storage

Storage that is appropriately located and provides adequate space is a very high functional priority for efficiency. It is also important that ample storage be available as all equipment and supplies are stored out of sight when not in use, in order to keep the hallways and patient rooms free of the clutter of medical equipment. Adequate storage areas are required for the following functions:

- Food storage – to be located near the kitchen and near to the delivery area for ease of movement of supplies.
- Equipment storage – the hospice will require an inventory of equipment to be available for use with patients as needed. Storage space is required for large and small items of equipment. The amount of storage space required is much greater than for traditional residential care and acute care units as all equipment is stored when not in use.
- Supply storage – A “clean utility” type space is required for the storage of linens, blankets, towels, and bulk storage of consumable supplies, such as medical, hygiene and household supplies. This area should be near to patient rooms and the bathing area.
- Office supplies – should be stored in or near the office/reception area.

Soiled Utility/Janitor

The janitorial area may be combined with a soiled utility area and located adjacent to the laundry. For the janitorial area, a floor sink and adequate storage space for equipment and supplies is required. A floor drain is required.

The soiled utility area must provide space for the storage of soiled laundry, waste, and soiled equipment and supplies. This area should be at least 8.0 x 12.0 m². The amount of space required will depend on the equipment size and the system used for laundry and garbage collection and removal. Nurses must be able to readily access the space to empty full bedpans into sanitizer. This area should be near to patient rooms, the bathing area, and the elevator to facilitate movement of waste out of the hospice.

Ample storage is critical for maintaining a home-like setting
Section 2: Development of Hospice Residences

2.6 Hospice Environment

Emergency Generator

Provision for emergency power is functionally important as it relates directly to patient safety and comfort, and to ensuring that staff are able to provide appropriate care, even in circumstances of a power outage. An emergency generator is required to ensure at least the provision of minimal services, such as lighting, in the event of a loss of power.

2.7 System and Clinical Standards

Admission to Fraser Health Hospices

Potential hospice patients may be identified by any healthcare provider working with the patient. Eligibility for hospice admission is determined by the local HPC Consultation Team Clinical Resource Nurse (CRN), Clinical Nurse Specialist, or HPC physician.

Criteria for Admission

The HPC consultation team screens patients for hospice admission using the following specific criteria.

The patient:
• Is an adult registered on the HPC Program*.
• Is in the final weeks (usually 3 months or less) of a life-threatening illness.
• Has a “Do Not Resuscitate” (DNR)/ “NO CPR” order in place prior to admission.
• Does not require services of an acute hospital (diagnostic tests or treatments) at time of admission.

* The hospice environment has been developed for an adult population and in most cases children will not be able to be accommodated in Fraser Health Hospice Residences. However, individual cases will be considered by the Director, Hospice Palliative and End of Life Care and the Medical Director, Hospice Palliative and End of Life Care.

Once the patient qualifies for hospice admission, the patient is placed on the waitlist for hospice admission. At this time, the patient and family must decide upon two preferred hospices for admission. Whenever possible a patient will be admitted to a hospice close to his/her home to facilitate the maintenance of contact with the patient’s family and/or community network. Sometimes family prefer that the patient be admitted to a hospice close to the main caregiver or most frequent visitor(s). If admission is required and no bed is available in the community in which the individual resides or prefers, then the patient will be admitted to his/her second preference hospice. Transfer to the closer hospice will be accommodated when a bed is available if patient and family still want the move.

Principles and guidelines for movement of HPC patients have been developed by HPC professional stakeholders. Priority for admission is given to patients living within Fraser Health communities. Patients in hospitals are not moved to hospice until goals of care have been discussed and agreed to by the patient and/or family. The document “Principles and guidelines for movement of HPC patients from acute and hospice settings” is available on the Fraser Health website.
Section 2: Development of Hospice Residences

2.7 System and Clinical Standards

Central Access to Hospices

In Fraser Health, a central access system has been developed to provide appropriate and timely access to hospice beds. A full-time Hospice Access Coordinator position has been created to provide central access and coordination of admission to Hospice Residences throughout Fraser Health. This position is similar to the Residential Access Coordinator position, with some adaptations to meet the specialized needs of the HPC population, including the complexities caused by the rapidly changing conditions of HPC patients. The Hospice Access Coordinator role description is available on the Fraser Health website.

The HPC Consultation teams determine who is appropriate for hospice admission, the urgency of admission and priority of admission of patients from their local community. The Hospice Access Coordinator (1) discusses issues with team members, hospice staff and contact persons, (2) provides direction, and (3) makes decisions in order to maximize effectiveness and efficiency in moving appropriate patients to hospice. The Hospice Access Coordinator is responsible for allocating hospice beds according to urgency and pre-determined priorities. The Admission Flowchart is available on the Fraser Health website.

Hospice Waitlist

The admission process is a two-part process that includes registering the patient on the future needs waitlist (Waitlist - Part 1) and then moving the patient to the regular waitlist (Waitlist - Part 2). Part 2 provides guidelines for a discussion with the Hospice Access Coordinator to ensure that the hospice has all the physical and human resources required to meet the care needs of the patient. Sometimes admission must be delayed to allow time for the hospice to obtain equipment or supplies, or to allow time for planning for complex patient/family needs. (Part 1 and Part 2 Waitlist and Admission documents are available on the Fraser Health website). When all aspects of pre-admission are complete and the patient is ready to move to hospice, the sending and receiving nurses and physicians must have verbal contact. Transfer documents are faxed from the location of the sending nurse to the receiving hospice or sent with the patient.

Hospice Accommodation Charges

Fraser Health hospice patients are required to pay the minimum residential accommodation rate. Those Fraser Health hospice patients who are unable to pay, due to insufficient income/financial hardship, may have all or part of the per diem waived. (The Accommodation Charges policy is available on the Fraser Health website.) In Fraser Health, a brief financial assessment has been developed, based on the B.C. Cancer Agency financial assessment, to determine an amount that the hospice patient is able to pay. The HPC social worker does the assessment and reports the outcomes to the hospice unit clerk, who transmits billing information to the Finance office.
Section 2: Development of Hospice Residences

2.7 System and Clinical Standards

Planned Short-term Admissions

Patients may be admitted to hospice for planned short-term admission in order to support caregivers at home who need a break in order to continue with care-giving. When the caregiver requires a break, the Home Care Nurse or HPC team member helps arrange for admission to the next available hospice bed. These beds cannot be booked for specific time frames because beds need to be available for urgent admissions from the community. Patients must meet the regular criteria for admission. This ensures that patients can remain in hospice if, during the short-term stay, the family decides they cannot take the patient back home.

Pharmacy Requirements

The pharmacy chosen to supply medications to a hospice must be willing to meet Fraser Health HPC Pharmacy standards. Clinical support comes from Fraser Health HPC Pharmacist (provides expert consultation, covering several communities). The following basic requirements of the distribution pharmacy must be met in order to meet the acuity level of hospice patients in Fraser Health.

The distribution pharmacist must be able to provide the following:

- Daily Medication Administration Records (MARs) and the ability to adjust medication times to suit patient’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
- Limited after hours and weekend 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)

In addition should be able to:

- Attend meetings as needed
- Notify when there will be a delay in supplying medication
- Receive and be responsible for destruction of expired or unusable medications (including narcotics)
Section 2: Development of Hospice Residences

2.7 System and Clinical Standards

Fraser Health Pharmacy Standards include:

- HPC Directives
- Crisis Event Orders
- Hospice Bowel Protocol
- No automatic stop orders for opioids
- HPC Standard Equivalence Chart
- Pharmacy manual covering: pharmacy service, medication administration record, medication incidents, opioids and other controlled drugs, process for ordering, receiving and returning medications, process for ordering non-ward stock pharmacy supplies. This manual is adapted for each hospice site, to accommodate local pharmacy requirements and procedures.

Other Considerations:

- The distribution pharmacy will have input into configuration of drawers in medication carts. The hospice manager will determine primary location of storage of opioids (medication cupboard or medication cart) prior to configuration of med carts and determination of required millwork in medication room.
- A Fraser Health Hospice Narcotic book is available to all hospices. It includes the usual controlled medications used in Hospice Residences, thus reducing writing time for nurses.

Patient Chart

The hospice patient chart has been developed specifically for Fraser Health Hospice Residences. Several documents within the chart are also used in other specialized HPC settings, such as palliative care and tertiary units. Due to the fact that the first two Fraser Health Hospice Residences were opened in settings with no established committee structures for documentation approval, it was possible to build a patient chart ‘from scratch’ based on the needs and practices within the hospice setting. A search for applicable chart documents and articles from across Canada provided the basis for chart development. An interdisciplinary task group worked together to adapt existing documents or design new documents to meet the needs of the patient population and reflect patient and family as a unit of care. Trials of all key chart documents were done by nursing staff and documents were revised according to feedback. This cycle of feedback and revision continued for about two years before the chart was finalized. The final hospice chart and subsequent changes have been approved by the Fraser Health HPC Program Practice Advisory Council.

The hospice chart includes focus charting within interdisciplinary progress notes and several flow sheets. Flow sheets were developed to efficiently record key assessments, interventions and evaluation. These flow sheets provide prompts for novice HPC nurses and make it easier for relief staff to move from one hospice to another, as all hospices use the same chart. In addition, flow sheets for pain and symptom management provide comprehensive documentation with less charting time, and encourage aggressive and rapid management and treatment of pain and other symptoms by including severity scores, medications and non-drug treatments, and evaluation of each intervention on a single page. The Hospice Residence Chart can be viewed on the Fraser Health website.
Section 2: Development of Hospice Residences

2.7 System and Clinical Standards

Hospice Brochure

Initially, all Hospice Residences developed their own hospice brochures. In order to provide an attractive, high quality brochure with consistent information, a generic hospice brochure has been developed and is now used by all Hospice Residences in Fraser Health. This brochure can be viewed on the Fraser Health website.

Fraser Health Hospice Clinical Nursing Manual and Hospice Manual

When the first hospices were opened, they adopted an acute care nursing manual for hospice use, as there was no time available to develop a hospice specific manual. Recently, a nursing manual has been developed by adopting or adapting selected nursing policies and procedures from other Fraser Health settings (acute care, residential care, or home health) depending on which area best fit with the practice of Hospice Residences. This manual will continue to be expanded over time.

In addition, a Hospice Manual has been developed for each hospice. This manual includes administrative and system information adapted to the specific site. For example, physician and clergy contact information, information regarding other services (including lab, music therapy, how to access other team members, ambulatory care), volunteer role, waitlist and admission, death and discharge, Meditech, and transportation booking. This manual is adapted for each hospice in order to match facility procedures and requirements.

Hospice Team Education

Hospice Start-up Orientation for New Team

When a new hospice is approaching the opening date, Fraser Health provides two weeks of orientation for nursing staff, as well as orientation for Hospice Society volunteers, dietary and housekeeping staff, and other team members. This intensive orientation is essential because everyone who works in the hospice at start-up is new to the setting and most are unfamiliar with working together in this unique way. There are no established norms that can assist a new team member to integrate into the team. They must build the norms together. The orientation includes introduction to the vision for the hospice environment, HPC education including symptom management and psycho-social-spiritual care, discussion and team-building amongst all paid staff, volunteers and HPC team members. A sample schedule for a two week orientation is available on the Fraser Health website.

In addition to the start-up orientation, one to two weeks of orientation is provided for nursing staff that do not have previous experience in a designated HPC setting. This additional orientation time is customized to fit the needs of the staff that have been hired, and is offered prior to the start-up orientation. The purpose of this pre-orientation is to provide classroom information and clinical experience to help bring these nurses to the level of understanding about HPC principles and values, and basic knowledge that enables them to successfully participate in the hospice orientation. Experienced staff members have also participated in this...
Section 2: Development of Hospice Residences

2.7 System and Clinical Standards

Pre-orientation to help teach and mentor staff new to HPC. Examples from their experiences help the new nurses understand and appreciate the realities of HPC from the perspectives of their peers.

Ongoing Hospice Orientation for Nurses

Once the hospice is open, orientation is required for casual and regular staff members that continue to be hired over time. Each staff member can be more easily integrated into the hospice setting as they are hired one at a time. A ‘Hospice Orientation Program for Nurses has been developed to provide a self-directed learning package for new nurses. The program is designed to be covered during the first three months of employment in hospice. The program is divided into three phases and includes: development of an individualized learning plan, readings, use of a reflective journal, attendance at three established Fraser Health HPC classroom days, clinical practice with a mentor, and regular meetings with a nurse in a leadership position, to provide guidance and supervision. In addition, tools and articles have been included to guide clinical mentors and clinical supervisors in their roles. The Hospice Orientation Program is available on the Fraser Health website.

Continuing Education

After orientation, ongoing continuing education opportunities are provided for nurses and other team members. Regularly scheduled full day ‘Education and Networking Workshops’ are provided for hospice nurses each spring and fall. A full day ‘Managing Acuity’ workshop is held regularly for hospice and home care nurses with several months HPC experience. The Pallium Project - Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) curriculum has been adopted for on-going HPC education in each Fraser Health community. In addition, mentorship workshops are offered twice a year, to prepare nurses and volunteers for mentorship roles. Other educational opportunities are provided to team members, as needs are identified.
Section 2: Development of Hospice Residences

references

9 Capital Health, Edmonton. Regional Palliative Care Program Annual Report; April 1, 1999 - March 31, 2000
12 College of Licensed and Practical Nurses of BC. Practice Guidelines: Appropriate Utilization of LPNs. Burnaby, BC: CLPNBC.
16 Chez, R, Jonas, W. The challenge of complementary and alternative medicine. Primary Care. 1997;177:1157
18 Author unknown.
Fraser Health Hospice Residences
Creating a healing & caring environment at the end of life

Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence
3.1 Work Plan for Start-up of Hospice Residence

Introduction

The majority of the hospices in Fraser Health are Fraser Health owned and operated. In some situations Fraser Health has pursued opportunities for leasing space in multi-purpose buildings, working with a contracted service provider or working in a Hospice Society/Fraser Health shared management model. Fraser Health has an established RFP process that must be followed by service providers interested in operating a Hospice Residence. The contract, capital equipment budget and operating budget are negotiated by the Director of Hospice Palliative and End of Life Care, and the service provider.

The licensing requirement for each hospice is dependent upon the location of the hospice. Currently, most Fraser Health hospices are licensed under the Hospital Act. Some hospices are licensed under the Community Care Facilities Act. The Fraser Health HPC Program has been discussing licensing requirements with the Ministry of Health. The Ministry of Health is currently considering licensing requirements specific to Hospice Residences.

Steps of Planning Process

Regardless of which hospice model is established in a particular community, key planning steps must occur to ensure coordinated and timely collaboration, decision-making, and action in the development and implementation of a new Hospice Residence. The following steps provide a guideline for planning.

1. **Review hospice design plans**

Key individuals representing the service provider and Fraser Health meet with the architect, as many times as required, to ensure plans meet:

- Fraser Health design expectations/requirements
- safety, infection control and efficiency requirements for nursing staff
- licensing requirements

This group also considers food delivery and other practical considerations that may have implications for hospice design.

2. **Set up Steering Committee**

The Steering Committee is comprised of key stakeholders in the local community and Fraser Health representatives. Fraser Health representatives include the Director, End of Life and HPC and the Clinical Nurse Specialist - Hospice. The service provider determines their own representatives. Other Steering group members may include: members of the local HPC Team, representatives from the local Hospice Society, and other key community members. The members of this committee work to understand and support the goals and standards of the established Fraser Health Hospices. The Steering Committee monitors construction timelines, progress and decision points. The Steering Committee establishes task groups to work on the details required for development and start-up of the hospice. These task groups report back into the Steering Committee. The committee meets as often as necessary to coordinate the
Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence

development and opening of the hospice. This is usually monthly until the last months approaching opening, when bimonthly or weekly meetings may be necessary.

3. Set up Task Groups

Planning and implementation of a Hospice Residence setting and clinical operations requires much group work and collaboration to understand and agree upon key decisions, discuss concerns and issues early in development, understand established standards and rationale, and modify general guidelines and processes to meet local needs. Working together also helps build a cohesive team, a trusting partnership with Fraser Health, and assists with successful implementation and on-going operations of the hospice.

Common task groups include:
Interior and Exterior Design

In contracted facilities, the interior and exterior design is determined by the service provider. In Fraser Health owned and operated facilities, interior design has generally been done by an interior designer with input from a group representing Fraser Health and Hospice Society volunteers. In Fraser Health, Hospice Societies have done much of the fundraising for equipment, furnishings and added-value items. They have been included in collaborative decision-making regarding interior design decisions within the established budget.

i. Purpose - Make recommendations/ decisions about interior decoration and furnishings, and exterior landscaping requirements.

ii. Deliverables - Determine general theme, colours, millwork, etc. required for interior decoration of hospice. Determine timeline for purchase and delivery of furnishings. Choose and buy furniture, pictures, bed coverings and other decorative items. Make recommendations regarding exterior landscaping and structures.

Clinical Practice

i. Purpose - Determine clinical policies, protocols, processes, standards and orientation.

ii. Deliverables - Provide forum for education and discussion of issues and concerns related to clinical policies, processes and standards. Review and adopt current Fraser Health HPC policies, manuals, processes and standards used in established hospices. Identify and modify policies and processes requiring adaptation to local setting. Identify and incorporate other service provider policies related to care. Adapt standard start-up orientation to meet needs of local staff and community. Plan and implement orientation for team (staff and volunteers). Link with Fraser Health patient registration and reporting system, and Pharmacy.

Infrastructure and Support Services

i. Purpose - Identify support services required, coordinate input from these services, plan and coordinate start-up of services.
Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence

ii. Deliverables - Identify services required, set up meetings with heads of key support services, create a plan for start-up and service, review plans to ensure coordination of all services at start-up, and implement start-up of services.

iii. Support services may include - food services, laundry, house-keeping, linen, maintenance/plant services, patient registration, Information Management (Meditech set-up), computer and telephone, infection control, mailroom, material services, occupational health and safety, parking, porters, protection services/security, purchasing, sterile processing, volunteers, and workplace safety. Set up pharmacy system and link with distribution and clinical pharmacists. Establish process of information flow between hospice and Finance/Billing. Establish processes with Health Records that fall outside the norm for acute and residential care. It is also important to establish a working relationship with the following departments which may be on or off site: ambulatory care, emergency, and community lab services.

Physician Model

i. Purpose - Fraser Health HPC Medical Director meets with local HPC physicians to determine the most appropriate model for physician coverage for a specific community and recruit hospice physicians.

ii. Deliverables - Identify physicians interested in working as designated hospice physicians. Develop processes related to coverage, education and remuneration for services. In addition, educate hospitalists, family and emergency room physicians about hospice standards of care and processes for admission.

Hospice Society Volunteers

i. Purpose - Hospice Society staff and Fraser Health staff meet to clarify roles, policies and processes for volunteers within Hospice Residence.

ii. Deliverables – It is the responsibility of the Hospice Societies to ensure that their current practices, policies, resources, etc. are within the framework of the Volunteer Standards for HPC in British Columbia 2007 developed by the BC HPC Association (BCHPCA). This task group will identify time frames that hospice volunteers will be available in hospice, as well as role, responsibilities and activities of volunteers within the hospice setting. The Hospice Society will identify the number of volunteers required to meet these needs, then recruit and train volunteers in anticipation of hospice opening. Policies, procedures, communication links and processes specific to hospice setting will be established, including linkages to nursing staff and notification of admissions and discharges. Hospice Society volunteers that provide complementary therapies in Hospice Residences must meet the guidelines established by Fraser Health.

Communications

i. Purpose - To provide a unified voice to the staff and public in relation to education about hospice in general, and local hospice development and events.
Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence

ii. Deliverables - Prepare media releases. Respond to requests from Fraser Health Communications for information. Responds to media, staff and public queries and comments. Oversee planning of tours, open houses and grand opening event for hospice.

Fundraising

i. Purpose - To raise funds for equipment, furnishings and added-value items.

ii. Deliverables - Establish an agreement between service provider, Fraser Health and Hospice Society related to who is responsible for fundraising of specific items and funds required for budget. Coordinate communication regarding fund-raising activities with the Communications Task Group. Establish an agreement regarding disbursement of Hospice Residence in-memoriam donations to hospice volunteers, contracted service provider and/or Fraser Health after hospice opening. Develop a common brochure to have available to visitors in hospice and others interested in making donations to the hospice.

4. Establish Work Plan

A work plan with timelines is established to track required completion of key milestones. More detailed work plans (including those of task groups) are derived from this high-level work plan and timeline. The work plan includes key tasks/ milestones as identified in this planning section. For each milestone, an action plan, person(s) responsible, target completion date, status of progress, indicator of progress (on target, minor or major issues), and comment section are included. The Steering Committee monitors the work plan on a regular basis. Frequency of monitoring increases as opening approaches. The purpose of the work plan and timeline is to coordinate the work of individuals and task groups, ensure sharing of information among task groups and make timely decisions in relationship to all aspects of planning and development to time of opening. A work plan template is available on the Fraser Health website.

5. Monitor Construction

Ongoing monitoring of construction is provided by members of the Steering Committee in order to provide input related to hospice environment and care delivery at key construction decision points.

Key decision points include:

i. Plumbing - equipment decisions affecting size and placement of drains must be made before concrete foundation is poured

ii. Electrical - all wiring decisions including general wiring of outlets and lights, fire system, nurse call system, security features (enter phone, monitor of inside and outdoor areas, keypads or proxy card readers, panic buttons, etc), wiring for phones and computers (internal staff system and system for patient/family access), cable for television, etc.

iii. Millwork - including requirements for medication cupboards, locked drawers and doors, etc.

Detailed workplans and timelines are key to success
Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence

Regular site visits are critical for reviewing plans ongoing. The team present for site visits will vary according to focus of each site visit. Individuals present may include architect, construction supervisors, workplace health, infection control, security, information management, director and manager of Hospice Residence, including at least one nurse who can comment in relation to clinical practicalities. This team will be able discover problems and potential design problems that are not obvious when viewing plans on paper. It is also important to monitor changes in construction timelines as it effects the probable completion date for the hospice and opening date.

6. Plan for Procurement

The planning for equipment and furnishings purchases is dependent upon the management model for a particular hospice. In Fraser Health there have been three lists developed over time: required medical equipment, required furnishings, and added value items (lists of medical equipment and added-value items are available on the Fraser Health website). These separate lists have been developed to allow key decision makers to proceed efficiently and effectively in making purchases from budgeted funds. Added-value items may be provided by the hospice society and/or contracted service provider, to enhance the hospice environment.

A point person must be assigned to choose vendors and order medical equipment, furnishings and other required items. This person must ensure equipment is ordered well in advance to ensure delivery prior to installation timeline or hospice opening, as applicable. They need to follow-up with vendors to confirm delivery dates and troubleshoot when delivery dates are not met.

Coordinating arrival of equipment and furnishings includes:

i. Some equipment must arrive at time of installation (e.g. tub must be installed while area is open to provide lifting it into place).

ii. Plan for arrival of equipment directly into rooms, if possible.

iii. Arrange for off-site storage if construction timelines shift and vendor cannot delay delivery.

iv. Develop system to verify each piece of major and portable equipment and furnishings that has arrived and its location. Portable equipment usually requires secured storage space off site. Keep track of equipment that has not arrived in order to anticipate problems and follow-up with vendors before patients are admitted.

7. Establish Information Management System

It is an established standard that all hospices (regardless of management model) are connected to the Fraser Health computer patient information system (Meditech). This system provides: linkages to patient registration system, Billing and Pharmacy, access to patient information in hospital and hospice settings, and custom Hospice Residence reports.
Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence

As each new hospice opens, the following arrangements must be made:

- High level planning and allocation of Information Management resources
- Determination of type of connection for Meditech (wired or wireless)
- Arrange for connection of Meditech to new hospice and wiring requirements
- Develop linkages with Patient Registration, Pharmacy and Finance, as applicable
- Determine locations of computers, printer, fax machine and place order
- Allocate location for Hospice within Meditech system
- Set up custom reports in system
- Set up users, once staff hired
- Education of nurses and unit clerks
- Plan ‘Go live’ date with computer experts on site, unit clerk and unit clerk trainer on site
- Set up processes for on-going troubleshooting, especially during first two weeks of start-up

8. Hire Hospice Manager

Hiring the Hospice Manager should occur well in advance of opening of hospice, when possible, so that the manager is one of the group members making decisions that will relate to how the hospice is designed and equipped, as well as operational management. Experience has shown that managers who are hired near the end of the planning process miss important discussion and information that cannot be compensated for later. Also, the manager that is hired later has not become immersed in the vision and may not agree with all decisions made. If the manager does not fully embrace the established Fraser Health vision of Hospice Residence care, then he/she will not champion the new vision and assist staff to make the necessary adjustments that promote a healing and caring environment.

9. Recruit Staff

Hiring a Patient Care Coordinator (PCC) who has HPC experience, strong clinical skills and a passion for hospice nursing provides an on-site leader and champion who can assist nurses in building and maintaining HPC skills and the hospice culture. If the PCC is hired before other staff then he/she can assist in interviewing the rest of the staff and will have a better understanding of their strengths and learning needs.

When a new Hospice Residence opens, it is generally staffed by a team of nurses, volunteers, physicians and other disciplines who have never worked in a Hospice Residence before. The fact that everyone is new to the hospice setting makes the choice of staff more critical than staff hired later. The first team of nurses hired will be establishing the culture and norms of the Hospice Residence. It is critical to have a strong team of nurses who have the knowledge, skills and qualities to provide excellent care within the hospice philosophy and standards. Later, new staff members will be hired one at a time and can be more easily assimilated into the culture of hospice, working with other staff that already know and understand that culture on all levels and have solid skills and practice.
Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence

Some new team members will have worked in other HPC settings, such as a palliative care unit or home care. These individuals will bring HPC skills and knowledge that will be important to providing timely high quality patient and family focused care. They will learn to adjust their practice over time, to meet the norms of the hospice.

Nurses who have worked in residential care have provided end-of-life care within a different philosophy and structure. Working in hospice may require a change in philosophy, broader role expectations and intensity of care, a shift to patient and family managed decision-making and a patient/family focused model of care. In hospice there is a younger population, and more acuity and complexity of both patient and family communication and care exists. The expectation is that symptoms and emotional needs and issues will be addressed promptly and followed closely until outcomes are satisfactory to the patient and family.

Nurses who have previously worked in acute care need to adjust to a slower pace, very different priorities, increased interactions with families, and a change from rigid nursing routines to patient-centered organization of care.

The hiring process includes: establishing staff rotations and schedules, posting positions, allowing time for recruitment of specialty nurses, interviewing and hiring the patient care coordinator, regular and casual nursing staff, and unit clerk.

The opportunity to job shadow with an experienced hospice nurse in another hospice is an experience that may be provided prior to employment or during orientation, to meet the needs of the nurse. The manager must also determine and hire additional team members (e.g. spiritual care, music therapist), and determine how to access disciplines required on an “as needed” basis (e.g. occupational therapist, dietician/nutritionist).

As Hospice Residence is a new service in each community, managers generally conduct interviews for the regular nursing staff together with an HPC Clinical Nurse Specialist. This is a good opportunity to share ideas and collaborate in determining whether an applicant has the knowledge, experience and qualities to enact the hospice philosophy and skill set required in Hospice Residence care.

10. Coordinate Building and Operational Commissioning

Commissioning includes ensuring that every physical component of the building, its supporting systems and program operating systems function effectively and efficiently, individually and collectively.

Building systems include: access system (enter phone, proxy card readers, proxy cards, keypads), security systems (intrusion, panic alarms), cable system, ceiling lifts, electrical system, elevator, fire alarm, generators, heating system, fan systems, plumbing system, kitchen, lighting systems, nurse call system, overall layout, parking system, and telephone system computers and install fixed equipment.

Sub steps include: installation, testing, owner demo, maintenance manual information delivered, warranty period identified and recorded, spare replacement parts delivered. Several inspections are required prior to approval for building occupancy. Signage must be installed. Protocols need to be established for identified systems.
Section 3: Implementation

3.1 Work Plan for Start-up of Hospice Residence

11. Coordinate Hospice Start-up

i. Clinical Commissioning - Once a ‘go live’ date has been determined, it is necessary to develop a plan to manage set-up logistics including coordinating cleaning after construction, installing equipment and furnishings, opening events, clinical cleaning, and start-up of all required services.

- Install appliances and furnishings
- Stocking of hospice: The following must be ordered and stocked: medical supplies (sterile and clean), paper and other supplies for office area, chart forms, linens, housekeeping supplies, garbage containers, etc. Medical equipment must be checked and stored. The patient care coordinator, unit clerk and frontline nurses, should all be involved in deciding where items are located.
- Plan start-up for supporting systems and processes – e.g. Regular deliveries of linens and medical supplies, Meditech connections, pharmacy print-out of medication records, and infection control equipment. Processes for use of lab, pharmacy, sterilization of equipment, food services, finance, health records, mail, material services, parking, maintenance, computers, phone service (reception, answering machine, mechanism for forwarding calls to patient rooms), cable, etc must be initiated.
- Plan final decorating, such as installing pictures on walls, adding pillows, covers for beds, decorations in all rooms, etc.
- Coordinate initiation of support services

ii. Hospice Opening Events/Public Relations - A coordinated communication plan allows for planned community announcements and consistency of key messages by all stakeholders.

Hospice openings generally include some or all of the following: grand opening event, tours for staff and volunteers, tours for public, donor dinner, physician event with orientation information. Many steering committees choose to have a ceremony to bless the hospice just prior to opening. This is an intimate event specifically for those team members who will be working in hospice.

Hospice opening events should be planned to occur prior to any patients being admitted to hospice. This is important in order to ensure privacy for patients and their families, and for maintaining the calm, quiet hospice environment. Cleaning prior to and after opening events is important to ensure that the hospice meets infection control standards at time of patient admission.

iii. Hospice Team Start-up Orientation - Orientation occurs during clinical commissioning (as described above). In addition to the previous discussion about start-up orientation, nurse orientation should include practical in-services and demonstrations by vendor representatives on major equipment such as nurse call, phone and security systems, ceiling lifts, reclining tub, tub stretcher, reclining chairs, etc.

iv. Staff start-up - The manager or Patient Care Coordinator arranges a number of new employee requirements including staff and volunteer identification photos, proxy card access if applicable, user access for Meditech, parking arrangements, name tags, etc.
**Section 3: Implementation**

3.1 Work Plan for Start-up of Hospice Residence

**13. Admit Patients**

In Fraser Health a gradual start-up plan for admitting patients at the time of opening has been adopted. The purpose of gradual start up is to enable safe patient care, by ensuring that all factors affecting patient care are reviewed when determining the number and type of patients that will be admitted. Consequences of opening too many beds too quickly may include: medication errors, inadequate pain and symptom control for patients, and inadequate emotional support and teaching for patients and families of dying patients. Patients admitted during the first few months must be relatively stable on admission. Later, patients may be more complex and may be admitted for symptom management. A tentative plan for opening is available on the Fraser Health website.

**Factors to Consider when determining speed of opening hospice beds:**

The plan for admissions is adjusted on a day to day basis, taking into consideration the factors below:

- How complete is the construction and set-up of unit? What equipment is missing or not working?
- All nurses are unfamiliar with the setting and equipment
- How much experience does nursing staff have in an HPC setting?
- How many LPN's have experience working at full-scope? (If LPN's have not worked at full scope, then maximum number of patients in hospice should remain at 5 until LPN is fully able to manage medications, treatments and patient care in a timely way with competence and confidence.)
- Do all nursing staff have recent experience providing total patient care? (Nurses who have previously worked in residential care often do not).
- Is there an adequate number of oriented casual staff in place to cover any illness/vacation?
- Nurse rotations – How many days/weeks before all staff has worked at least one day shift?
- Hospice Admissions for all hospices are planned during weekdays (due to resources available)
- HPC Consultation Team members work Monday to Friday
- Hospice Access Coordinator works Monday to Friday
- Number of patient deaths during start-up
- Even experienced hospice nurses can generally manage only 2 new admissions per day due to workload and amount of time required with new patient and family to assess, document and make comfortable in hospice setting with change of goals of care.

In Fraser Health it has been helpful to plan a teleconference at a pre-determined time each day during the first week of operation and as long as necessary to troubleshoot problems that arise. The participants include the nursing manager, patient care coordinator, selected members of the HPC Consultation team, CNS Hospice, Hospice Project Coordinator, and managers of all support departments involved in start-up.
Section 4:
Current Challenges And Future Directions

4.1 Planning Challenges
4.2 Admission Challenges
4.3 Staffing Challenges
4.4 Transition Challenges
4.5 Future Directions
4.1 Planning Challenges

A number of challenges were experienced when a new Hospice Residence was introduced to a community. The first challenge was that sometimes the community vision of what a “hospice” should look like and how it should be staffed did not fit with the operational and cost realities. Discussions between hospice leaders and local leadership teams helped teams come to a realistic vision within the subacute funding formula.

The closure of acute care units and beds in hospital and the transfer of the resources to the hospice was also a difficult challenge for both healthcare providers and the community. Local leaders and HPC providers wanted to keep the palliative care units and add hospices, but this was not financially feasible, nor did the population needs demonstrate that the acute specialty beds were required. These providers had championed the development of specialized palliative care units many years ago, when the palliative care movement was just beginning, and they felt the loss of this local specialized care. The new model allowed hospice patients to be cared for in an improved environment, while HPC patients requiring acute care received the care on a local medical unit or a tertiary unit in another community.

It was realized early in the process of developing hospices that frequent meetings with elected officials, Hospice Society boards, staff and the public were necessary to ensure an understanding of the kind of care being delivered in the Hospice Residence and how it differed from care at an acute or residential care site. In addition, the role of a Hospice Residence needed to be understood in the context of changes and developments occurring in the Fraser Health HPC program as a whole. Hospice Residences are only one part of the continuum that is required if the needs of patients and families are to be met. Thus while Hospice Residences were being opened, the regional HPC program plan also included increasing support for patients at home, educating primary providers and designating three acute tertiary units.

Given the variety of management models that were implemented, it was also very important that the Fraser Health standards be communicated to the service provider. If regional standards were to be implemented evenly across all sites, then buy-in to the various policies, procedures and guidelines was important. This buy-in was obtained through formal committee structures which allowed community providers to participate in the development and ongoing revision of the standards where applicable.

4.2 Admission Challenges

An efficient admission process is integral to the success of a Hospice Residence and is an area where a significant amount of time and effort has been spent in developing, refining and improving the process. Several challenges occurred that required changes to the system and on-going consideration and creativity by all team members.

During planning for the access system, it was expected that requests for admission would be planned so that the admission would occur on the day following the request. This would allow time for the patient and family to be prepared by the nurse and time for discussion among family members to take place. It would also allow time for both sending and receiving physicians to speak and transfer care, nurses to discuss any issues and transfer care, any special supplies or equipment to...
Section 4: Current Challenges and Future Directions

4.2 Admission Challenges

be obtained, the bed to be cleaned, etc. The reality is that acute care hospitals are often congested and there is much urgency to send patients to hospice on the same day as they are deemed appropriate for hospice care, in order to free up acute care beds for general patients waiting in Emergency departments.

The speed at which admissions must occur to meet acute care system needs causes tension among team members who are sending patients, providing screening, and organizing admissions. HPC consultation teams have limited capacity to deal with urgent needs. Nurses and physicians in acute hospitals do not always understand the resource limitations of a Hospice Residence in comparison to acute care. There is an assumption that equipment, supplies and human resources are available at the same level as acute care. This may result in patients being transferred without the required supports in place.

Admissions are planned during business hours on weekdays. Most patients are admitted to hospice during the week. Patients known by the team, who may require admission on a weekend, can have arrangements made in advance to facilitate admission on the weekend, should it become necessary. Arrangements include: obtaining physician orders and coverage during the weekend, ensuring availability of medications, arranging availability of housekeeping staff to clean the bed and room, ensuring that all discussion about goals of care, etc. have occurred prior to the HPC team leaving work on Friday. Coordination of the actual transfer on the weekend may be facilitated by the HPC On-Call CNS. Difficulties have been encountered when weekend admissions are attempted without prior planning, as required human resources are currently not in place on weekends and statutory holidays.

Considerable tension can occur between the many members of the team involved in the admission process (the family physician, home care nurse, acute care nurse, consultant team member, and hospice nursing staff) when roles are unclear or details of the process are not followed. Most issues that occur around admissions are related to admission of patients with some complexity without adequate preparation and communication of information from the sending location (home or hospital) to hospice, or inadequate communication between teams, when the patient is sent to Hospice Residence outside his/her own community.

Late referral to the HPC team leads to a higher percentage of acute care patients being admitted close to death. It is expected that some people will want to stay at home until the very end of life. Currently, about 30% of hospice patients die within three (3) days of admission to hospice. The majority of these admissions are from acute care. The workload for hospice nurses is increased significantly by this high percentage of short term patients. In addition, patients and families are not able to access the supports available in a hospice environment for a longer, more optimal amount of time.

Due to a variety of factors such as having hospices located in facilities a distance from acute care, most physicians do not follow their patients into the hospice setting. Care must be transferred to a designated hospice physician. The timely transfer of medical care from the family physician to the designated hospice physician has been problematic due to the need to interrupt the family physician during office hours in order to transfer medical care. Processes to resolve this problem have not been consistently successful.
4.2 Admission Challenges

It is expected that the hospice will have an occupancy rate of about 90%, providing time for families to say goodbye and follow end-of-life faith practices, as well as allowing opportunities for urgent admissions from home during the last few days of life. However, the short length of stay experienced in many of our hospices has resulted in a number of empty beds at any given point in time. Given the pressure from busy emergency departments and shortages of acute care beds, the hospices often experience pressure to take patients that are unknown to the HPC program, not appropriate for this type of care, or who should be managed in a residential care setting. Admission of patients who do not want to be in a hospice or whose needs cannot be met in hospice is unsafe and extremely upsetting to healthcare providers, patients and families. Continued dialogue with acute care is important to ensure that the eligibility criteria and the admission process are followed. In 2006 the wait time for a hospice bed from the time the patient was ready for admission was only 1.5 days, indicating an efficient and responsive process is in place.

4.3 Staffing Challenges

The current nursing shortage provides challenges in relation to hiring nursing staff. In addition, the specialized nature of hospice nursing creates problems in recruiting nurses with HPC experience and expertise. The number of experienced nurses available has generally been higher in communities where a palliative care unit previously existed and nurses were transferred to the hospice. In other areas, there have been very few nurses within the community that have met the preferred qualifications. Nurses that have previously worked in acute care or home care have generally been best suited, in terms of experience and practice, to adapt to practice expectations within hospice.

Casual RNs and LPNs are much more difficult to orient to the hospice environment than regular staff due to costs associated with orientation and the need for casualties to work in a variety of settings in order to get adequate work. To mitigate this problem, work has begun to explore the options of a float and/or relief pool specifically for Hospice Residences. The rationale behind this potential solution is to provide ongoing work within the hospice setting in order to build and maintain the expertise of the nurses and to allow nurses more opportunities to work in their preferred setting. It would also improve the cost-benefit ratio for providing comprehensive orientation to casual nurses.
Fraser Health Hospice Residences
Creating a healing & caring environment at the end of life

The decision to move to hospice is often difficult for patients and families

Section 4: Current Challenges and Future Directions

4.4 Transition Challenges

The transition from cure to supportive care becomes more visible when the patient moves from hospital to hospice. In order to move to a hospice, patients and families must be approached and honest discussion must take place about goals of care. This, of course, is ideal whether the patient changes settings of care or not, but it is possible to avoid much of the discussion when the patient remains in hospital. The discussion about hospice and the decision to move to hospice is often difficult for patients and families as they feel that they are “giving up” when they leave the acute care setting and accept hospice care.

The Fraser Health experience to date has been that when a new hospice is opened in a community, home deaths generally decrease. It may be that this is due to families having the option of choosing hospice, when previously they felt pressure to manage at home so that their loved one would not need to leave the community or go to hospital. It is important that discussions take place on all levels to ensure that Hospice Residence is not used by default rather than by choice of the patient and family.

Despite these challenges, the introduction of Hospice Residences has been welcomed in all Fraser Health communities. Existing standards and processes facilitate timely admission of patients and quality care within the Hospice Residences.

4.5 Future Directions

In Fraser Health the needs of the majority of HPC patients can be met in the four available settings - home, acute/tertiary, hospice and residential care. Three populations of patients may be better served by more specialized settings: patients with brain tumors or brain metastases, patients receiving palliative treatments such as chemotherapy, and patients requiring pre-scheduled respite for caregiver relief.

Currently, there are no specialized settings for patients with brain tumors or brain metastases. These patients are generally younger and are mobile but have periods of confusion, personality changes, etc. These patients do not fit the admission criteria for Fraser Health hospices as the prognosis is often 3 to 12 months. A hospice for this group of patients would ideally provide a safe environment that provides space to wander while preventing elopement, yet provide activities, routines and HPC resources to meet the specialized needs of this population.

Another group of patients who would benefit from a home-like rather than acute care environment are those that are receiving chemotherapy for symptom management or hematological malignancies where the patient requires frequent platelet or blood transfusions. These palliative patients require care by staff comfortable in assisting patients and families to deal with end of life and quality of life issues, while providing more acute care than that provided in a hospice environment. In Fraser Health, the decision has been made not to treat these patients in hospice due to several reasons including: staffing levels, inability to keep staff certified with infrequently used skills, and the likelihood of eroding the calm of the hospice environment. This latter reason is particularly significant as medical tasks and urgencies disrupt the focus on quality of life and end of life planning for all the patients in the Hospice Residence.
Section 4: Current Challenges and Future Directions

4.5 Future Directions

An HPC setting that provides pre-scheduled respite for caregivers is not currently available in Fraser Health. As mentioned previously, patients can be admitted to hospice in order to provide caregiver relief, as the need arises. However, due to the need to provide ongoing availability of hospice beds to patients near death, these beds cannot be booked in advance and cannot be booked to allow family members to plan vacations. Caregivers must request a respite bed in a residential facility in order to make such plans. Staffing levels and lack of HPC education of the staff in these areas does not always provide the level of assessment, physical and psychosocial-spiritual care required by patients and families. Access to these beds is not readily available according to the time frame that works for this population of caregivers. These caregivers may not be able to access these beds in a timely manner due to their limitations in being able to plan far in advance. In Fraser Health, some residential care respite beds have recently been grouped so that several beds are in one location rather than single beds scattered in a variety of facilities. This grouping may provide an opportunity to educate and build HPC skills in a small group of nurses and adjust staffing levels, to enable the needs of palliative patients to be met in these locations.

It is anticipated that the full complement of planned hospice beds will be in place by 2010. At that time a thorough review will be undertaken to address outstanding needs and gaps in services in relation to future hospice bed development.
HPC is an approach to care that is designed to provide comfort and relief of suffering at the end of life. The development of hospice beds outside the acute care setting is an integral part of the HPC Program in Fraser Health. The ability to support patients in this setting has been possible due to the integrated structure and processes within the Fraser Health HPC program, and the commitment, dedication and hard work of the Fraser Health Board and Executive, staff, Hospice Societies and community providers.

Decision makers can see demonstrated system efficiencies as patients are transferred from other settings, yet are reassured that quality care will not only be maintained but enhanced. Hospice provides a home-like setting where there is a focus on quality of living, while normalizing dying. Staff and volunteers work together to create a healing environment that supports patients and their families at end of life. The impact of a Hospice Residence will and should be different in each community given the nature of the population and other community supports in place. Much work remains to be done in studying the effects of this model of care and continuing to improve and enhance care for the dying.