Vancouver Coastal Health
Standards and Guidelines for the Planning, Development and Operations of Hospices
Revised - 2016

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Acknowledgments

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

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Table of Contents

Introduction

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

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

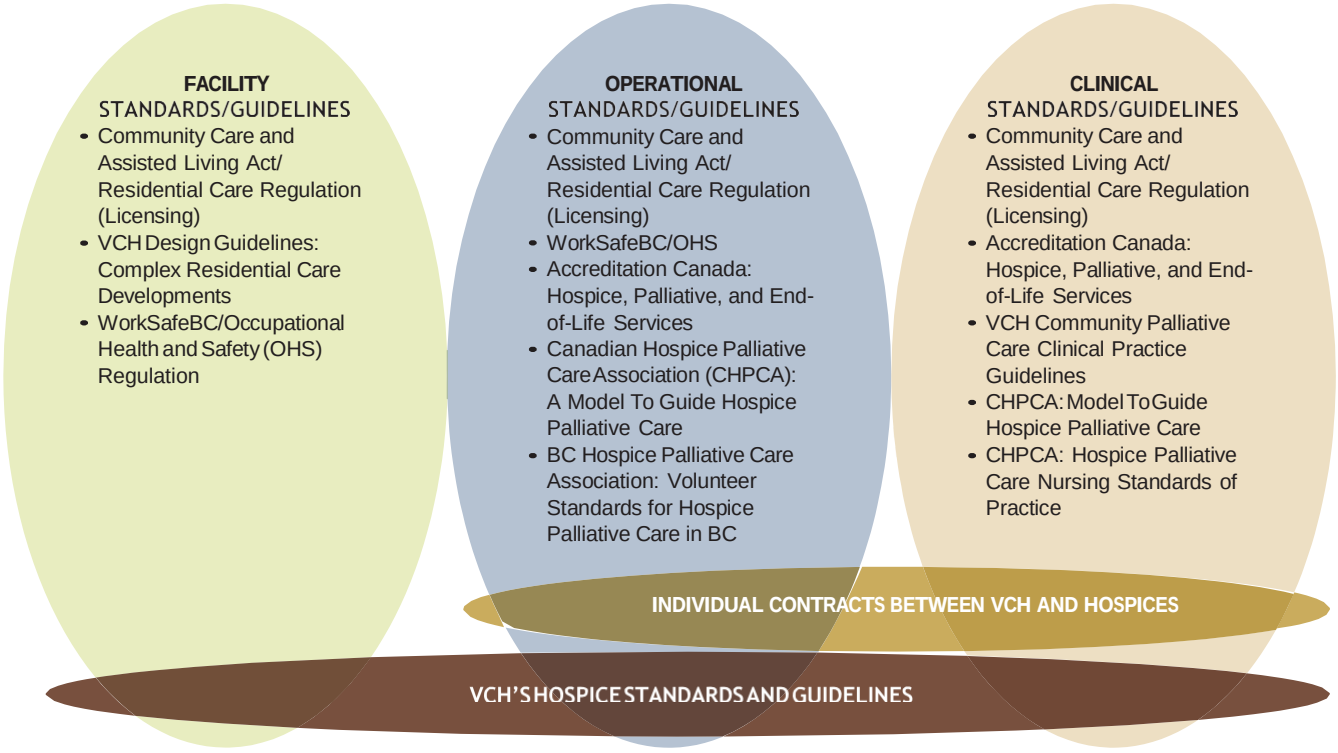
The initial development of these standards and guidelines consisted of a year-long process that included interviewing current hospice owners, service providers and VCH hospice palliative staff; researching standards and guidelines from other experts in the provision of hospice care; and collaborating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

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

How To Use This Document

There are a number of standards, guidelines, regulations and requirements that relate to the development and operations of hospices. Those outlined in the diagram below are only a subset of a larger body of standards and guidelines that exist;

However, they are generally the most relevant for hospices within our boundaries. This document will assist you in navigating through these various documents including our own VCH standards and guidelines.



Useful Documents

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

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

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

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

Refer to:
https://accreditation.ca/hospice-palliative-and-end-life-services

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

- VCH's *Regional Hospice Palliative End-of-Life Strategy, November 2005 and 2015*
- British Columbia's Ministry of Health Services' *A Provincial Framework for End-of-Life Care, 2015*

Refer to:
http://bcbudget.gov.bc.ca/2015/stplan/2015_Strategic_Plan.pdf

http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care-and-palliative-care

http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/short-term-residential-care



Notes on Terminology

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

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

Hospice Care in VCH

Hospice Palliative Care

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

Refer to:

http://www.who.int/cancer/palliative/definition/en/

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

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

The Canadian Hospice Palliative Care Association (CHPCA) broadened the definition of palliative care to incorporate, "the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with, or dying from, a progressive life-threatening illness, or are bereaved."(CHPCA 2002) Within Canada, the term hospice palliative care is used to broadly describe the philosophy and services consistent with these definitions.

Refer to:

http://www.chpca.net/

http://www.chpca.net/media/7562/chpca_strategic_plan_2010_2015.pdf

Hospice Care

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

In VCH hospices, the focus is on quality of life and ensuring the comfort of residents and their families. Hospices will provide supportive care, symptom management and comfort measures to support a natural death. As well, where appropriate hospices will provide respite, therapeutic measures and medications to manage acute conditions, within the limits of the hospice facility to which the client is being admitted. While each hospice strives to create a homelike environment, they are staffed with a team of skilled care providers who are available to support the needs of the residents and their families. However, like a home, there are certain limitation which means that there are things hospices are not able to do, such as major diagnostic tests and complicated treatments.



History of Hospice Development in VCH

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

May's Place opened in 1990 as the first hospice in British Columbia. It was created by individuals in the community who realized the need for a more homelike environment for people at the end of their life with less of a hospital or institutional setting. The focus was to be on comfort and quality of life, with a more holistic approach to care. Demand eventually outnumbered the availability of beds at May's Place, and a second Vancouver hospice, Cottage Hospice, was opened in 1999. Cottage Hospice is located in a heritage home in a beautiful neighborhood setting.

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

St John Hospice is the third Vancouver hospice which opened in Sept 2013. It is located on the grounds of the University of British Columbia and is a partnership between the Order of St. John, UBC and VCH. It is operated by Providence Health Care.

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

North Shore Hospice opened in the fall of 2010. It was developed as a result of a partnership between the Lions Gate Hospice Society, Family Services of the North Shore and the Coastal Community of Care (CoC). The hospice is operated by VCH.

The Sunshine Coast, part of the Coastal CoC, has two designated hospice beds, operated by Vancouver Coastal Health. These beds are located within a complex residential care setting in Sechelt and supported by the Sunshine Coast Hospice Society and the Sunshine Coast Palliative Care Program.

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

VCH initiated a regional End-of-life planning process which developed a strategy that was accepted in principle by VCH in November 2005 and refreshed in 2015. The overall themes of the strategy were to extend the number of people receiving hospice palliative care by expanding the patient population served to include more clients with non-cancer diagnoses, to increase community



capacity for more people in home or homelike settings, and to receive timely, well-coordinated care within health service delivery area in which they reside.

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

Development of a provincial policy framework for hospice is ongoing, as more hospice residence beds are being created within VCH and other health authorities. The VCH regional strategy estimated the required number of hospice beds, based on benchmarking with other programs, at approximately 8-10 beds per 100,000 people in the population. This is intended to support:

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

This projection model is dynamic and will be reviewed annually. The required hospice bed numbers projected by this model match the targets within the strategy and confirm the need for ongoing hospice bed development. The VCH strategy advocates for consistency in access, service standards and service levels within all hospice palliative care across VCH. In addition to hospice residence beds, the VCH strategy also recognizes the need to develop day hospice within the continuum of care. The identified need for short term respite care (up to 14 days) and the potential for possible short term symptom management (up to 14 days).

Mission

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



Values

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

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

Guiding Principles

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

Death is a Natural Part of Life

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

Access Based on Need and Choice

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



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

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

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

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



Hospice Partnership Framework

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

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

Contractual Agreement

Because VCH provides operational funding and hospices are situated within the complex residential care sector, VCH does have a legal obligation and fiduciary responsibility to ensure an appropriate and consistent standard of excellence in hospice care.

All hospice service providers must sign a contract with Vancouver Coastal Health Authority. Generally, these contracts specify services, payment, and access to information and reporting, as well as some information relating to the standards that hospice service providers are expected to meet in consistency with the standards and guidelines outlined in this document.



Hospice Service Provider Models

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

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



Partnership Role of VCH

Provide Operational Funding

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

Manage Wait-listing and Admissions

VCH will be responsible for the management of the pre-admission processes including triaging and wait-listing of all potential hospice residents.

Establish Staffing Guidelines

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

Evaluate Hospice Design

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

Ensure Excellence in Delivery of Care and Services

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

Facilitate Integration between Hospice Service Providers and the VCH Health Care Community

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

Provide Support to Hospice Service Providers

While VCH provides operational funding, it also provides support through other means such as access to resources, tools and education. It is encouraged that participation in interdisciplinary education is promoted e.g. Indigenous Cultural competency training. VCH wants to ensure that its hospice service providers are successful in providing high quality service to its residents and families



Partnership Role of Hospice Service Provider

Work to Integrate into the Health Care System

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

Deliver Quality Care

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

Ensure Financial Responsibility

A hospice service provider is responsible for the administration of VCH allocated funds and for ensuring adequate funding for all other operating and capital costs including residents' payment of the minimum residential fee as determined by the Ministry of Health Services.

Financial accountability, such as submission of an annual budget and quarterly financial statement to VCH, is required.

Lead Development and Design

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

Manage Day-to-Day Operations of the Hospice

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



Admission to VCH Hospices

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

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

- 19 years of age or older.
- Enrolled in the BC Palliative Care Benefits Program.
- Diagnosed with an end-stage illness with a life expectancy of three months or less.
- Understands the philosophy of hospice care, e.g. relief of suffering, but not prolonging life; has a No Cardiopulmonary Resuscitation document or Medical Orders Scope of Treatment (M1 or M2) signed.
- Signed Hospice Consent & Admission Agreement (Appendix II)
- Willing and able to move into the available hospice within 48 hours of notice.

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

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

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

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

Summary of the process for admissions and wait-listing

	North Shore	Sunshine Coast	Richmond	Vancouver
Admission Process and Documentation	For admission into hospice, the patient must be on the North Shore Palliative Care Program and have a completed referral form. If referred by the general physician (GP) or hospitalist, the palliative physician assesses referral. If in the community and on the palliative list, when the home nurse realizes something is changing, she contacts the patient's GP or palliative care on call physician (PCOC) if no GP is available. GP or PCOC will then arrange admission. When a bed becomes available, the patient is placed. If in acute and on the program, the patient will be moved to hospice, if appropriate, and when a bed is available. If under the care of a hospitalist, care must be handed over to the PCOC.	Referrals coordinated through palliative coordinator. Palliative coordinator discusses with involved parties (home and community nurse, GP, internist). Beds allocated on a needs basis. Criteria used to assist decision-making. Exceptions discussed with GP and home and community care manager.	Hospice referrals are coordinated through the Richmond Integrated Hospice Palliative Care Team (RIHPCT). If being referred from hospital (including PCU), the RIHPCT is involved to discuss the patient and then a decision is made whether or not hospice placement is appropriate.	Hospice referrals are coordinated through Vancouver Community Health Palliative Access Line (PAL).
Wait-listing	Program has its own database, which includes list of palliative patients, diagnosis, GP, family members, etc. used for wait-listing. The process for wait-listing focuses on urgency of need.	Clients are waitlisted based on priority of need, urgency and personal choice.	Clients are waitlisted based on priority of need, urgency and personal choice.	Clients are waitlisted based on priority of need, urgency and personal choice.
Respite Care and Short term symptom management	Available for persons meeting the criteria and requiring care to be admitted from the Community for up to 14 days with an agreement that the person returns home following this period.	Available for persons meeting the criteria and requiring care to be admitted from the Community for up to 14 days with an agreement that the person returns home following this period.	Available for persons meeting the criteria and requiring care to be admitted from the Community for up to 14 days with an agreement that the person returns home following this period.	Available for persons meeting the criteria and requiring care to be admitted from the Community for up to 14 days with an agreement that the person returns home following this period.
Day Centre	The day center is available four days/week and open to anyone registered in the palliative program. It is staffed by a registered nurse and acute care aide. Clients can come for a full day (9-5) or ½ day. Services include bathing, salon and activities.	Currently not available.	Currently not available.	Currently not available.



Hospice Accommodation Fees

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

Hospice residents admitted for short term respite care and/or short term symptom management will not be charged the per diem rate for up to and including 14 days. If the resident continues to stay at the hospice following, then the individual will be charged the daily rate for hospice care.

Policy Related to Holding Hospice Beds

If a hospice resident is transferred to acute care and it is anticipated that they will return back to the hospice, VCH's policy is to hold the bed for up to 72 hours upon the discretion of the manager and/or palliative care team.

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



Hospice Physical Environment Guidelines

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

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

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

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

Physical Design	Expectations/Requirements	Additional Desirable Features
Hospice Size	• Preferably a minimum of 10 beds in order to accommodate an adequate and efficient staffing plan.	• Hospice has potential to expand if required to meet future needs.
General Design for All Areas (Resident Rooms, Hallways, and Public Areas)	• Use of materials, indirect lighting and layout that create a homelike quality for the residence that is distinct from an acute or institutional setting (e.g., wood-like materials for doors, frames and flooring; mouldings; sconces; incandescent ceiling fixtures; pot lights; lamps; accents; and millwork). • Furniture that is homelike rather than institutional; use of wood products and furniture wherever possible. • Homelike storage cupboards in hallways and other key areas to eliminate typical linen/supply carts and other equipment of an acute unit. • Create comfortable, calm and quiet setting (e.g., no overhead paging, quiet call bell system). • Internet, TV & phone access in all client/family areas • Environmental management strategies (both interior & exterior), including design & layout features to manage clients with dementia and wandering behaviours (alarms, exit control, etc.) • Hallways & doorways accommodate movement of patients on beds, stretchers and wheelchairs, including bariatric patients • Wall mounted handrails in all resident area hallways • Elevators and stairs between all levels	• Dimming ability of fixtures. • Incandescent fixtures (rather than fluorescent). • Call bells that are toned down and or a system that is not disturbing to the residents (e.g., wireless system using portable phones or pagers with vibrating mode). • Wire-in bed alarm system.

Resident Rooms	• hospital bed, bedside table, 1 reclining chair, 1 arm chair, wall unit with drawers and wardrobe and space for a mini-fridge
	• Continuous suction
	• Wall mounted oxygen (access to O2 concentrators or O2 tanks)
	• Storage with either a locked drawer or cupboard for personal valuables.
	• Shelves and ledges for personal belongings and family pictures.
	• Private phone lines, internet, cable and music system in each room.
	• Overnight sleeping accommodation for family members (e.g., sleeper chair, day bed or pull-out couch).
	• Building materials include wood-like products that create a homelike setting (e.g., headboards, cupboards, closets, shelves, storage and over bed tables).
	• Dimmable lighting or lamps and/or wall sconces.(3 way light switching)
	• Provision for safe transfer of residents (e.g., ceiling lift).
	• Extra electrical outlets (e.g., for TV, stereo, lamps, etc.).
	• Private room with toilet and sink.
	• Room specific heating/cooling
	• 1-2 rooms for bariatric patient use including the following features:
	  • built in overhead XY Gantry high capacity patient lift
	  • oversized toilet seat; heavy duty grab bars; floor mounted sink
		• Overhead ceiling lift Track into resident bathroom; lift and wall charger stored in bathroom.
		• Ensuite showers are not required; however, if they are present they must be designed to accommodate a wheelchair and safe transfer of residents by multiple caregivers

Reception Area	• Reception area should be separated from nurses' station.	• Main reception central to main entrance.
Physical Design	**Expectations/Requirements**	**Additional Desirable Features**

Nurses' Station	• Nurses' station screened from view as much as possible in order to reduce "clinical environment". • Workspaces for unit clerk, nurses and other team members (e.g., one to six people at any given time). • Provides safe distance from families/residents and allows for staff to chart privately. • Nurse call station. • Medication area with locked medication cupboard, locked cupboard for resident valuables, medication preparation area, sink, small fridge for meds and security as required, (e.g., locked medication room vs. area in open station). • Space for storing two medication carts and paper supplies. • Secure records storage area for retention of patient records • Computers (2), fax, photocopier, telephone. • Ergonomically correct computer workstations.	• Staff area for break/lunch and small staff meetings
Memorial Space	• Memorial space created to recognize past residents – located near entrance or other common area.	• Near a garden space
Family Lounge	• Separate sitting areas (groupings of furniture) for 8-12 people • Telephone, TV/cable, VCR/DVD, music system. • Fireplaces in key lounge areas. • Bookshelves. • Materials and lighting that create homelike atmosphere.	• Dimming ability of fixtures. • Area to do puzzles or other quiet activities. • Visiting children's area. • Computers/printers for families' use.
Kitchen and Dining	• Main (working) kitchen area should include sink, commercial ice- maker, Cook top, oven, fridge/freezer, microwave, commercial dishwasher/sterilizer, cupboard and adequate counter space, pantry, kitchen exhaust fan to exterior, separate hand washing sink • Kitchen area for family to prepare drinks and snacks including a small fridge, cupboards, sink and microwave. • Dining table and chairs to accommodate (8-12 or more)	• Kitchen area wheelchair accessible (at least in part).
Family Room/ Guest Lounge	• The family room and its furnishings should accommodate multiple functions including quiet time, counselling and complementary therapy treatments. • Telephone for private family calls. • TV /cable • Acoustical requirements for confidentiality. • foldout couch with barrier free washroom with wheelchair, shower and lavatory	• More than one room available.
Physical Design	**Expectations/Requirements**	**Additional Desirable Features**
Central Bathing Facilities	• "Spa-like" environment. • Adequate circulation space to ensure resident/staff safety. • Wheelchair accessible shower, therapeutic tub, sink, toilet. • Floor drain. • Barrier free	• Stretcher tub with built in ceiling lift preferred; consult with occupational therapist prior to purchase. • Should be located near residents' bedrooms. • Hair washing station • Space & wiring for towel warming • Cabinet

Family Washroom/ Shower	• Separate from residents' rooms. (barrier free, including baby change table)	
Cigarette Smoking Area	• All VCH sites are smoke free; hospice residences that receive funding from VCH are strongly encouraged to develop similar smoke-free premise policies. • However, some hospice residents will smoke and, consistent with the hospice philosophy, efforts may be made to accommodate them. • In facilities that do allow smoking, the smoking area must meet all municipal bylaws, be located outside and far enough away from residents' windows and building ventilation intakes to ensure that second-hand smoke does not filter back into the facility.	• Additional ventilation support for the exterior smoking area may be required.
Garden/ Outdoor Space	• Must have centralized access to outdoor space. • In considering access to outdoors, there should be recognition of security issues and issues related to the population served. • Doors and ramps to outdoor area accommodate wheelchairs and reclining chairs. • Garden area has solid pathways for walkers and wheelchairs.	• Same floor access. • Garden can be accessed from patios from each individual room. • Doors and ramps accommodate beds. • Night lighting in garden area.
Staff/Volunteer Lounge and Washroom	• Locked space for personal belongings. • Space for coats and shoes. • Fridge for staff.	Sink, counter, shower and cupboards.
Laundry Facilities	• Must have a working (commercial) laundry specifically for hospice and/or washer and dryer available for staff/family to use for resident's personal laundry. • Counter space, laundry sink and flushing sink required for soaking and rinsing soiled linens and garments. • Storage space is required for soiled laundry. • Laundry room is considered a "soiled" area and a clear functional flow of soiled to clean is required, with separation and storage of soiled and clean laundry.	• If working (commercial) laundry is located within the hospice, it should be centrally located (near residents' rooms/ bathing facilities) and appropriately equipped. Depending on numbers of residents, full size heavy-duty washers and full size heavy-duty dryers required; due to regulations, family use of working laundry not permitted.
Physical Design	**Expectations/Requirements**	**Additional Desirable Features**
Meeting Room and Office Space	• Meeting room should be able to accommodate multiple purposes such as family conferences, education sessions and team meetings; should have space for table and chairs for 8-10; acoustical requirements for confidentiality. • Adequate office space as required. • Two Counseling offices for 3-4 people • Meeting rooms to have telephone, wireless, television/computer, projector connections, voice/video conferencing connections	• Separate office available to support work of supervisor/other team leaders.
Storage	• Adequate storage for clean and dirty supplies, linen and equipment (including wheelchairs, walkers, commodes, etc.) in order to eliminate clutter in hallways, resident rooms, bathing areas, etc. • Storage rooms or cupboards with hidden doors; ability to lock these storage rooms/cupboards.	

Safety and Security	• Ability to prevent wandering residents from leaving unit/building and safely provide 24/7 access to visitors. • Security and or ability to create safety plans as required in each facility for patient/resident and staff safety and to support access to hospice care in complex situations. • Secure storage of medications and controlled substances. • Smoke detectors. • No injections of illicit drugs on the premises. • Emergency generator for provision of minimal service. • Best practices or beyond for energy efficiency • Materials, surfaces and finishes must adhere to infectious disease control requirements (e.g.: non porous, wipeable materials, etc) • Wall mounted handrails in all resident area hallways	
Entrances	• Two entrances – one for visitors/one for funeral home personnel.	• Extended overhang to allow vehicles to drive up to the entrance and be protected from the elements while dropping off/picking up
Parking	• Safe and adequate parking for visitors and staff.	
Dirty Utility Space	• Janitorial area may be combined with dirty utility area. • Sink and counter space, floor drain, and hopper. • Include sterilizer for bedpans/urinals. • Storage for dirty supplies and equipment, waste, etc.	
Clean Utility Space	• Shelves for clean medical supplies, linens, blankets, etc. • Include blanket warmer.	
Mechanical/ Technology Areas	• Mechanical room for HVAC, water heating, electric panels • Communications room for telecom, cable, LAN, wireless internet, etc. • Janitor area for storage of cleaning materials, janitors sink, trash holding area	

Hospice Staffing/Resource Guidelines

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

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

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

For Nurse Practitioner (NP) and Registered Nurse (RN) scope of practice and nursing standards refer to CRNBC website:
thttps://www.crnbc.ca/Standards/Pages/Default.aspx

For Licensed Practical Nurse (LPN) scope of practice and nursing standards refer to CLPNBC website:
https://www.clpnbc.org/

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

Expectations relating to hospice staff and functions

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

Expectations relating to hospice staff and functions

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

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

Table continued...

Expectations relating to hospice staff and functions (Continued)

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

Hospice Staff Orientation and Ongoing Education

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

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

Hospice Palliative Care Clinical Guidelines

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

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

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

Patient Care Delivery

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

Patient Chart

The hospice resident chart is different in each of the facilities. However, there is an expectation that all charts contain the same basic information including details relating to completed MOST form or documented No CPR form, Advance Care Plan, medical history, pain and pain management, symptoms and symptom management, medications and non-drug treatments, care plan and evaluation of each intervention.

Refer to:

http://www2.gov.bc.ca/assets/gov/health/forms/302fil.pdf

http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning

Hospice Operational Guidelines

Each hospice will be expected to develop its own set of operational guidelines. These should include guidelines related to personnel, administration, safety and physical plant, among other areas. Licensing requirements should be incorporated into these guidelines.

1.1 Organizational and Administrative Requirements

	Expectations/Requirements
Service Innovations	Collaborate within and across teams to identify and develop service innovations to improve access, responsiveness, effectiveness and efficiency of client care
Client Contributions	Have in place the infrastructure, mechanisms and procedures to collect client contributions in accordance with MOH policies and to report the amounts collected to VCH
Client Complaints	Maintain a system for addressing client concerns and complaints which includes providing clients with information and the opportunity to express concerns and complaints, responding to concerns or complaints in a timely manner and ensuring corrective action and reporting back to clients. Contracted providers are responsible for notifying VCH staff of relevant concerns and complaints and risk or safety issues.
Emergency Response Plan	Maintain an Emergency Response Plan (ERP) that will ensure a level of service during emergency situations and disasters. The ERP is to provide uninterrupted Services to clients
Risk Management	Maintain and develop strategies and tools that address risk issues and provide mitigation including but not limited to MSIP and Working Alone legislation of WorkSafe BC, VCH Policies and best practise requirements
Infection Control	Maintain infection control policies and procedures that meet or exceed VCH requirements;
Hospice Operations	Provide all necessary administrative services required to operate and provide the Hospice Services in an efficient and effective manner
Accreditation	Be working towards accreditation or be accredited with Accreditation Canada or such other body acceptable to VCH
confidentiality	Be fully compliant with FOIPPA and meet all confidentiality requirements of applicable legislation, policy and as required by VCH and MoH
Incident Reporting	Have approved incident reporting processes in place which record incidents and near misses and the steps taken to improve processes following an incident or near miss
Staff Identification	Provide all staff with photographic identification
Supplies	Provide all necessary staff supplies to deliver client care which include masks, gloves, hand hygiene supplies, gowns and other supplies as determined by VCH
Invoicing/Billing	Comply with, as applicable, VCH invoicing and billing requirements

1.2 Client Referral and Admission Process

	Referrals for hospice services are made exclusively by VCH and providers are expected to have the infra-structure and appropriate staff in place to accept referrals in accordance with the time frames required by VCH. Providers are required to report when they receive the referral, the anticipated start date of the service, the actual start date of the service and the % of compliance of meeting anticipated start dates
	Providers are expected to provide Services within the allocated time.
	VCH has the sole discretion to determine and refer clients to the successful provider, and the provider will provide the hospice services to all such clients referred to it. In situations where the provider is unable to provide service to a referred client, it is expected the provider immediately escalate the concern to VCH and work towards a plan to mitigate concerns in a timely manner.

Hospice Indicators

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

The following are indicators that will be in place for tracking purposes in 2016. Other proposed quality- related indicators are currently being reviewed, with the goal of ensuring that they are integrated into the care process and based on Accreditation Canada's Qmentum Program 2010, Standards for Hospice, Palliative and End-of-Life Services.

- Average wait time for hospice
- Number of admissions – cancer patients versus non- cancer patients
- Hospice length of stay (1-14, 15-30, 31-45 46-90, 90+) and average length of stay
- Location immediately prior to admission (acute, residential care, home, etc.)
- Hospice average age of clients
- Hospice discharge to (death, acute, residential care, home, etc.)
- Number of patients placed in preferred location vs. placed in any location
- Occupancy rate
- Average bed turnaround time (from time bed available to client match)
- Number of patients who died while waiting for transfer to hospice

Appendices

Appendix I – Summary Grid

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

Table continued…

Appendix I – Summary Grid (Continued)

Item	Reference Document	Reference Page #
Facility Requirements: Common Areas and Work Areas		
Dining Areas	*Residential Care Regulation (Licensing)*	14
Lounges	*Residential Care Regulation (Licensing)*	14
Designated work areas	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	15 40-43
Outside activity areas	*Residential Care Regulation (Licensing)* *VCH Design Guidelines: Complex RC Developments*	15 28-30
Staff		
Character and skill requirements, continuing health of employees, continuing monitoring of employees, management and supervisory staff, staffing coverage, employee trained in first aid, food services employees	*Residential Care Regulation (Licensing)*	15-17, 39
Investing in hospice palliative and end-of-life services, engaging prepared and proactive staff	*Hospice, Palliative, and End-of-Life Services; Accreditation Canada, Qmentum Program 2015*	11-17
Volunteers		
Standards	*Volunteer Standards for Hospice Palliative Care in British Columbia, 2008*	Entire document
Operations: Admission and Continuing Accommodation		
Prohibited service, admission screening, advice on admission, other requirements of admission, continuing accommodation	*Residential Care Regulation (Licensing)*	18
Operations: General Care Requirements		
Emergency preparations, harmful actions, privacy, general health and hygiene, program of activities, identifications of persons in care off-site, access to persons in care, release or removal of persons in care, family and resident council, dispute resolution, self- monitoring of community care facility	*Residential Care Regulation (Licensing)*	19-23
Clinical Practice Guidelines	*Clinical Practice Guidelines, Community Palliative Care, VCH, 2007*	Entire document
Clinical Practice Guidelines for Quality Palliative Care	*Clinical Practice Guidelines for Quality Palliative Care, National Consensus Project, 2009*	Entire document
Nursing Standards of Practice	*Hospice Palliative Care Nursing Standards of Practice, Canadian Hospice Palliative Care Association, February 2002*	Entire document
Providing safe and appropriate services, enhancing quality of life, monitoring quality and achieving positive outcomes	*Hospice, Palliative, and End-of-Life Services; Accreditation Canada, Qmentum Program 2015*	Entire document

Table continued...

Appendix I – Summary Grid (Continued)

Item	Reference Document	Reference Page #
Operations: Nutrition		
Menu planning, food preparation and service, food service schedule, participation by persons in care, individual nutrition needs, eating aids and supplements	*Residential Care Regulation (Licensing)*	23-25
Operations: Medication		
Medication safety and advisory committee, packaging and storage of medication, administration of medication, changes to directions for use of medication, return of medication to pharmacy	*Residential Care Regulation (Licensing)*	25-27
Operations: Use of Restraints		
Restrictions on use of restraints, when restraints may be used, reassessment	*Residential Care Regulation (Licensing)*	27,28
Operations: Matters That Must Be Reported		
Notification of illness or injury, reportable incidents	*Residential Care Regulation (Licensing)*	29, 40, 41
Records: Records for Each Person in Care		
Records for each person in care, records respecting money and valuables of persons in care, short term care plan on admission, care plan if more than 30 day stay, implementation of care plans, nutrition plan, use of restraints to be recorded in care plan	*Residential Care Regulation (Licensing)*	30-33
Maintaining accessible and efficient clinical information systems	*Hospice, Palliative, and End-of-Life Services; Accreditation Canada, Qmentum Program 2015*	49-52
Records: Additional Records		
Policies and procedures, records respecting employees, food services records, record of minor and reportable incidents, record of complaints and compliance, financial records and audits	*Residential Care Regulation (Licensing)*	33-35
Records: General Requirements Respecting Records		
Currency and availability of records, how long records must be kept, confidentiality	*Residential Care Regulation (Licensing)*	36

Vancouver Coastal Health

Admission agreement and consent for Hospice services

Client Name: _____ **PHN #**_____ **PARIS #**_____

On behalf of the client named above, I (the client or his or her substitute decision maker) agree to the following:

Hospice Philosophy of Care

I understand that my **Goals of Care** will be planned in partnership with me, my family and the hospice care team and meet the focus of hospice care including;

- That relief of symptoms, including pain, emotional, psychosocial and spiritual suffering, are the most important goals.
- That my care will be directed towards maximizing the quality of life to the end of my natural life.
- I understand that extraordinary life saving measures will not be provided. This includes cardiopulmonary resuscitation (CPR).

  Therapeutic measures and medications to manage acute conditions may be provided within the limits of the hospice facility.

(Initial:_____)

I understand my diagnosis and prognosis and accept that no further treatments will reverse the course of my illness.

I accept that treatments to reverse the course of my terminal illness will not be provided.

I have reviewed my Advanced Directives ☐ or Advance Care Plan ☐ and provided this information to the hospice care team.

I understand that Hospice inpatient care is provided for 3 months or less.

(Initial:_____)

Hospice Agreement

- I allow that, during the course of my care, the information contained in my health record (paper or electronic) may be shared with authorized providers of my care, as may be permitted by the Freedom of Information and Protection of Privacy Act.
- I agree to be available to be admitted to the hospice within 48 hours of notice of a vacancy.
- I recognize that while every effort is made to protect the possessions of each resident, Hospice cannot accept responsibility for damage or loss of personal effects
- Should I change my mind about my treatment goals, or no longer agree with the hospice philosophy of care, I agree to advise my care team. As the hospice setting is no longer appropriate, a move back home or to an alternative setting will be planned with me, my family, and the hospice care team.
- I understand, and agree, that if my condition stabilizes or improves, the hospice team will reassess whether there is an ongoing need for hospice care. This reassessment will take place 8 weeks after admission, as well as whenever my condition changes. If the hospice setting in no longer required a move back home, or to an alternative setting, will be planned with me, my family, and the hospice care team.
- I understand that short term hospice care (or respite care) will be provided for a maximum of 2 weeks.

(Initial:_____)

Admission agreement and consent for Hospice services

Hospice Program of Care & Covered Services

I understand that there is a BC Health Ministry daily charge for residential hospice services and I agree to pay the daily rate of $_____.

If I am unable to pay the daily fee, I will provide documentation as soon as possible to reduce or waive the hospice fee.

If I am utilizing the hospice for ***respite or for a short stay admission***, I will be responsible for the daily residential hospice charge if my stay at the hospice exceeds 14 days.

I understand that any prescription costs not covered by the BC Palliative Care Benefits Plan will be billed directly to me (or my representative). If I have extended benefits, I may recover fees through my benefit plan.

Signed: _____ _____

(Patient. or person legally authorized to give consent) (Date)

_____ Signature of Provider obtaining consent:_____

(Relationship to patient if not patient)

Print Name_____ Print Name Provider:_____

(If not patient)

Witness:_____ Print Name Witness:_____