INTERDISCIPLINARY CLINICAL
Policy & Procedure

Title:	Hospice Eligibility	Number:	CL-HOS-001
Sponsor:	Director, Palliative Care Integration	Page:	1 of 6
Approved by:	VP, Integrated Health Services	Approval Date: Effective Date:	Aug. 19, 2019 Sept. 24, 2019
Applies To:	All NSHA Staff		

PREAMBLE

1. Hospice residences are home-like community-based settings where Palliative Care is provided for eligible individuals.
2. Clear eligibility criteria for Hospices helps ensure safe, equitable, sustainable, high-quality Hospice-Level Care for those with a limited life expectancy.
3. All Hospice residence policies are guided by the Nova Scotia Community Hospice Residence Standards.

POLICY STATEMENT

Initial Eligibility

1. In order to be eligible for Hospice, patients must:

   1.1. Have a predicted life expectancy of 3 months or less.

   1.2. Have a Palliative Performance Scale (PPS) score of 50% or less (See Palliative Performance Scale Version 2)

   1.3. Be 16 years of age or older. Younger patients may be considered on a case-by-case basis in consultation with the IWK Hospital to determine if the setting is appropriate to meet the care needs of the child.

2. Patients or their Delegate/Statutory Decision Maker (SDM) must:

   2.1. Be aware of the patient's diagnosis and life expectancy, with no further plans for diagnostic tests or monitoring.

   2.2. Confirm their understanding that resuscitation and other life-prolonging interventions are not provided in Hospice.

2.3. Have explored all appropriate and available community supports but can no longer be supported at home, or have expressed that a home death is not desirable.

2.4. Agree to a transfer to a different care setting if the patient no longer meets the eligibility criteria described in this policy.

3. A Hospice assessment request is made (as per CL-HOS-002 Hospice Assessment Request) if the patient's Most Responsible Health Care Professional believes that the patient is appropriate for Hospice based on the eligibility criteria in this policy.

Ongoing Eligibility

4. Hospice care team members are responsible to assess a patient's continued eligibility for Hospice on an ongoing basis as part of their regular assessment.
5. If no longer eligible, the most appropriate discharge destination is determined based on the health care team's assessment and in collaboration with the patient/Delegate/SDM.
6. Patients are discharged when:
   6.1. They and their families express the wish to return home, or it has been determined that the course of the illness and/or Goals of Care have changed and would be more appropriately addressed in either an acute care or long term care setting.
   6.2. The patient no longer meets the eligibility criteria.
   6.3. The attending Hospice physician is responsible to make decisions about discharge in consultation with the Hospice care team, patient, and family.
7. Each Hospice site must have a discharge process or policy based on local resources and patient flow procedures.

GUIDELINES:

1. Eligibility Considerations
   1.1. Hospice Care is not appropriate for:
   - Mobile patients with wandering or aggressive behaviors that threaten their safety or the safety of other patients and staff.
   - Patients with stable Frailty who meet the eligibility criteria for long-term care.
   - Patients who wish to come to Hospice for the sole purpose of receiving Medical Assistance in Dying (MAiD).
   - Patients who are actively dying and are admitted in another care facility (death is anticipated within 24 hours).
   - Patients who require planned and regularly scheduled transportation to off-site medical appointments.

   1.2. Patients who require interventions or management strategies **not** provided by Hospice are **not** eligible for admission. Examples include, but are not limited to:
   - Patients who are ventilator-dependent.

- Patients receiving dialysis.
- Patients requiring ongoing platelet or whole blood transfusions.
- Patients requiring or requesting the ongoing use of intravenous lines (peripheral or central) for any medications (including chemotherapy, antibiotics) or fluid.
- Patients with active, infectious diarrhea (e.g. Clostridium difficile).
- Patients with active airborne disease (e.g. measles, tuberculosis, disseminated Herpes zoster).
- Patients with active Implanted Cardiac Defibrillators (ICDs).
    - Deactivation prior to admission (or a plan to deactivate as soon as possible, if feasible).

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

- High-flow oxygen (more than 15L/min)
- Negative pressure wound therapy (NPWT)
- Bi-Level Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP)
- Enteral feeding
- Antineoplastic therapies including hormonal/oral agents
    - A discussion with the treating specialist about stopping oral agents is recommended prior to admission.
- Procedures for symptom management that require ongoing transportation to an acute-care facility (e.g. thoracentesis, paracentesis, palliative radiation therapy)
- Peripherally inserted central catheters (PICCs) or central venous catheters (CVCs)
    - PICCs and CVCs are removed before or shortly after admission to Hospice.
    - If they cannot be removed, PICCs and CVCs will not be used or maintained in Hospice. Dressings will be changed according to local protocols.

REFERENCES

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

Government of Nova Scotia. (2010). "Personal Directives Act – Information for Health Care Providers."

Nova Scotia Department of Health and Wellness. (2015). Service Eligibility Policy. https://novascotia.ca/dhw/ccs/policies/policyManual/Service_Eligibility_Policy.pdf

Personal Directives Act, Statutes of Nova Scotia (2008, c. 8). Retrieved from the NS Legislature website https://nslegislature.ca/sites/default/files/legc/statutes/persdir.htm

Other

Nova Scotia Health Authority. (2017). Nova Scotia Community Hospice Residence Standards.

RELATED DOCUMENTS

Policies

NSHA CL-HOS-002 Hospice Assessment Requests

Tool

PPSv2 Tool

Appendices

Appendix A: Definitions

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Delegate/Statutory Decision Maker (SDM)	The person named in a Personal Directive or authorized under the *Personal Directives Act* to make decisions on behalf of the patient when that person can no longer speak for themselves.
Frailty	Frailty is a stage of life that is the result of the cumulative effects of health and functional deficits over the life course. When this accumulation of deficits depletes the physiologic reserve to the point that day-to-day activity is affected, a person is said to be "frail".
Goals of Care	Describes people's goals for their care, including treatment of the disease and/or symptom management. In some cases, it includes limits on the interventions that people want, such as DNR orders.
Hospice	A term that encompasses both a *setting* of care and a *type* of care for those near the end of life, focused on comfort rather than acute care. Hospice as a *setting* can include stand-alone facilities or designated Hospice beds in other locations. In this policy, "Hospice" will refer to a Hospice Residence.
Hospice-Level Care	For those who cannot or do not wish to die at home, care is provided in the last weeks of life. Hospice is for those who are relatively stable but require monitoring and interventions that are unavailable in their home setting for a variety of reasons.[i]
Medical Assistance in Dying (MAiD)	In accordance with federal legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: administers a substance that causes an individual's death; or prescribes a substance for an individual to self-administer to cause their own death.
Most Responsible Health Care Professional	The health care professional who has the overall responsibility for directing and coordinating the care and management of a patient at a specific point in time.
Palliative Care	Care that improves the quality of life of patients/families facing life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. Includes end of life care offered to dying persons and a palliative approach to care

integrating key aspects at appropriate times for those with advanced illness at increased risk of dying.

Palliative Performance Scale

The Victoria Hospice Palliative Performance Scale (PPS, version 2) is an 11-point scale designed to measure patients' functional status in 10% decrements from 100% (healthy) to 0% (death) based on five observable parameters: ambulation, ability to do activities, self-care, food/fluid intake, and consciousness level. It is designed to provide a snapshot of functional assessment at the time of assessment.

Personal Directive

A legal document that allows a person to name a Delegate to make health and personal care decisions on behalf of the individual, if they are not mentally capable and/or set out instructions or expression of wishes about future personal-care decisions. A personal care decision includes decisions about health care, nutrition and hydration; where the person would like to live and die and comfort measures.

Version History

Major Revisions (e.g. Standard 4 year review)	Minor Revisions (e.g. spelling correction, wording changes, etc.)

[i] Caregivers Nova Scotia Association. (2015). Caregiver *Language*. Accessed from: http://caregiversns.org