

<b>Policy Title:</b>	Home Parenteral Nutrition (PN) - Adults	
<b>Applies To:</b>	Team Members and gastroenterologists requesting referral to Home PN program	
<b>Approved:</b>	<b>Effective:</b>	<b>Next Review:</b>
November 30, 2023	January 23, 2024	November 30, 2027
<b>Sponsor:</b>	Senior Medical Director, Integrated Acute & Episodic Care Network  Senior Director, Integrated Acute & Episodic Care Network	
<b>Approval Authority:</b>	Clinical Operations Council (COC)	
<b>Number:</b> CL-PT-050	<b>Manual:</b> Interdisciplinary Clinical	

## PURPOSE

This policy directs Team Members and gastroenterologists when referring a patient from any Nova Scotia Health facility to the Home parenteral nutrition (PN) program. It outlines the criteria for acceptance into the program, and responsibilities while in hospital, and post discharge from hospital.

## POLICY STATEMENTS

- To be accepted into the Home PN program, the patient must meet the following eligibility criteria:
  - Have a Non-functioning Gastrointestinal Tract as determined by a gastroenterologist.
  - Have demonstrated intolerance or contraindications to enteral nutrition via nasogastric/gastrostomy, nasojejunal or jejunostomy tubes for a minimum trial of two to four weeks.
  - Be hospital dependent on parenteral nutrition (PN) with demonstrated therapeutic benefits while receiving PN.
    - They must be Metabolically Stable for a period of weeks, without frequent alterations to PN solution, and cyclic PN must have been initiated (Example: 16, 12, 10 hours overnight).
  - Require Home PN for longer than six months.

- Be ambulatory and able to care for **all** personal needs, unassisted.
  - Have a care partner able to learn the procedures for support, as needed.
  - Have a back-up plan for emergencies (example: power outage).
  - Be a resident of Nova Scotia.
2. The patient must have a single-lumen central tunneled catheter (Hickman®) in situ.

**Note:** This is **not** a Port-a-Cath or peripherally inserted central catheter (PICC).

- 2.1. If the local site does not routinely insert Hickman® catheters, pre-arrangements must be made with the closest Interventional Radiology (IR) service, or the Victoria General (VG)/Halifax Infirmary (HI) IR service to have one inserted.
- 2.1.1. This is the responsibility of the transferring physician.
- 2.2. If arrangements are made with the VG/HI IR service to insert the Hickman®, it will be inserted when the patient is transferred to the VG/HI unit for teaching.
3. The referring gastroenterologist must collaborate with a VG/HI physician for the patient's transfer to the VG or HI site (under the accepting physician's care for teaching purposes).
4. At discharge, the patient must be directed to go to Emergency department if feeling unwell (Example: fever, chills, problem with Hickman - leaking, unable to flush, redness, swelling).

## RESPONSIBILITIES

1. The referring **gastroenterologist** is responsible to complete and fax the following to the Home PN Team:
- The [Nova Scotia Home TPN Program Checklist for Home Assessment form](#), and
  - The referral.
2. The **Home PN Team** is responsible to review the referral and advise the referring gastroenterologist of the decision.
- 2.1. If accepted into the program, the referring gastroenterologist is responsible to arrange transfer to a physician at VG/HI.

**NOTE:** The **referring gastroenterologist** is responsible to arrange the transfer.

## Admission to VG/HI Unit

3. While on VG/HI unit, the **accepting physician** is responsible for the patient's overall care, including:
- Medical issues, and
  - Management of their PN (in collaboration with the unit dietitian).

4. The **Home PN Team** is responsible for patient teaching and discharge planning for Home PN in collaboration with the unit team members.
  - 4.1. The Home PN Team provides the patient with education and instruction, and evaluates the patient for the following:
    - The ability to prepare and administer PN independently and safely,
    - Compliance with morning and night routines, and
    - Taking responsibility for their well-being.
  - 4.2. The evaluation includes assessment of the home environment either by a home visit or using the Home Environment and Safety Checklist.

## Discharge

5. The patient's **referring gastroenterologist and family doctor** are responsible to follow the patient for medical issues.
6. The **Home PN Team** is responsible to:
  - Follow patient for nutrition/PN, order and monitor routine bloodwork for potential complications of PN (Example: liver enzymes, electrolytes imbalances) and provide all required medical and pharmacy supplies for Home PN. This includes:
    - Making any required formula changes to PN, adjustments in rates of PN and/or lipids as required.
    - Assessing the patient to determine if additional hydration is required, and ordering accordingly.
  - Address patient concerns regarding their PN/equipment/supplies etc.
  - Arrange follow up appointments with the Home PN program.

## Subsequent Admission to Inpatient Units (all zones)

7. The **admitting physician/unit dietitian/pharmacist** is responsible to notify the Home PN Program at the VG Pharmacy Department at **(902) 473-7802** of the patient's admission and to discuss PN needs while in hospital and discharge planning.

## REFERENCES

- American Society for Parenteral & Enteral Nutrition. (2022). <https://www.nutritioncare.org/>
- Durfee, S.M., Adams, S.C., Arthur, E., Corrigan, M.L., Hammond, K., Kovacevich, D.S., McNamara, K., & Pasquale, J.A. Home and Alternate Site Care Standards Task Force, A.S.P.E.N. (2014). Standards for nutritional support: Home and alternate site care. *Nutrition in Clinical Practice*, 29(4): 542-555. <https://doi.org/10.1177/0884533614539017>
- University Health Network. (n.d.) *Home PN* (Policy).

## RELATED DOCUMENTS

### Policies

[Central Venous Access Devices: Care and Maintenance \(Umbrella Policy\) - NSHA CL-PT-001](#)

[Central Venous Access Devices: Dressing Changes And Securement - NSHA CL-PT-005](#)

[Flushing Peripheral, Medline Intravenous and Central Venous Access Devices - NSHA CD-PT-005](#)

### Forms

[Nova Scotia Home TPN Program Checklist for Home Assessment form \(fillable\)](#)

[Nova Scotia TPN Program Checklist for Home Assessment form](#)

### Brochures

[My Home Parenteral Nutrition Emergency Plan](#)

[Care of a Hickman Line](#)

[Home Parenteral Nutrition Learning Guide](#)

### Appendices

Appendix A: Definitions

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## Appendix A: Definitions

<b>Home Parenteral Nutrition Program (HPN)</b>	<p>The Provincial Home Parenteral Nutrition Program is a tertiary service of Nova Scotia Health for patients in any zone of Nova Scotia Health. It is managed by a multi-disciplinary team providing parenteral nutrition support at home to patients (that meet criteria outlined in policy) who would otherwise be hospital dependent.</p> <p>Initiating HPN requires a hospital admission for two-four weeks (for teaching purposes). Before teaching is initiated, the patient’s PN should be stabilized and cycled to an intermittent schedule (example: 16, 12, 10 hours overnight).</p>
<b>Home PN Team</b>	<p>The HPN multidisciplinary team is comprised of a gastroenterologist, PN nurse coordinator, PN pharmacist and a PN dietitian.</p>
<b>Metabolically Stable</b>	<p>Metabolically Stable includes the following:</p> <ul style="list-style-type: none"> <li>o Weight – stable or increased weight</li> <li>o Bloodwork – stable electrolytes</li> <li>o General well-being – Patient states feeling well</li> </ul>
<b>Non-functioning Gastrointestinal Tract</b>	<p>An individual who is unable to maintain their nutritional needs through conventional methods (orally, enteral).</p>

## POLICIES BEING REPLACED

CC 25-022 Provincial Home TPN Program

### VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2024-01-23	Clinical Operations Council (COC)	N/A