



Hospice Palliative Care (HPC) in Sarnia Lambton

Right Patient in the Right Place at
the Right Time

Palliative Care across the Continuum
February 2010

Contents:

- Table 1 -Description of Hospice Palliative Care Settings and Services
- Table 2 - Typical HPC Interventions/Procedures/Services Provided ON SITE (by Patient Location)
- Table 3 - Typical Eligibility Criteria for Hospice Palliative Care (by Patient Location)
- Flow Chart – Key Decision Points (regarding location of care)

Handouts adapted from:

*Report on current Services and Recommendations for Future systems Hospice Palliative Care in Erie St. Clair–
B. Lambie& ESC EOLCN December 2008*

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Sarnia Lambton

Table 1 – January 2010

Description of Hospice Palliative Care Sectors/Care Settings

Locations below are 24/7 care settings

Description	In Home- CCAC & Community Service Provider Agencies (CPSA)	Residential Hospice St. Joseph's	Acute Care (AC) BWH 2 sites	Complex Continuing Care BWH 2 sites	Long Term Care Homes
Model of Care	CCAC provides single-entry coordinating services for clients being cared for in the community. Professional homecare and home support services are contracted to the private sector. (VON, Bayshore, VHA in Sarnia)	Dedicated Palliative Care beds in a stand-alone setting - 10 beds. Non –residential support programs are provided at adjacent Resource Centre.	Sarnia : Medical / Palliative unit with 6 beds dedicated for Palliative Care at Sarnia site. Consultation provided to other units by trained Palliative Care nurse. CEEH: No designated beds	Sarnia: Dispersed beds within a CCC medically complex unit & a cognitively complex unit. Consultation provided from Palliative Care unit. CEEH: No designated beds	Models of Palliative Care vary significantly. Beds typically not dedicated to Palliative Care only – some specialty areas/rooms available for EOL care
Volumes	MIS code 95 220 clients (2006/07)	140 admissions first year—projected	Admissions - 240 Deaths - 246 (2008/09)	Admissions-109 Deaths - 53 (2008/09)	Approximately 334 deaths in LTC beds (2006/07)
Access to Physician Specialist (for Hospice Palliative Care)	Consults and care by a Palliative Care Physician as requested.	Consults and care by a Palliative Care Physician. .	Consults by a Palliative Care Physician as requested by GP/MRP (most responsible physician)	Consults by a Palliative Care Physician as requested by GP/MRP (most responsible physician)	Variable by home
Access to: Non-physician specialist level expertise (for Hospice Palliative Care)	-Team is in process of being implemented to provide specialist level expertise within the community settings. -Dedicated CCAC Case Managers typically have specialist level of expertise. -CSPA have varying levels of secondary level expertise (e.g. fundamentals/CAPCE etc.). - CCAC employed NP	-Expectation is that all staff will have secondary level HPC expertise within their own professional scope of practice (e.g. CAPCE). -Clinical Director will have specialist level nursing expertise	-Expectation is that all staff will have secondary level HPC expertise within their own professional scope of practice. CAPCE is expectation for each nurse on unit -Charge nurse has specialist level nursing expertise.	Consultation available from Palliative Care Unit as required.	-Wide variation in expertise. Many LTCHs have Fundamentals, CAPCE & AHPCE trained staff. -PPSMC (Ann Brignell) available to providers in all LTCHs.
Consultation	Consultation to care providers is provided by the Palliative Pain and Symptom Management Consultation Program (PPSMCP).				
Education	Formalized training for staff available from Palliative Pain & Symptom Management Consultation Program (Fundamentals, CAPCE, AHPCE, and sector specific education etc.).				
VON Volunteer Hospice Program	Potential to assist with volunteer training and recruitment across sectors. Currently in S/L working with patents in community only.				

Table 2 – Sarnia Lambton Typical HPC Interventions/Procedures/Services Provided ON SITE - By Patient Location Locations below are 24/7 care settings – Mobile/transportable patients may travel from their primary location to receive these interventions/procedures/services as outpatients at hospitals and RCPs					
LEGEND: Y= Yes, most facilities provide this N= No, most facilities do not provide this ; S=A significant number of facilities provide this service/intervention/procedure;					
	In Home- CCAC and CSPA	Residential Hospice	Acute Care	Complex Continuing Care	Long Term Care Homes
*Tertiary Care Interventions	N	N	Y	N	N
Paracentesis/Thoracentesis	N	N	Y	Y	N
Initiation of Intraspinal pain management	N	N	Y	Y	N
Initiation of Ventilator/Respirator Care	N	N	Y	N	N
Management of Ventilator/Respirator Care (Bipap)	Y	N	Y	Y	S
Blood transfusions	N	N	Y	Y	N
IV therapy – fluid replacement	Y	Y	Y	Y	S – with CCAC teaching
IV therapy – antibiotic therapy	Y	Y	Y	Y	N
Initiation of Central Line	N	N	Y	S	N
Management of Central Line	Y	Y	Y	Y	S – with CCAC teaching
Palliative Chemotherapy	Y-oral meds and monitoring pumps	N	Y	Y	N
Diagnostic Imaging	N	N	Y	Y	N
Diagnostic Lab	Lab pick up with cost	Lab pick up with cost	Y	Y	Lab pick up 1x per week
Surgical & Anesthesiology Intervention	N	N	Y	S	N
Palliative Radiotherapy	N	N	RCP locations only	N	N
PCA Pumps	Y	Y	Y	Y	N
Services which are common to virtually all locations	Management of : tube feedings, pressure ulcers, oxygen therapy, Some degree of support from Pharmacy, Allied health, Volunteers,				
Format and content adapted from work done by Windsor/ Essex End of Life Care Committee under the leadership of Sandra Kroh - validated by each county's EOLCN committee.					

***Tertiary Care includes treatment for: bowel obstructions, spinal cord compression, febrile neutropenia, hypercalcemia, acute severe symptom management (restlessness, agitation, confusion, pain crisis, and anxiety)**
Tertiary Care also includes specific treatment regimes and care co-ordination such as: palliative sedation for refractory symptoms, oncological emergency care, urgent referrals to Cancer Centre, etc.

Table 3

Typical Eligibility Criteria for Hospice Palliative Care in ESC

(Locations below are 24/7 care settings – day programs/clinics/ambulatory care services may support patients in these locations particularly patients in home)

Expert teams significantly enhance care and connections at home and across sectors.

	In Home CCAC and CSPA	Residential Hospice	Acute Care	Complex Continuing Care	Long Term Care Homes
General Description	-patient requires in -home coordinated multidisciplinary care, -Is not eligible for other settings or chooses care in home. - Typically significant degree of family / informal care provider support & resources are required particularly in later stages.	- EOL predicted on admission - Would be appropriate for in home care if family / informal care provider support & resources were available	Need for Palliative Care approach may be at time of initial diagnosis/ palliative prognosis or acute exacerbation; -Management of severe symptoms; -May require intensive *tertiary level interventions to manage symptoms	-Provide continuing and specialized services to medically complex patients, who usually have multiple health problems and/ or functional impairments.	-Provide care to individuals who no longer are able to live independently and have fully utilized all available resources and services within the community.
DNR established on admission	DNR may or may not be established	Yes – DNR on admission	DNR may or may not be established	-General CCC beds: DNR may or may not be established -Designated HPC units: DNR on admission	DNR may or may not be established
Level of Care / Monitoring Required and available	-Varying degrees of monitoring and care levels -24/7 professional support may be offered in last 2 weeks of life	-24/7 registered staff with patients -high degree of supportive care -advanced skill level in EOL care -sub-acute level of care requirement	-24/7 registered staff with patients -high degree of aggressive clinical/ medical interventions	-24/7 registered staff with patients -Care needs exceed that available in community or LTC settings	-24/7 registered staff on site -PSW 24/7 coverage -Care needs exceed that available in community
Prognosis / typical LOS/ coding	Coded MIS 95 when prognosis is approx 3 months	-PPS greater than or equal to 60 - approx 3 months -ALOS Hospice -21 days	Coded Z51.5 when a case meets BOTH of the following criteria: -patient has a terminal illness and is receiving palliative care (“comfort care”, “supportive care”, “compassionate care” or “pain control only”)	-General CCC beds: no predetermined or typical LOS -Designated HPC beds: terminal dx. with ALOS approx. 4 months -HPC needs are not well captured with CCRS coding.	-Most patients requiring HPC are those who are already residents and enter EOL phase. -longer LOS than other setting typically
Physician Intervention	-Variable levels of Physician involvement required -House calls typically required for EOLC	-Use of diverse pharmacology requires frequent Physician intervention	- May require care from various specialists to identify & control symptoms	-Use of diverse pharmacology requires frequent Physician intervention	Variable levels of Physician involvement required
Criterion which are common to all locations	Patient: consents to care in this setting; requires professional health care; Typically requires pain and symptom management and psychosocial support; May require lab and other diagnostic testing to identify and control symptoms; has valid OHIP.				
Format and content adapted from work done by Sarnia Lambton End of Life Care Committee under the facilitation of A. Baker – validated by each county’s EOLCN committee.					

*Tertiary Care includes treatment for: bowel obstructions, spinal cord compression, febrile neutropenia, hypercalcemia, acute severe symptom management (restlessness, agitation, confusion, pain crisis, and anxiety)

Tertiary Care also includes specific treatment regimes and care co-ordination such as: palliative sedation for refractory symptoms, oncological emergency care, urgent referrals to Cancer Centre, etc.

Flow Chart

EOLC in the Home—Decision Points

