**PROGRAM MISSION & VISION**

**The Salvation Army Canada and Bermuda Territory Mission Statement**

The Salvation Army exists to share the love of Jesus Christ, meet human needs and be a transforming influence in the communities of our world.

**Rotary Hospice House Mission Statement**

Rotary Hospice House… a community that honours life, values humility, and shares hope.

**Rotary Hospice House Vision**

When we think of hospice, we envision a place where:

* residents and families are accompanied through the journey of dying, death and bereavement with hope, sensitivity, and trust
* value and respect is given to individual choices and decisions
* it is seen as a privilege to share in one of the most intimate and sacred times in life
* embraceand express the concept of community and its value in hospice
* recognize our common humanity, our spirituality and our connection to each other
* the dignity and value of life is affirmed
* the search for meaning and purpose in one’s life is upheld
* the whole person – body, mind and spirit – is valued
* the mystery of life is acknowledged

**CONTRACTUAL AGREEMENTS**

The Salvation Army Rotary Hospice House has entered into a contract with the Vancouver Coastal Health Authority for the provision of ten hospice beds in partnership with Richmond’s *lntegrated Palliative Care Hospice Program Services*.

Please see Appendix ‘A’ for a copy of the current contract.

**PROGRAM GOALS & OBJECTIVES**

|  |  |
| --- | --- |
| **Goals** | **Objectives** |
| 1. Enhance the profile of hospice in our community.
 | * Activate and update website
* Create opportunities for education and awareness through service clubs, etc.
* Tell stories of our good work through community newspapers and media
 |
| 1. Affirm, support & value our staff
 | * Reflect and debrief with employees
* Celebrate our multicultural diversity
* Provide opportunities for staff to share goals and challenges through the performance management process
* Provide more educational opportunities
 |
| 1. Review program expansion opportunity
 | * Bereavement support
* Respite care
* Pain management
 |
| 1. Better fundraising
 | * Identify and develop a current needs list
* Publish ‘wish list’ in hospice and community
* Work with DHQ PR department
 |
| 1. Improved communication
 | * Priority access
* More communication with family members
* Staff members
 |

**RESULTS OF COMMUNITY SURVEY**

Unlike many of the health authorities that have developed hospice residence beds as part of a regional hospice palliative care strategy, hospices within what is now VCH were established prior to a standardized regional approach to hospice palliative care service development. The Rotary Hospice House of Richmond, like other hospices in the region, arose from a need within the community.

Opened in February 2006, Rotary Hospice House is owned and operated by The Salvation Army. It was developed as a community partnership between the Richmond Health Service Delivery Area (HSDA) and three community service groups: the Rotary Club of Richmond, the Richmond Hospice Association and The Salvation Army.

In 2004, VCH initiated a regional hospice palliative end-of-life care planning process which developed a strategy that was accepted in principle by the VCH Senior Executive Team in November 2005. 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 care capacity for more people in home or homelike settings, and to have a coordinated continuum of care within each health service delivery area. 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.

According to the British Columbia Vital Statistics Agency, from 2003 to 2008, the number of hospice deaths within British Columbia had increased from 776 to 2118. The VCH regional strategy estimated the required number of hospice beds, based on benchmarking with other programs, at approximately 7 to 9.18 beds per 100,000 people in the population. When the regional palliative care team and the hospice working group began work in 2006, further work was done to refine the projected number of hospice beds required to meet the growing demand for hospice care, as well as to meet the anticipated provincial performance targets for shifting care to community settings.

A model was created to project the number of required hospice beds from 2007 to 2015, for each HSDA. The model is based on:

* 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 for 2015 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.

**DESCRIPTION OF TARGET POPULATION**

The Salvation Army Rotary Hospice House is available to anyone 19 years or older who is experiencing a life-limiting condition with an estimated life expectancy of less than 3 months who would benefit from end-of-life hospice palliative care, and who meet the admission criteria.

Our ten beds are allocated as follows:

* Eight (8) beds are for residents of Richmond
* Two (2) beds are for residents of Vancouver

**ORGANIZATIONAL CHART**

See Appendix ‘B’

**PROGRAM DESCRIPTION**

The hospice is a place outside the acute hospital environment where end-of-life care is provided to people who are in their final months or weeks of life and who need ongoing management of their symptoms. Hospice provides an option for people requiring end of life care who do not require care in hospital, but who cannot be cared for at home or choose not to die at home.

**ADMISSION CRITERIA & PROCEDURE**

 ***Criteria***

1. Chooses to be admitted to Hospice, rather than remain at home
2. Does not require acute/palliative care in a hospital setting, and/or is not receiving treatments with aggressive and/or curative intent such as chemotherapy, radiation, renal dialysis, intermittent paracentesis, mechanical ventilation, continuous intravenous, tube feeding, etc.
3. Does require active intervention to alleviate distressing symptoms related to physical, psychosocial and spiritual needs. Can include oxygen therapy, tracheostomy care, and subcutaneous intervention for symptom management. Radiation therapy, blood transfusion and/or paracentesis for the purposes of either pain management or for comfort are acceptable and would be conducted at another facility. However, transportation to the facility is not provided by Rotary Hospice House.
4. Accepts that the focus of palliative care is on quality of comfort and promotion of quality of life, not on a cure.
5. Accepts DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) status.
6. Has a prognosis of less than 3 months.
7. Is not an elopement risk.
8. Does not require continuous suction

***Procedure***

* 1. The Integrated Hospice Palliative Care Consultation Team will be responsible for screening referrals to the hospice and will be responsible for assessing the resident as appropriate, for providing education to primary care providers about the hospice, and in coordinating admission when necessary.
	2. Sending facility, or home care nurse, completes Hospice Transfer Checklist.
	3. Ideally, new residents arrive Monday to Friday between 1000 and 1400 hours.
	4. All medications is faxed or phoned in to Mark’s Pharmacy by 1300hrs the day prior to admission for medication availability at hospice on day of admission
	5. RN or LPN will admit resident to hospice, using the admission package found at the nursing station, which includes the Updated Hospice Assessment from Point Click Care, dietary needs form, admission agreement, flow sheets, and ADL chart.
	6. Resident and family are oriented to room and hospice, noting safety checks such as call bell and bed in low position. Resident is referred to OT/PT for mobility assessment, unless resident is clearly safe to transfer safely.
	7. Hospice palliative care physician will admit resident within 24 hours of arrival.
	8. If resident requires an interpreter, interpreter services will be accessed at 604-675-4099, coordinating the time to include the physician assessment as well.
	9. RN or LPN notifies Chaplain, Executive Director, and Kitchen of the new resident’s arrival.

**ASSESSMENT TOOLS AND PROCESS**

In accordance with British Columbia’s Adult Care Regulations (#9.3), Rotary Hospice House will ensure that all residents have an individualized care plan within one week of admission and update thereafter as needed.

1. The care plan will take into consideration the abilities, the physical, social and emotional needs and the cultural and spiritual preferences of the resident.
2. Residents will be encouraged to participate in the development and review of his/her care plan.
3. Staff will use their skills and knowledge to develop and implement individualized care plans for each resident within one week of admission.
4. Admission assessment, ongoing assessment tools, ongoing progress notes from all care providers involved in the resident’s care, as well as information and goals identified by the resident, will form the basis for the individualized care plan.
5. The care plan must include:
6. A plan for the resident’s health care, including any self-medication plans
7. A plan for the resident’s oral health
8. A nutritional care plan, including any nutritional items from home or from family members.
9. The care plan must be reviewed on a regular basis and modified according to the current needs, goals and abilities of the resident.
10. The care plan will be accessible at all times to staff that provide direct care to the resident. The care plan can be accessed in the resident’s chart and nursing care plan. Flow sheets developed from the care plan are to be kept with the Care Plan in the ADL binder.

For a copy of the current care plan, please see Appendix ‘C’.

**TRANSFER CRITERIA & PROCEDURE**

Rotary Hospice House believes in maintaining the personal dignity of all residents. Therefore, we will continue to support and maintain this belief at the time of a resident’s death.

***In the event of an expected death:***

* 1. Notify the RN or LPN caring for the resident that expected death has occurred, and the respective nurse will pronounce the death, noting time and date, absence of respirations, and chart accordingly in resident’s health record.
	2. Notify resident’s physician during his/her regular office hours.
	3. If family/significant other absent at time of death, notify the primary contact, as per any pre-planned arrangement.
	4. Notify chaplain or faith group leader as resident makes known his/her wishes or family desires.
	5. Ensure resident’s physician or hospice palliative care physician completes Medical Certificate of Death.
	6. Prepare body and room for viewing by relatives, if they so desire.
	7. Have resident’s legal representative/executor call the Funeral Home when family is ready (as per BC Cremation, Interment and Funeral Services Act, March 2014), indicating that there is no rush, and they may take their time saying goodbye and expressing their feelings. Call must be made within 8 hours of death
	8. Complete Notice of Death and Release of Body form and have Funeral Home Transport representative sign to indicate release of body of the deceased from Rotary Hospice House to the Transport driver. If available, give original Medical Certificate of Death at this time. If not completed by physician, it can be faxed at a later time.
	9. Use ‘Leaving Quilt’ to cover the stretcher as the deceased leaves the hospice. Return the quilt to the laundry room afterwards.
	10. In the absence of relatives, two (2) staff will check all belongings, list them in duplicate, pack and place them in storage boxes, and place them in storage area (1 month maximum) until the Executor of the estate can be notified.
	11. Attach one list to belongings and send original list to the Receptionist for filing.
	12. Return or disposal of resident’s belongings - Ask family if they would like to have the resident’s belongings (jewelry, etc.) to go along with the deceased or the family to take home with them. Other belongings, such as small appliances, ornaments and clothes, can be taken home by the family (within 24 hr. of resident’s date of death).
	13. Document all resident’s belongings in the progress notes (resident belongings) of the electronic health record and the location of the belongings.
	14. Complete check list on “Notice of Death” form where it states “Resident’s Personal Belongings”.

***In the event of an unexpected or sudden death:***

1. Notify relatives/significant other.
2. Notify hospice palliative care physician on call, chaplain, Director of Care and Executive Director.
3. Notify Coroner and Community Care Licensing.
4. Involve members of the Integrated Hospice Palliative Care Team for added support for family and debriefing for staff, if required and desired.

**FOLLOW UP PROCESS**

The follow up process at Rotary Hospice House mainly involves the next of kin/primary contact person for each resident that has passed away. In each case

1. A sympathy card, signed by members of the Hospice care team, is sent to the family.
2. On the three-month anniversary of the residents’’ death, a phone call is made to see how the family is doing and to offer information about bereavement support.
3. Family members are invited to the next Celebration of Life service to be held at the hospice. These events are held twice per year.

**RESIDENT RIGHTS TO SERVICE**

As a licensed community care facility within the province of British Columbia, The Salvation Army Rotary Hospice House abides by the residents’ Bill of Rights enacted under the Community Care & Assisted Living Act (Section 7).

See Appendix ‘D’

**PROGRAM COMPONENTS**

In 2005, the World Health Organization (WHO) described palliative care as “…an approach that improves quality of life of clients and their families facing the problem associated with life-threatening illness, through the prevention of suffering by early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual”.

With that definition in mind, the primary components of hospice palliative care are:

1. ***Respect for the worth and dignity of each person.***

**Description**: Each person who comes into the care of Rotary Hospice House is respected as a unique individual who has intrinsic value and worth. The person and family have the right to be up-to-date and to participate in decisions and care to the degree that they wish. The individual has the right to receive personalized care as his/her own meanings and hopes change.

**Outcome**: Residents remain independent and comfortable during their final days of life.

1. ***Dedication and commitment to the highest quality of compassionate care.***

**Description:** Quality care is achieved when all members of the integrated palliative care team work together according to the standards of VCH and The Salvation Army. Residents are treated with compassion, attentiveness and a firm desire to improve the overall quality of life of the residents.

**Outcome:** Nursing staff members are competent & confident in their roles. They are well-educated and continually being trained in necessary areas. Alleviation of pain & discomfort is experienced. Care is provided on a 24/7 basis.

1. **A palliative approach to care.**

**Description:** Palliative care is a multidisciplinary approach of focused medical care for people with terminal illnesses. It emphasizes providing residents with relief from the physical and mental symptoms of a serious illness—whatever the diagnosis. The goal of palliative care is to improve the quality of life for both the resident and the family. A palliative approach supports neither the hastening nor the postponing of death.

**Outcome:** Residents experience an enhanced quality of life in their last days. Family members experience peace and satisfaction related to their loved one’s transition from life to death.

**PROGRAM STAFF**

Program Staff includes:

1. **Registered Nurse (RN)** – There is one RN on shift at all times (24/7). RNs are registered with the College of Registered Nurses in British Columbia (CRNBC). To become registered in British Columbia a person must have completed a nursing education program, met competence requirements, passed the registration exam and consented to a criminal record check.
2. **Licensed Practical Nurse (LPN)** - There is one LPN on shift at all times (24/7). LPNs work in collaboration with other members of the health care team. Their education and practice - while rooted in the same body of knowledge as other nurses - focuses on foundational competencies within the LPN scope of practice and standards. To become registered to practice as an LPN in BC, you must successfully complete Practical Nurse Education training & the Canadian Practical Nurse Registration Examination (CPNRE)
3. **Registered Care Aide (RCA)** – There is one RCA shift each day of the week. The shift usually occurs during the “day shift”. To be eligible to work as an RCA in any publicly funded health care setting in BC, applicants must be registered with the BC Care Aide & Community Health Worker Registry.

**AGENCY RELATIONSHIPS**

1. **Integrated Hospice Palliative Care Program in Richmond** provides holistic, integrated and interdisciplinary hospice/palliative care to persons living with and dying from life limiting conditions. The care is flexible and appropriate to client and family's needs and available resources. The program is accessible to clients 24/7 across different settings: home, community hospice and acute care while remaining sensitive to personal, cultural and religious preferences. The Rotary Hospice House connects with the IHPCP by:
* Facilitating the participation of other members of the IHPCP team at the hospice and not interfering with their work
* Attending weekly clinical rounds
* Attending IHPCP meetings at the hospital in Richmond.
1. **Vancouver Coastal Health Authority** – the Rotary Hospice House is a licensed residential care facility and, as such, all facilities must be in compliance with the *Community Care and Assisted Living Act* and the Residential Care Regulations. The hospice participates in regular inspections with VCH and takes corrective action where standards are not found to be in compliance.
2. **Richmond Hospice Association** provides emotional and social support for patients and family members coping with a life-threatening or life-limiting illness. Trained volunteers visit clients in a variety of settings, including home, hospital, hospice and community care facilities. Their services include personal visits, bereavement support and education to promote an understanding of death as the final stage of living.
3. **Rotary Club of Richmond** – this service club was a key supporter of the hospice when it began and it continues to support the facility in its current operations. The Executive Director of the hospice is traditionally a member of the club.

**VOLUNTEER OPPORTUNITIES**

1. Providing support and care to family members, with respect to their emotional comfort needs, practical needs, caregiver relief, vigil support needs, and spiritual needs.
2. Providing reception and office administration support after hours, monitor hospice visitors, security, safety, and facility operating systems.

**PROGRAM BUDGET**

See Appendix ‘E’

**PROGRAM EVALUATION**

The Rotary Hospice House’s program will be evaluated on an annual basis using The Salvation Army’s Program Evaluation Toolkit. See Appendix ‘F’.

Persons involved in this evaluation process will be the Executive Director, Director of Care, and program staff.

**PROCESS FOR IMPROVEMENT**

Rotary Hospice House will make use of evaluation tools to determine areas of care that require improvement. Tools will include: exit interviews, internal and external surveys, questionnaires, staff interviews and licensing reports. Results will be analyzed and recommendations for improvement will be made to the Executive Director. Timelines and parties involved will be determined by management, in consultation with staff.

**FOCUSED SURVEILLANCE ON INFECTION CONTROL**

In order to support resident safety, Rotary Hospice House has an Infection Control policy that addresses the use of universal precautions and other methods to prevent and manage adverse outcomes which may result from the delivery of care. See Appendix ‘G’.

**QUALITY INDICATORS**

The performance indicators measure key indicators in the following areas:

• Clinical utilization and outcomes

• Family perception/satisfaction

• System integration and change

• Financial performance and condition

• Measures related to acute and ED utilization