Hospice Standards and Hospice Admission Guidelines And Design Standards

Introduction

The development of the national hospice standards and hospice admission guidelines and design standards was primarily funded by the Saudi Health council with the aim of supporting quality palliative care in the Kingdom of Saudi Arabia. The Hospice Standards for providing quality palliative care (the national standards/the Standards), and the hospice admission guidelines and design standards will enable services to establish and design hospice care units and to set standards and admission guidelines and also undertake a self-assessment to determine opportunities for improvement in their performance in relation to the national standards. We would like to thank the national oncology center and the members of the palliative committee and the Standards Working Group and individuals throughout the palliative care who have given their time and expertise to this project.

Definition of Hospice

A program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease. Hospice offers physical, emotional, social, and spiritual support for patients and their families. The main goal of hospice care is to control pain and other symptoms of illness so patients can be as comfortable and alert as possible. It is usually given at home, but may also be given in a hospice center, hospital, or nursing home.

Interdisciplinary team

The interdisciplinary team is the group that provides care in most of palliative care programs including Hospice. The hospice interdisciplinary group includes physicians, nurses, home health aides, social workers, counselors, chaplains, therapists and trained volunteers.

Hospice Admission Guidelines

Hospice Admission Criteria

Hospice admission criteria:

- 18 years and older
- Experiencing a progressive life limiting or life threatening disease and wishes to focus on comfort and quality of life
- The patient/surrogate decision maker has indicated that they no longer require or are benefitting from life sustaining medical treatment and agreed to end of life care.
- Palliative performance scale (PPS) of 50% or less
- Do Not Resuscitate (DNR) order is completed
- The patient/family is not awaiting consultation for initial assessment, staging or treatment of disease. Patients waiting for palliative radiation are eligible for admission
- Expected length of stay of approximately six months or less; exceptions may be considered
- Wishes and agrees to transfer to hospice to receive end of life care when remaining at home is no longer possible or acute care is no longer required
- Agrees to reassessment for alternative level of care if condition stabilizes and disease trajectory appears to exceed expected length of stay
- The patient has been assessed by a palliative care consultant and has met all the above criteria for hospice

Guidelines for Data Gathering to Refer Your Patient to Hospice

1. Terminal diagnosis and related conditions, other significant diseases and medical conditions

2. What led to the referral: Recent or frequent hospitalizations, new symptoms or other recent changes

3. Functional Assessment: Current Palliative Performance Scale (PPS) and CHANGE of it in the last weeks/months (see opposite page); degree of Activity of Daily Living (ADL) assistance needed and any recent CHANGE; what abilities has the patient lost in the last weeks/months; falls, stiffness, weakness (focal or general); speech changes; dysphagia, diet, aspiration signs, drooling

4. Structural Assessment: Decubitus ulcers, degree; contractures and stiffness; wasting syndrome

5. Cognitive Assessment: Global mental function; memory, emotional or perceptual functions; expressive or receptive aphasia, integrative language functions

6. Nutritional Assessment: Current weight and weight CHANGE in the last weeks/month; Percent of oral intake; albumin or pre-albumin; dysphagia affecting caloric intake

7. Environmental Changes: New Durable Medical Equipment (DME)

8. Pertinent Treatment Plan: Total Parenteral Nutrition (TPN); tube feedings; Vacuum Assisted Closure (VAC) system; oral or IV Chemo; radiation (Completed _____of _____times); thoracentesis; paracentesis; surgical procedures; blood transfusions; imaging scans (MRI, PET, CT, etc.)

9. Uncontrolled symptoms that need immediate medication adjustments.

The Hospice Design Standards

The Hospice Design Standards

Introduction

The Design Standards for the Hospice Program ("Design Standards") is designed to assist Organizations to develop and to promote right-sizing facilities to support efficient delivery of hospice care services and to limit excessive operating costs over the lifetime of facilities.
The focus of this document is to provide guidance in defining space allocation and is not intended to provide complete technical facility design guidance. For technical building requirements such as building codes, electrical/emergency power, heating, ventilation and air conditioning, infection control, sterilization procedures, and construction-related issues, the Proposing Organization and its design team must refer to the applicable legislation, codes, standards, and other best practice industry sources.

Purpose

The purpose of the Design Standards is to:

- Identify the types of space for an approved hospice project
- Identify the maximum amount of space for an approved hospice project
- Outline the basic steps to develop the space needs of a hospice facility.

The Planning and Design Objectives:

A fundamental goal in the planning and design of health care projects is to create an environment that enables health services to be delivered in the most effective and efficient, accessible and safe manner while respecting the needs of patients or clients, and staff. Capital resources should be used effectively so that all projects are built as a long-term investment for the community they serve.
The planning and design goals and objectives are captured under the following principles:

- **O**perational Efficiency
- **A**ccessibility
- **S**afety and Security
- **I**nfection Prevention and Control
- **S**ustainability

When undertaking a capital project, the ministry expects these objectives to be met.

Overview of the Space Planning Process

The design standards are organized under the following sections in 2.3 Space Tables:

1. Community Hospice Space

2. Hospice Space associated with Long-Term Care Home (LTCH)

3. Hospice Space in a Hospital

Each of these sections contains a design objective and design standards component and may have additional commentary on industry best practices.

Design Standards

The design standards represent minimal standards. Organizations may choose to expand individual space amounts or add additional room types or additional features to these requirements (e.g. add showers to resident bedrooms or add administrative spaces).

The space tables below provide a complement of rooms that may occur in a hospice. Each room has an assigned Net Square Meter (NSM) area that defines the net amount of space, not including space for circulation or building structure and thickness of walls. The NSM for each room represents standard room size limits. The sizes established define the space necessary to provide effective functionality and infection prevention and control. Room sizes and requirements are listed in the tables below:

1. Table 1: Room Sizes and Requirements for Community Hospices
2. Table 2: Room Sizes and Requirements for Hospice Associated with a LTCH
3. Table 3: Room Sizes and Requirements for Hospice Associated with a Hospital

Community Hospice Space

Design Objective(s)

The design objective for hospice facilities is to design a space that provides:

- A home like environment for the resident/patient
- Support spaces to enable family to support and be with the resident/patient through the end of life experience
- Additional functional support spaces for operational requirements of the facility (e.g. administrative, building operations and medical support spaces)
- Spaces that support a homelike feel but enable the functionality of any required medical support during the end of life experience

The following space standards have been developed to represent a ten (10) bed community-based hospice care model operating from either a purpose-built structure or a leasehold location.

Capital projects that are considering less than 10 beds should provide a proportional decreased amount of family support spaces.

The formula(s) for calculating the proportional decrease is identified in the space table below for relevant space types.

Capital projects that are considering more than 10 beds should provide a proportional amount of increased family support spaces. The formula(s) for calculating the proportional increase is identified in the space table below for relevant space types.

Organizations may choose to exceed space standards or add additional space types.

Table 1: Room Sizes and Requirements for Community Hospices

Description of Space Type	Quantity	Area (sm)	<10 Beds	> 10 Beds
Vestibule	1	7		
Multi-Use Room (Spiritual/Quiet Room)	1	15		
Reception	1	12		
Multi-Use Room (Family Activity room)	1	15		
Kitchen [1]	1	28	Decrease by 20 sm per less resident to a min. of 200 sm	Additional 3 sm per bed over 12
Dining Room	1	20		Additional 2 sm per bed over 12
Living Room	1	28		Additional 3 sm per bed over 12
Barrier-Free Washroom	2	7		Additional 1 per 10 beds
Multi-Use Room (Meeting Room)	1	20		
Staff Washroom	1	5		Increase based on Staffing model
Staff Room	1	12		
1 Patient Bedroom with Sleeper Chair, Barrier-Free Washroom with Shower	1 Per Resident	32		
OR 1 Patient Bedroom with Sleeper Chair, Barrier-Free Washroom (no Shower)	1 Per Resident	26		
For this option, the hospice is to provide additional bathing space as follows: 1 Tub room (3-sided access)		16		
or 1 Stretcher Shower 1 Family		7		

Shower/Change Room			
Medication Room	1	5	
Clean Utility	1	12	
Soiled Utility	1	14	
Elevator Machinery Room[2]	1	7	
Communications Room	1	5	
General Storage	1	20	
Mechanical Room3	1	20	
Electrical Room[3]	1	10	
Sprinkler Room[3]	1	10	
Laundry	1	10	Additional 5 sm per 5 beds
Janitor	1	5	

[1] Kitchen is required where care model is that families and/or volunteers prepare meals for residents. Where organization prepares meals for residents, there must be space for food storage/preparation (sf TBD by organization) as well as a Pantry of 75 sf with refrigerator, microwave and sink for families to bring in and heat meals for residents. Kitchens must contain sink unit, refrigerator, stove, exhaust hood, microwave, kettle, toaster/toaster oven, dishwasher and dishes, cutlery and cups.

[2]Elevator machinery room is only required in multi-floor new build designs. Not required in leasehold where these spaces are in common/landlord managed areas

[3]Mechanical, Electrical and Sprinkler rooms not required in leasehold where these spaces are in common/landlord managed areas

Hospice Care Space Associated with a Long-Term Care Home

Design Objective(s)

The design objective for hospice space associated with a LTCH is to design a distinct space either within the physical LTCH structure but separate from the LTCH or in a structure physically separate from the LTCH.

The space standards for this hospice type mirror those of the Community Hospice with the exception where the hospice can share specified service space types with the existing LTCH, while meeting the requirements and to ensure LTCH resident safety, privacy and infection/prevention/control. These space types will not be required to be duplicated in the hospice space.

Table 2: Room Sizes and Requirements for Hospice Associated with a LTCH

Description of Space Type	Quantity	Area (sm) > 5 Beds	Area (sm) < 5 Beds	Requirement Conditions
Vestibule	1	7	7	Required in a structure separate from the LTCH or where outdoor entrance is required

Multi-Use Room (Spiritual/Quiet Room)	1	15	10	Required in a structure separate from the LTCH
Reception	1	12	10	
Multi-Use Room (Family Activity	1	15	10	Required in a structure separate from the LTCH
Kitchen / Pantry / Dining Room	1	28	20	Required in a structure separate from the LTCH where care model is that families and/or volunteers prepare meals for residents. Where organization prepares meals for residents, there must be space for food storage/preparation (sm TBD by organization) as well as a Pantry of 7 sn with refrigerator, microwave and sink for families to bring in and heat meals for residents
Living Room	1	28	14	
Barrier-Free Washroom	2	7	7	
Multi-Use Room (Meeting Room)	1	20	10	Required in a structure separate from the LTCH
Staff Washroom	1	5	5	Increase based on Staffing model
Staff Room	1	10	10	Increase based on Staffing model
1 Patient Bedroom with Sleeper Chair, Barrier-Free Washroom with Shower	1 Per Resident	32	32	
OR 1 Patient Bedroom with Sleeper Chair, Barrier-Free Washroom (no Shower)	1 Per Resident	26	26	
For this option, the hospice is to provide additional bathing space as follows: 1 Tub room (3-sided access)		16		

or 1 Stretcher Shower 1 Family Shower/Change Room		7		
Medication Room	1	5	5	
Clean Utility	1	12	10	
Soiled Utility	1	14	10	
Elevator Machinery Room	1	7	7	Required in a structure separate from the LTCH that is multi floor
Communications Room	1	5	5	
General Storage	1	20	10	
Mechanical Room	1	20	10	Required in a structure separate from the LTCH
Electrical Room	1	10	10	Required in a structure separate from the LTCH
Sprinkler Room	1	10	10	Required in a structure separate from the LTCH
Laundry	1	10	5	
Janitor	1	5	5	

Where hospice space associated with a LTCH is being developed that will have more than or less than 10 beds, please apply the same calculations for proportional increase/decrease of space type volumes or space type square foot allocation per the Community Hospice Space Table.

Hospice Care Space in Patient Care Unit of a Hospital

Design Objective(s):

This design and space standards for hospice care space in a Hospital is to support the conversion of a limited number of existing acute care patient rooms within an existing patient care unit of a hospital to support hospice resident/patients.

Table 3: Room Sizes and Requirements for Hospice Associated with a Hospital

Description	Quantity	Area (sm) > 5 beds	Area (sm) < 5 beds	Requirement Conditions
Multi-Use Room (Spiritual/Quiet Room)	1	15	10	
Multi-Use Room (Family activity/consultation Room)	1	15	10	**Required where there is no room available for this function on the unit**
Kitchen/Dining Room	1	30	20	**Required where there is no comparable pantry on the unit assuming that meals**

Living Room	1	30	15	**Required where there is no patient/family lounge on the unit**
Barrier-Free Washroom	2	7	7	
Multi-Use Room (Meeting Room)	1	20	10	**Required where there is no similar room in the unit**
Staff Washroom	1	5	5	**Required where there is no staff washroom on the unit**
Staff Room	1	10	10	**Required where there is no staff room on the unit**
1 Patient Bedroom with Family Area, 1 sleeper chair, Barrier-Free Washroom with Shower OR 1 Patient Bedroom with Family Area, 1 sleeper chair, Barrier-Free Washroom	1 Per Resident 1 Per Resident	32 26	32 26	
Medication Room	1	5	5	**Required where there is no room available for this function on the unit**
Clean Utility	1	12	10	**Required where there is no room available for this function on the unit**
Soiled Utility	1	14	10	**Required where there is no room available for this function on the unit**
Communication Room	1	5	5	
General Storage	1	20	10	
Laundry	1	10	10	
Janitor	1	5	5	
Elevator Machinery room (if multi-level building)	1	7	7	

[1]Elevator machinery room is only required in multi-floor new build designs. Not required in leasehold where these spaces are in common/landlord managed areas

Design Considerations

For all capital projects, it's expected that all facilities will be compliant with all National codes and standards.

Hospice Admissions Policy and Procedures

1. Purpose

1.1 To identify the criteria needed for patients whom referral to Hospice would be appropriate.

1.2 To outline the referral process through which patients gain access to services provided by Hospice.

2. Policy

2.1 This policy applies to all clinical staff employed by Hospice including all adult patients referred to Hospice. Pediatric referral service has different eligibility criteria.

3. Eligibility

3.1 To access the services, patients should fulfill the following criteria:

3.1.1 Patients should have active and progressive disease. The focus of care will be palliation of symptoms and improve quality of life. The patient life expectancy should be considered by the referring health professional as likely to be in the last 6 months of life. This can be either due to malignancy (cancer) or a non-malignant condition such as end stage heart failure, respiratory failure, renal failure or a progressive neurological condition.

3.1.2 The patient has specific palliative care needs that cannot be managed at home and relatively low in complexity that doesn't need a bed in acute palliative care unit. The care will be based on whole person centered approach, this whole-person patient centered approach focuses on quality of life, respect for patient autonomy and choice, and encompasses both the dying patient and their family. However if palliative care requirements exceed the resources of the hospice primary team a referral to specialist palliative care services will be necessary to address issues, which might be:

3.1.2.1 Physical – uncontrolled physical symptoms.

3.1.2.2 Psychological – uncontrolled anxiety or depression or other cognitive and behavioral issues.

3.1.2.3 Social – complex issues involving children, family, and careers, or complex issues relating to physical and human environment.

3.1.2.4 Spiritual – unresolved issues around self-worth, loss of meaning and hope, requests for euthanasia, or unresolved religious and cultural issues.

3.1.3 18 years and older

3.1.4 Experiencing a progressive life limiting or life threatening disease and wishes to focus on comfort and quality of life

3.1.5 The patient/surrogate decision maker has indicated that they no longer require or are benefitting from life sustaining medical treatment and agreed to end of life care.

3.1.6 Do Not Resuscitate (DNR) order is completed

3.1.7 The patient/family is not awaiting consultation for initial assessment, staging or treatment of disease. Patients waiting for palliative radiation are eligible for admission

3.1.8 Expected length of stay of approximately six months or less; exceptions may be considered

3.1.9 Wishes and agrees to transfer to hospice to receive end of life care when remaining at home is no longer possible or acute care is no longer required

3.1.10 Agrees to reassessment for alternative level of care if condition stabilizes and disease trajectory appears to exceed expected length of stay

3.1.11 The patient has been assessed by a palliative care consultant and has met all the above criteria for hospice

3.1.12 Patients care needs cannot be managed at home and should be relatively low in complexity for example:

3.1.12.4 Stable Neuraxial block management in the maintenance stage (greater than 5 days post insertion)

3.1.12.5 Stable tracheostomy care

3.1.12.6 Indwelling chest or abdominal drainage tube

3.1.12.7 BIPAP & CPAP will be assessed on an individual basis

3.1.12.8 Patients no longer receiving chemotherapy and or radiation

3.2 Patients will not be transferred to the hospice if:

3.2.2.4 He would pose a significant infection control risk to other patients or staff e.g. Active C. difficile infection or active TB in the unit where the patient is currently being cared for.

3.2.2.5 Wandering or exit seeking

3.2.2.6 Patients requiring transfusions or enteral feeding

3.2.2.7 Patients/families who pose a risk of violence or harm to self/others

3.3 All cases will be considered on an individual basis and the transfer will be arranged as soon as safe.

3.4 The referring team on the referral form should identify these issues.

4. The patients need must met the services provided by Hospice as the most appropriate agency for these services.

4.1 Referrals can be made by General practitioner, Palliative care team including Consultants, Clinical Nurse Specialists and Senior Allied Health Professionals.

4.2 In each case it is expected that the patient will have seen a specialist in the disease area for which they are referred. i.e. a respiratory physician in the case of respiratory failure or a cardiologist in the case of heart failure. A system of “shared care” will be in place so that their specialist teams (medical and clinical nurse specialist) remain involved even after referral and available for advice.

5. Referral Procedure

5.1 A Hospice referral form will be completed for each referral, filled by the referring team. Forms that omit key points will be returned. The referral will be reviewed by the interdisciplinary team of the hospice.

5.2 Once a patient has been referred to Hospice, and the referral has been accepted. The other services we offer can be provided for the patient without further recourse to the referring source. If there are doubts as to eligibility for Hospice services then the referral will be assessed by the Clinical Director before committing services.

5.3 Patients in the Community

5.3.1 This includes patients living at home, in nursing homes or residential homes.

5.3.2 The GP has primary medical responsibility for those patients. In most cases the referral will be done direct from the GP if not feedback will be required on achieving approval from the patient's GP for the intervention suggested.

5.4 Patients in Hospital.

5.4.1 The Hospital Consultant has medical responsibility for patients under their care in the hospital.

5.4.2 These patients can only be referred with the approval of the Consultant.

5.4.3 Referrals must be completed by a member of the medical team, clinical nurse specialist or senior allied health professional.

5.4.4 In case of discharge the original hospital is obligated to accept the patient if she/he in need of there services

6. Initial Assessment

6.1 The Hospice Clinical Team will respond appropriately to any request being determined by the clinical situation.

6.2 Patients will be assessed holistically either as an outpatient, in hospital or at their residence.

6.3 As part of the initial assessment the interdisciplinary team will assess the personal and cultural needs of the patient and caregiver.

7. Discharges

7.1 Criteria for Discharge - Regular caseload review will identify situations where discharging the patient from Hospice services may be appropriate.

Discharge from Hospice services may be considered in the following situations:

7.1.1 where identified goals have been achieved, or problems resolved to an acceptable level for the patient.

7.1.2 where a patient is no longer assessed as being likely to be in the last 6 months of life.

7.1.3 where the patient/SDM is declining further input at the present time or requesting discharge.

7.1.4 where another service is considered to be more appropriate to address the identified needs.

7.2 Discharge Procedure

7.2.1 Patients for whom discharge is being considered should have their details added to the agenda of the next interdisciplinary team meeting.

7.2.2 Arrangements for discharge, if possible, should be made with the agreement of the patient/SDM, involving caregiver as appropriate.

7.2.3 The member of the Hospice clinical staff making the discharge should inform the GP and other professionals involved in the care of the discharge plan and follow up appointment will be given with the original referring service.

7.2.4 If the patient is discharged to another facility hospital or hospice all his medical data should be provided to the other team and confirmation of bed availability should be received prior to patient transfer.

Index 1
Palliative Performance Scale PPSv2

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a ‘best fit’ for the patient which is then assigned as the PPS% score.

2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, ‘leftward’ columns (columns to the left of any specific column) are ‘stronger’ determinants and generally take precedence over others.

Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not ‘total care.’

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a ‘best fit’ decision. Choosing a ‘half-fit’ value of PPS 45%, for example, is not correct. The combination of clinical judgment and ‘leftward precedence’ is used to determine whether 40% or 50% is the more accurate score for that patient.

4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient’s current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

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Definition of Terms for PPS

As noted below, some of the terms have similar meanings with the differences being more readily apparent as one reads horizontally across each row to find an overall 'best fit' using all five columns.

1. Ambulation

The items '**mainly sit/lie**,' '**mainly in bed**,' and '**totally bed bound'** are clearly similar. The subtle differences are related to items in the self- care column. For example, 'totally bed 'bound' at PPS 30% is due to either profound weakness or paralysis such that the patient not only can't get out of bed but is also unable to do any self-care. The difference between 'sit/lie' and 'bed' is proportionate to the amount of time the patient is able to sit up vs need to lie down.

'**Reduced ambulation'** is located at the PPS 70% and PPS 60% level. By using the adjacent column, the reduction of ambulation is tied to inability to carry out their normal job, work occupation or some hobbies or housework activities. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

2. Activity & Extent of disease

'**Some**,' '**significant**,' and '**extensive'** disease refer to physical and investigative evidence which shows degrees of progression. For example in breast cancer, a local recurrence would imply 'some' disease, one or two metastases in the lung or bone would imply 'significant' disease, whereas multiple metastases in lung, bone, liver, brain, hypercalcemia or other major complications would be 'extensive' disease. The extent may also refer to progression of disease despite active treatments. Using PPS in AIDS, 'some' may mean the shift from HIV to AIDS, 'significant' implies progression in physical decline, new or difficult symptoms and laboratory findings with low counts. 'Extensive' refers to one or more serious complications with or without continuation of active antiretrovirals, antibiotics, etc.

The above extent of disease is also judged in context with the ability to maintain one's work and hobbies or activities. Decline in activity may mean the person still plays golf but reduces from playing 18 holes to 9 holes, or just a par 3, or to backyard putting. People who enjoy walking will gradually reduce the distance covered, although they may continue trying, sometimes even close to death (eg. trying to walk the halls).

3. Self-Care

'**Occasional assistance'** means that most of the time patients are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.

'**Considerable assistance'** means that regularly every day the patient needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush his or her teeth or wash at least hands and face. Food will often need to be cut into edible sizes but the patient is then able to eat of his or her own accord.

'**Mainly assistance'** is a further extension of 'considerable.' Using the above example, the patient now needs help getting up but also needs assistance washing his face and shaving, but can usually eat with minimal or no help. This may fluctuate according to fatigue during the day.

'**Total care'** means that the patient is completely unable to eat without help, toilet or do any self-care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to him or her.

4. Intake

Changes in intake are quite obvious with '**normal intake**' referring to the person's usual eating habits while healthy.

'**Reduced'** means any reduction from that and is highly variable according to the unique individual circumstances.

'**Minimal**' refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

5. Conscious Level

‘**Full consciousness**’ implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc. ‘**Confusion** ’ is used to denote presence of either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple possible etiologies. ‘**Drowsiness**’ implies either fatigue, drug side effects, delirium or closeness to death and is sometimes included in the term stupor. ‘**Coma**’ in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24 hour period.

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Index 2

Hospice Admission Guidelines for different disorders other than malignancies:

Pulmonary Disease

- Severe chronic lung disease
  - Disabling dyspnea at rest, poorly responsive to bronchodilators
  - FEV1 after bronchodilator < 30%
- Progression of end-stage pulmonary disease
  - Recurrent pulmonary infections
- Hypoxemia at rest, on room air: pO2 < 55mmHg - or O2 sat < 88%
- Right heart failure secondary to pulmonary disease
- Unintentional progressive weight loss >10%
- Persistent resting tachycardia

Stroke and Coma

- Karnofsky Performance < 40%
- Inability to maintain nutrition/hydration
  - Weight loss > 10%, serum albumin < 2.5 gm/dl, pulmonary
- aspiration, severe dysphagia
- Coma with any 3 of the following on day 3 of coma
  - Abnormal brain stem response
  - Absent verbal response
  - Absent withdrawal response to pain
  - Serum creatinine > 1.5 mg/dl

Cardiac Disease

- Symptomatic despite optimal treatment with diuretics and vasodilators
- Recurrent CHF
  - Ejection fraction < 20%
- New York Heart Association Class IV
- Supporting factors
  - Arrhythmias are resistant to treatment
  - History of cardiac arrest or resuscitation
  - History of unexplained syncope
  - Cardiogenic embolic disease (e.g., CVA)

Renal Disease – Acute Renal Failure

- Patient is not seeking dialysis or transplant
  - Creatinine > 8mg/dl (> 6mg/dl for diabetics)
- GFR < 10ml/min
  - Creatinine clearance <10cc/min (<15cc/min for diabetics)
- Co-morbid conditions

Renal Disease – Chronic Renal Failure

- Patient is not seeking dialysis or transplant
- Creatinine clearance <10cc/min (<15cc/min for diabetics)
  - Creatinine > 8mg/dl (> 6mg/dl for diabetics); GFR < 10ml/min
- Symptoms: uremia; oliguria; confusion; nausea; vomiting; pruritus; restlessness; hyperkalemia > 7.0, not responsive to treatment; intractable fluid overload, not responsive to treatment.

Liver Disease

- PTT > 5 seconds over control
- Serum Albumin < 2.5gm/dl
- End-stage liver disease
  - Ascites refractory to treatment
  - Spontaneous bacterial peritonitis
  - Hepatorenal syndrome
  - Hepatic encephalopathy, refractory to treatment
- Supportive factors
  - Progressive malnutrition
  - Continued alcoholism
  - Hepatocellular carcinoma

Dementia

- Functional Assessment score = 7
  - Unable to ambulate without assist
  - Unable to dress or bathe without assist
  - Urinary and fecal incontinence, intermittent or constant
  - No consistently meaningful verbal communication
- Complications such as aspiration pneumonia, UTI, septicemia, recurrent fevers

- Decubitus ulcers stage 3 or 4
- Weight loss of >10% over last six months

ALS

- Critically impaired respiratory function
    - Dyspnea at rest
    - Use of accessory muscles
    - Respiratory rate > 20
    - Reduced speech / vocal volume
    - Unexplained headaches, anxiety or nausea
- Severe nutritional insufficiency
    - Progressive weight loss of at least 5% of body weight
- With or without gastrostomy tube insertion

HIV

- CD4 count < 25 cells/mcl or persistent viral load >100,000 copies/ml
- Decreased performance status
- Supporting factors
    - Chronic persistent diarrhea
    - Persistent serum albumin < 2.5
    - Concomitant substance abuse
    - Age > 50
    - Advanced AIDS dementia complex
    - CHF or advanced liver disease.

References:

1) **National Cancer Institute Dictionary of cancer terms** https://www.cancer.gov/publications/dictionaries/cancer-terms/def/hospice
2) **Ontario Hospice Capital Program Design Standards version 1.0 June 2017** http://www.southwestlhin.on.ca/~/media/sites/sw/PDF/Capital/DesignStandards_HospiceCapitalProg_2017_07_19.pdf?la=en