North West LHIN
Regional Palliative Care Program
St. Joseph's Care Group

Guidelines for Discharge Planning for First Nations Patients Returning to Home Community for Palliative Care

These guidelines are intended to be a reference when planning discharges for First Nations patients who want to return to their home community in Northwestern Ontario for palliative care. It is recognized:

- In cases, where death is more imminent, all steps in this process may not be followed.
- There will be different barriers in communities that will make discharge impossible.
- The process for First Nations patients returning to communities in Northwestern Ontario area will be altered due to the differences in provincial structures, but the guidelines will apply. In these cases it is especially important that there is physician to physician discussion about the treatment plan.
- Verbal consent by patient to share information with key health contacts in home community has been obtained.

Procedure

1. Identify the key health contacts in home community the patient is returning to (including referring source). This may include the Nursing Station, Home and Community Care program, Community Physician, and/or Health Director.
2. **Verbal contact must be made with home community key health contacts** to make them aware that a discharge is being contemplated, and inquire about what services are available in the community. The key health contact(s) will have information about services available in the community that the patient and team will need to be aware of to begin planning.
3. Contact Home and Community Care Worker if available in the community and/or nursing station.
4. Contact Health Director and/or Community Health Representative (CHR)
5. A meeting between the hospital care team and those providing care in the home community should be held to determine if the plan to discharge to a home community is possible. Opportunities to use Telehealth for these meetings should be explored. Additional meetings may need to be held after this initial meeting.

   Attendees at the meeting need to include at least 1 person from each of the bullets below but are not limited to:
   - Patient, Substitute Decision Maker, primary caregiver at home, medical escort, and family - interpreter should be arranged
   - Hospital care team – clinical unit staff, Patient Navigator, hospital discharge planner, resource worker, palliative care, social work, PT, OT. (The participants will be based on each individual facility and who makes up the

team). Team members who cannot attend the meeting may be asked to provide their relevant information via another team member.

- Community team – Ask key community health contacts who needs to be included i.e. Home and Community Care services, Nursing Station, Health Director, MD for community, Community Health Representative, Chief, Council members, Elders, other family or community members who may care for patient at home.

Discussions must include the resources required in the community to address current and future care needs e.g. potential for bleeding or bowel obstruction.

- Identify the appropriate NIHB forms required for the planned discharge and who will complete them.
- Identify equipment, supplies, medications, and home adaptations as part of discussion.
- Identify what is in stock in the community and what needs to be ordered and how long it will take to request, approve, supply, and deliver. The patient cannot be sent home unless their medications and supplies (e.g. dressings) are confirmed to have arrived in the community and/or are being sent home with the patient.

If the discharge plan includes withdrawal of life-sustaining treatments (in the home community or before leaving the health care facility), the plan of care must be reviewed by the Most Responsible Physician (MRP) before proceeding with further discussions.

There may be factors identified during discharge planning that may make discharge to home community challenging, but the community may be able to address some of these issues if planning is done in advance. These issues may include but are not limited to:

- Inability to provide an environment where medications can be safely stored
- Family/caregivers are not able to meet care needs and/or problem solve when issues arise
- Consensus cannot be reached among caregivers (professional and family with care plan and/or goals of care
- Environmental factors that will not support care needs e.g. running water, electricity, heating source (wood stove), overcrowding in home

If there are concerns regarding the feasibility of the discharge, these must be raised and addressed by members of the care team and community team before proceeding.

IMPORTANT: Detailed NIHB forms need to be filled out accurately in order to be approved quickly. For assistance with NIHB forms contact NIHB Navigator.

Items that need to be discussed during the meeting include, but are not limited to:

- Equipment – what equipment will be required in the home and who will be responsible for arranging. Suppliers must be NIHB approved (see Appendix). Are there alternative options for accessing equipment that is needed but is not covered by NIHB? Does the home have room to accommodate equipment such as stretchers/hospital beds?
- Oxygen – (if needed) what will be required and who will be responsible for arranging – including obtaining needed approval. Will also need to include safety precautions such as presence of wood burning stoves – are there alternatives for heating?
- Medications – Palliative Care Physician or Most Responsible Physician will be responsible for ordering, dispensing, obtaining necessary approval, education, storage and disposal. Pharmacy must be NIHB approved.
  - Patients should be sent to the community with medication and explicit instructions on how to administer and get more medication when needed.
  - It is essential that the hospital pharmacist, MD, or RN reviews list of discharge medications with pharmacy provider prior to finalizing care plan to confirm availability, approvals required, and timelines for delivery. This is especially important if the patient requires medications that need to be compounded or are not on the FNIHB Palliative Care Drug Formulary (http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/med-list/palliat-eng.php)
  - If medications are not on the formulary, an application for exceptional drug status form needs to be completed and sent to Ottawa before medications can be dispensed. The pharmacy provider can assist with this process.
  - Safe storage of medications dispensed in the home is important. Team should explore the ability of the nursing station/ community health centre to store, prepare and dispense medications as needed.
- Home care services– what services are available in the community and who will be providing.
- Medical care – which physician or physician organization provides medical care in the community – and how to share pertinent information with them.
- DNR-C once completed
  - Identify parties that should receive a copy. e.g. nursing station or Community Health Centre, OPP and/or Community police service

(NAPS, Treaty#3), First Responders, Crisis Workers, Band Council, Provincial Medical Examiner's office, funeral home if applicable
    - Make sure that someone in the community has taken responsibility to inform appropriate providers identified above of the expected death
- Advance Care Planning – identify if it has been done and who is aware of it. Ensure that the Substitute Decision Maker(s) is clearly identified.
- Transportation to home in community
    - Timing of transportation to the community is often not predictable as it will be dependent on necessary medical equipment in home and community
    - Medical Transportation arrangements are made through NIHB. Contact NIHB Medical Transportation:
        - ❖ Sioux Lookout Zone Communities: 1-807-737-5080/5081/5082
        - ❖ Thunder Bay Zone Communities – 807-343-5390 (phone); 807-343-5308 (fax)
        - ❖ NIHB Fort Frances – 807-274-7771; 807-274-4285 (fax)
        - ❖ NIHB Kenora – 807-468-8961; 807-468-6257 (fax)
        - ❖ NIHB Geraldton 807-854-0383; 807 854 1907 (fax)
        - ❖ Wequedong Lodge – 807-625-6039 (phone); 807-622-5160 (fax)
        - Hospital discharge planner will contact key community health contact(s) to make sure they are aware that the patient is returning.
        - NIHB will need information about the physical health status of the patient to determine the most appropriate form of transport and if anyone is traveling with the patient as an escort.
            - ❖ If patients are able to travel by commercial airlines, NIHB will make arrangements.
            - ❖ If patient is not able to travel on commercial airline, Hospital will make arrangements for transfer via Medivac. If Medivac is required –the transport will not be confirmed more than 24 hours in advance. (Case by case situation as not usually covered by OHIP or NIHB).
        - Ornge will contact the sending facility to confirm the level of care that will be needed during the flight including:
            - ❖ The need to administer medications during transport
            - ❖ If oxygen is required the aircraft may need to be pressurized during the flight to conserve oxygen supplies.
            - ❖ Consideration should be given the possibility of a delay or interruption in the transfer of the patient to their

community e.g. bad weather, mechanical issues. Confirm who will be responsible for care in such circumstances with the transportation company and the local community.

- ❖ In some cases, it will be necessary to discuss the possibility that death could occur during transport. This should to be discussed with family and the transportation company. Transportation will need to be arranged on the ground in the community
- ❖ NIHB will contact the community once the flight is confirmed.

- Travel may not end with arrival at community airport. Patients may have to travel a considerable distance after arrival and discussions need to take place regarding who will provide care, including administration of medications, during this second phase of transport. If ground transportation is required in the community, the key community health contact will be responsible for making these arrangements. Some communities have medical vans available for transportation within the community who may pick the patient up at the airport. Information regarding patient's special needs e.g. need for stretcher, wheelchair, oxygen, etc. must be discussed with the community in advance.

- <u>Transfer to a health care facility in a community</u>
  - NIHB will not cover transportation costs to another health care facility
  - If patient is returning to a facility within the community, the sending facility should contact the receiving facility.
  - If a patient is returning to another hospital – the sending facility will make transportation arrangements.

- <u>Care at time of death</u>
  - Who will provide care and handling of body after death. This is decided by the community and may be different in each community.
  - Does the community use the services of a funeral home or do they do preparation of the body for burial in the community.
  - Notification of community physician to sign death certificate. Community nurse can pronounce but community physician will need to sign death certificate.
  - Notification of provincial medical examiner
  - Notification of first responders or local law enforcement agency
  - How to dispose/return medications
  - Availability of Nursing Station/Community Health Centre staff

Discussions during the meeting should be documented and shared back with all involved in the meeting.

6. If discharge to the home community is planned, a care plan should be developed in consultation with the care team in the community. The care team in the community may include representatives from: Home and Community Care services, Nursing Station, Health Director, MD for community, Chief, Council members, Elders, Community Health Representative, other family or community members. If the patient is returning to a community adjacent to a reserve, it will be essential to clarify who is providing services/care in the home – community team or CCAC.

The care plan developed should contain information on the following:

- Pharmacologic management of symptoms (current and anticipated)
  - List of medications prescribed on discharge
  - How and when to administer scheduled medications
  - How and when to administer breakthrough or prn (as needed) medications
  - Plans for storage, dispensing and preparation of medications.
- Non-pharmacologic strategies for management of symptoms
- How to meet other care needs
  - ADLs
  - Catheters
  - Dressings
  - Feeding/hydration/nutrition
- What to expect as illness progresses
  - Potential for symptoms such as seizures, bleeding, bowel obstruction, respiratory obstruction
- Contact information for team members including
  - Palliative care team who will be available for consultation once patient reaches the home community.
  - Physician providing care (MRP)
  - Home and Community Care team, Nursing Station, Community Health Centre, Health Director, Community Health Representative
  - OPP, NAPS or local law enforcement and first responders
  - Band council

Once completed the care plan should be shared with:

- Patient, Substitute Decision Maker, primary caregiver, and family
- Nursing station and/or Community Health Centre staff
- Home and Community care staff
- Physician designated to provide care for the community
- Community Palliative Care team
- Any other specialist or provider involved in the patient care

7. Determine who will support the community team and arrange conference calls/telemedicine consultations to support the community team while care is being provided and after the patient has died. The frequency of calls will vary depending on the condition of the patient but the initial appointment should be made at the time of completion of the care plan.
    a. A 24/7 Palliative Care Consultation Phone Line is available for support and guidance to healthcare providers – 1-844-343-2476.
    b. The Regional Palliative Care Program/SJCG Palliative Care Telemedicine Nurse Consultant is a resource to facilitate ongoing consultation. She can be reached at 1-844-343-2476.
    c. Renal Program
    d. Cancer Centre

8. Physician follow up
   The attending physician should contact the receiving physician (or community physician/Most Responsible Physician) to transition the medical plan of care immediately prior to transfer to the community. Refer to the hospital's Transfer of Responsibility policy.