Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

Palliative Care Program
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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 Manitoba 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 outside Manitoba will be altered due to the differences in provincial structures, but the guidelines will generally apply. In these cases it is especially important that there is physician to physician discussion about the treatment plan.

Procedure

1. Contact should be made with nursing station in the home community to make them aware that a discharge is being contemplated. The nursing station staff will have information about services available in the community that the patient and team will need to be aware of to begin planning.

2. A meeting between the facility 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.

   Attendees at the meeting may include, but are not limited to:
   - Patient and family – interpreter should be arranged Facility care team – clinical unit staff, aboriginal health services discharge coordinator, palliative care, social work, PT, OT.
   - Community team – Home and Community Care services, Nursing Station/Community Health Centre staff, MD for community, Band Representative, Elders

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

If the discharge plan includes withdrawal of life-sustaining treatments (in the home community or before leaving WRHA), the plan of care must be reviewed by the Palliative Care Program management team before proceeding with further discussions.

There may be factors identified during discharge planning that may make discharge to home community impossible. These 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

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

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
- 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
- Medications – identify who will be responsible for ordering, dispensing, obtaining necessary approval, education, storage and disposal.
    - Patients should be sent to community with medication and explicit instructions on how to administer and get more medication when needed.
    - It may be helpful to review list of discharge medications with pharmacy provider prior to finalizing care plan. 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/pubs/nihb-ssna/_drug-med/2016-prov-fourn-guide/index-eng.php#a27)
    - 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 and/or FNIB Pharmacist can assist with this process and with problem solving.
    - 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 – how to share pertinent information with them
- Law Enforcement Agency - Information about which agency provides law enforcement in the community (RCMP or aboriginal police force)
- Letter of Anticipated Death (LAD) – once completed –identify parties that should receive a copy. e.g. nursing station or Community Health Centre, RCMP and/or aboriginal police service, Band Council, Provincial Medical Examiner's office, funeral home if applicable.
- Health Care Directive-if in place and who should receive copies
- Transportation to home in community
    - Timing of transportation to the community is often not predictable as it will be dependent on the availability of equipment.
    - Transportation arrangements are made through FNIHB. Contact FNIHB Medical Transportation Unit (TRU) @ 1-877-9830911 or 204-984-4773.
        - FNIHB will contact nursing station to make sure they are aware that the patient is returning
        - FNIHB will need information about the physical health status of the patient to determine the most appropriate form of transport.
            - ❖ If patients are able to travel by commercial airlines, FNIHB will make arrangements.
            - ❖ If patient is not able to travel on commercial airline, FNIHB will make arrangements for transfer via Medivac. If Medivac is required –the transport will not be confirmed more than 24 hours in advance. TRU may also require a letter from a physician indicating the need for Medivac services.
        - MTCC 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. HCD/ACP should to be in place and reviewed with transport team.
- ❖ FNIHB will book ground transportation in WRHA using licensed transport providers
- ❖ FNIHB 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 to provide care, including administration of medications, during this second phase of transport. If ground transportation is required in the community, FNIHB will be responsible for making these arrangements.

- <u>Transfer to a health care facility in a community</u>
  - FNIHB will not cover transportation costs to a health care facility
  - If patient is returning to a facility within a Rural Health Region, the sending facility should contact the receiving facility. The receiving facility will then contact the Manitoba Transportation Coordination Centre (MTCC) to make arrangements for transportation to facility. Once arrangements are made, the receiving facility will notify the sending facility. The receiving RHA will pay the transportation costs. Negotiations will then take place between the region, province and FNIHB regarding payment.
  - If a patient is returning to a federal facility – Norway House or Percy Moore (Peguis) the sending facility will make transportation arrangements and pay the transportation costs. Once paid, a copy of the invoice should be sent to WRHA Regional Director of Transportation for tracking purposes.

- Care at time of death
    - Who will provide care and handling of body after death
    - Does the community use the services of a funeral home or do they have burial on site
    - Notification of provincial medical examiner - LAD
    - Notification of local law enforcement agency – LAD
    - How to dispose/return medications
    - Availability of Nursing Station/Community Health Centre staff

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

3. If discharge to the home community planned, a care plan should be developed in consultation with the care team in the community. The care team in the community must include representatives from: Nursing Station and /or Community Health Centre, and Community Care team. 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 regional health authority home care.

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
    - WRHA Palliative Care Program – palliative care team will be available for consultation once patient reaches the home community.
    - Physician providing care
    - Home and Community Care team, Nursing Station, Community Health Centre,
    - Regional Palliative Care Coordinator
    - RCMP and local law enforcement

- Band council

Once completed the care plan should be shared with:

- Patient and family
- Nursing station and/or Community Health Centre staff
- Home and Community care staff or Regional Home Care program staff
- Physician designated to provide care for the community
- WRHA Aboriginal Health Services
- WRHA Palliative Care team and Rural Palliative Care Coordinator

4. Follow up conference calls/tele-health should be scheduled to support community teams 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.

5. Physician follow up
   The attending physician should contact the receiving physician (or physician organization) to transition the medical plan of care immediately prior to transfer to the community. Information for ongoing consultation with WRHA Palliative Care program should be included in this transition meeting.