Policy Name:	Policy Number:
TRANSITION FROM AGAPE HOSPICE	**0112**
	Effective Date: **MAY 5, 2010**
Approved By: Executive Team	Date Revised: October 22, 2021
Reason for Revision: Click on item below and select item from list. **CONTENT- Enter BELOW Reason for change Ex: Combined Policy ## and ##.** New format being used. Changed wording from Care Program Coordinator to Social Worker. Changed the Procedure steps.	Next Date for Review: October 22, 2024
Section: Section 01 - Delivery of Care to Residents and Families	Page No: **Page 1 of 4**

Policy

The Salvation Army Agape Hospice provides individual end-of-life care. Admission to Agape Hospice is based on the criteria outlined in Admission to Agape Hospice, Policy 0108 – *Admission to Hospice*. Following admission to Agape Hospice, it is possible for a resident's condition to "stabilize," where their symptoms are adequately controlled on an established regime and their life expectancy is now greater than initially expected. These residents will be assessed on an individual basis to ensure they receive the most appropriate care in the most appropriate setting. If, after admission to Agape Hospice, the resident's care needs are assessed as being better met in an alternate care setting, Agape Hospice will initiate the transition to another location. Alternate care settings may include long term care facilities or other facilities, such as assisted living or a home environment. Transition from Agape Hospice must be handled in a sensitive, caring manner; transitioning out of the hospice environment can cause great stress to resident and family members. The team must be sensitive to resident/family needs and allow time needed for adjustments and concerns to be addressed.

REQUIRED FORMS AND EQUIPMENT REFERENCES

Electronic forms location – FORMS
Hardcopy forms location – Work area file cabinet.

- Transition Services-Hospice Referral Check List Form
- AHS Transition Services Transfer Worksheet
- Discharge Summary
- Medical Assessment form
- AHS, New Referrals to Palliative Home Care (PHC) from Hospice algorithm
- AHS Home Care Community Referral Form
- Hospice to Palliative Home Care Checklist
- Best Possible Medication History form
- AHS Hospice Transition Guidelines: Transitions to an Alternative Level of Care

CROSS REFERENCES

Policy # 0108 - Admission to Hospice
Policy # 0179 – Medication Reconciliation

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Procedure

1. When the resident may meet any of the following criteria, the IDT will discuss the resident's potential transition:

a. A self-expressed desire to return home or to another level of care.
b. Improvement and/or stabilization of the patient/resident's condition so that transitioning to an alternate level of care could meet current care needs as evidenced by:
    i. Stable or improving weekly PPS for four consecutive weeks
    ii. Stable or improving weekly POS for physical symptoms for four consecutive weeks
    iii. Stable intake (oral or via peg-tube)
c. Ability of alternate level of care to manage physical, medical, psychosocial and spiritual needs when prognosis is anticipated to be greater than weeks to months.
d. Requirement of a level of care that cannot be supported in the hospice setting, at the discretion of the inter-professional care team.
e. Requests for a level of care that cannot be supported in the hospice setting, by the resident or alternative decision maker.

2. If there is disagreement among the IDT members, the Medical Director can provide medical guidance. In situations where the decision for transition is unclear, a palliative consult should be requested. If the decision for transition remains unclear an organizational or AHS ethics consult should be requested via Nursing Lead or AHS Hospice Access and Operations.

3. The transition process will be activated with IDT members' agreement followed by Nursing Lead or Social Worker's sending the "Transition Services-Hospice Referral Check List Form" and its required documents to the Transition Services Coordinator. Nursing Lead will notify AHS Hospice Operations Manager.

4. The Physician will have the initial conversation regarding the potential transition and options with the resident, family and/or health advocate. Social Worker may receive a referral to address their concerns or questions. The physician's initial conversation may be offered during the above noted 4 weeks.

5. AHS Transition Services Coordinator will arrange a family conference. RAI assessment may be conducted at the same time. The resident's name will be placed in the LTC or assisted living wait list based on the RAI assessment and the conversation of the family conference. The wait list date will be back dated to the hospice admission date.

6. Transition Services Coordinator will communicate with the resident/family, hospice and receiving site when a bed becomes available.

TRANSITION TO SUPPORTIVE / FACILITY LIVING

1. Nursing Lead or Social Worker will follow the process and algorithm, Process of Referral from Hospice to Transition Services for Supportive/Facility Living set by AHS.

2. Social Worker will receive AHS Transition Services Transfer Worksheet from the Transition Services Coordinator and provide it to the Nursing Lead.

3. The Nursing Lead will contact the Attending Physician (or designate) to request a discharge order including discharge medications (ie) “Discharge to continuing care on current medications”. The Nursing Lead (or designate) will then complete the medication reconciliation.

4. The Attending Physician (or designate) will complete the Discharge Summary prior to the resident’s transfer and provide discharge medication orders.

5. A “Best Possible Medication History” (current and historical) will be completed based on the WellNet medication list obtained at the time of admission, Medication Reconciliation completed on admission, Agape Hospice Physician Order forms, and the current Medication Administration Record (MAR).

6. The Nursing Lead will ensure that all the necessary information, as indicated on the Hospice to Supportive/ Facility Living Information Transfer Checklist form, is prepared prior to the transfer. Direction will be given to the Unit Clerk to schedule transport for the resident.

7. The Nursing Lead or Social Worker will establish the date of transfer in consultation with the receiving facility. The Unit Clerk will book transportation with the ambulance if necessary. The family may choose to transport the resident in their vehicle. Date and time of transfer will be noted in the resident’s progress notes and on the report board.

8. On the day of transfer to the care facility, the Nursing Lead will ensure the Hospice to Supportive/ Facility Living Information Transfer Checklist form is completed; and that all information, medications, equipment and belongings are sent with whoever accompanies the resident. A verbal report will be given to the receiving facility and noted in the progress notes.

9. The Social Worker will make arrangements for a “good-bye” cart to be available in the resident’s room on the date of transfer, allowing resident/family and staff time to say goodbye.

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TRANSITION TO HOME ENVIRONMENT

1. Wish of discharge may be expressed by resident/family, or discharge is discussed by IDT Team if the resident does not required hospice level of care.

2. Discharge and its feasibility are discussed by IDT Team. IDT Team may receive the consultation of Home Care Manager, and Discharge Planning Meeting may be arranged if needed.

3. If a resident is being transferred to a home environment, the Nursing Lead or Social Worker will follow the process and algorithm, New Referral to Palliative Home Care (PHC) from Hospice, set by AHS.

4. Nursing Lead or Social Worker will send the Home Care Community Referral Form to AHS Community Care Access.

5. The Unit Clerk will prepare the information as indicated on the “Hospice to Home Information Transfer Checklist”.

6. The Nursing Lead will ensure that the “Best Possible Medication History” form is completed.

7. The Attending Physician (or designate) will complete the Discharge Summary and provide discharge medication orders.

8. On the day of discharge the Nursing Lead will ensure that the Hospice to Home Information Transfer Checklist is completed and all necessary information, medications, belongings and equipment are sent with the Resident.

9. The Social Worker will make arrangements for a “good-bye” cart to be available in the resident’s room on the date of discharge, allowing resident/family and staff time to say goodbye.