HOSPICE
NORTHWEST

Who We Are

Hospice Northwest is an incorporated non profit charity, which is governed by a volunteer Board of Directors and employs a small core staff. Hospice Northwest has been operating in Thunder Bay and area since 1987. The organization was founded with the sole purpose of providing compassionate support to persons living with a life limiting illness and their caregivers. Services through the District of Thunder Bay are provided primarily by volunteers, congruent with provincial and national standards of practice. The organization is a member of the Hospice Association of Ontario, the Canadian Hospice Palliative Care Association and the Ontario Palliative Care Association. All services conform to the standards developed by these organizations.

Hospice Northwest has six satellite offices with the Thunder Bay District, offering services to residents of the Terrace Bay/Schreiber area, Marathon, Manitouwadge, Nipigon, Longlac, Nakina and Geraldton. Throughout the District of Thunder Bay, services may vary according to community.

Client centered services are offered with the goal of enhancing the quality of life. Volunteers from all walks of life are given specialized training to be an integral part of the interdisciplinary teams that provide holistic, and hospice palliative care.

Trained volunteers provide support in the home, hospitals and long term care facilities, at no cost to the individual or family. This support is available to persons who are ill family members and friends, as well as bereaved persons who have experienced the death of a loved one.

Hospice Northwest Mission Statement

The mission of Hospice Northwest is to assist people living with a life limiting or chronic illness to experience a sense of connectedness, community and support through companionship.

MANITOUWADGE
FAMILY HEALTH TEAM

1 Health Care Crescent Manitouwadge, ON P0T 2C0

Tel: (807) 826-3174 Fax: (807) 826-3185 email: mfht.info@mfht.ca

For Hospice Northwest Volunteers: Clients are required to keep this form up to date and posted in an accessible area for easy reference

Client Emergency Contact Sheet:

Contact Name/Address:	Work Phone #:	Cell Phone #:	Pager #:

Other Directions in case of Emergency:

DNAR

☐ **NO**

☐ **YES** **Location:** _____

☐ **Call 911**

☐ **Do Not Call 911. Instead, do the following:**

Other Special Instructions:

HOSPICE
NORTHWEST

Application and Consent Agreement for Service

Client Name: _____

Name of Power of Attorney for Personal Care (if applicable)_____

I, _____, hereby apply to HOSPICE NORTHWEST for the services of a HOSPICE NORTHWEST volunteer for myself/for _____ (client).

In consideration of the acceptance of my application, I acknowledge that I understand and agree to the following:

1. I understand that HOSPICE NORTHWEST volunteers are screened and trained to provide compassionate, emotional, social, and spiritual support. This is in accordance with the Ministry of Health definition of a Hospice volunteer.

2. I agree to work together with the staff from HOSPICE NORTHWEST to determine what type of support and which services I will receive. These services will be reviewed from time to time and updated as necessary. I understand that I have the right to request changes to my service plan or to my service provider(s) by contacting the Hospice Northwest Volunteer Coordinator or Executive Director. I understand that I have the right to give or refuse consent, at any time, to services provided by HOSPICE NORTHWEST.

3. I agree to be contacted by HOSPICE NORTHWEST on a monthly, or bimonthly, basis (depending on the frequency of volunteer visits) so that I can discuss my satisfaction with the services HOSPICE NORTHWEST is providing me with.

4. Visits will be scheduled at such times that are agreed upon by my volunteer and myself. Should I be unable to meet with my volunteer at an agreed upon time, I will make sure that my volunteer is notified.

5. My volunteer is not trained to provide me with homemaking or nursing care services. I will not request my volunteer to provide such services.

6. My volunteer is not permitted to accept gifts other than things which can be consumed, or plants. I will not offer a gift to my volunteer.

7. I understand that information about advanced care planning is available to me through Hospice Northwest.

8. My relationship with my volunteer and with HOSPICE NORTHWEST is a confidential one. The confidentiality owed to me by my volunteer and by HOSPICE NORTHWEST does not extend to information received, from any source, that I may intend to harm myself.

At my first meeting with my volunteer I will provide my volunteer with a list of emergency phone numbers and directions to follow in case of an emergency, which I will update whenever necessary. I understand that:

- 911 will be called if the directions provided are incomplete or do not apply to the particular medical emergency that I am experiencing.
- HOSPICE NORTHWEST staff and volunteers are unable to determine the nature of medical emergencies or provide treatment.

Release of Information

Any personal information that is collected by HOSPICE NORTHWEST will only be used for the preparation, delivery and evaluation of the service being provided by HOSPICE NORTHWEST staff and volunteers. HOSPICE NORTHWEST will not share any personal information for any other reason. In order to respect the privacy of clients, HOSPICE NORTHWEST staff and volunteers, who will have access to my personal information, have agreed in writing to protect the privacy of this information.

Members of the health care team with whom we may share information for the above reasons, include:

- Community Care Access Centre
- Home Care Nurse(s)
- Personal Support Worker(s)
- Social Worker
- Occupational Therapist/Physiotherapist
- Any other institution or government agency if required by statute or regulation

Waiver

I understand and accept the conditions outlined in this agreement. I will not hold HOSPICE NORTHWEST responsible for demands, damages, costs, expense, actions and causes of action, in respect of death, injury, loss or damage to myself or my property, however it is caused, that comes out of, or is in any way connected to the services I receive through HOSPICE NORTHWEST.

DATED at Thunder Bay this __ day of ___, 2011.

_____ _____

Client or Power of Attorney for Personal Care Date

_____ _____

For HOSPICE NORTHWEST Date

HOSPICE NORTHWEST

1Health Care Crest, Manitouwadge, ON P0T 2C0 • Tel: 826 3174 • Fax 826 3185
Trena Roberts: t.roberts@mfht.ca • Website: www.hospicenorthwest.ca

HOSPICE NORTHWEST PALLIATIVE CARE SERVICES REFERRAL FORM

***IMPORTANT**--It is necessary for the client, or the client's Power of Attorney (POA), to give consent before a referral can be made to Hospice Northwest.* ☐ *Consent given by client* ☐ *Consent given by POA*

Date of referral: Year ..... Month ..... Day .....

Name/Employer of referring person: .....

Phone number: .....

LOCATION:

☐ Thunder Bay ☐ Nipigon ☐ Marathon ☐ Longlac

☐ Geraldton ☐ Terrace Bay/Schreiber ☐ Manitouwadge

CLIENT INFORMATION:

Name of client: .....

Client's date of birth: Year..... Month..... Day.....

Is client Indigenous? ☐ Yes ☐ No

Client's residence (street address, or facility unit and room number): .....

.....

Client phone number: .....

Client Diagnosis/Medical Precautions: .....

.....

.....

Prognosis: .....

Is client aware of diagnosis and prognosis? ☐ Yes ☐ No

Is client ambulatory? ☐ Yes ☐ No

Palliative Performance Scale Score (see attached): .....

Client history (work, hobbies, activities, etc): .....

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Does religion play a significant part in the client's life? ☐ Yes ☐No

If yes, please state religion: .....

Is English the first language of the client? ☐ Yes ☐ No

If not, please state language of preference: .....

CAREGIVER INFORMATION:

Name of primary caregiver or Power of Attorney (POA): .....

Phone number and address of caregiver or POA: .....

.....

Additional family information: .....

.....

VISITING HOSPICE SERVICES INFORMATION:

Type of volunteer requested: ☐ Male ☐ Female

Best time for visit: ☐ During the day ☐ Evenings ☐ Weekends

Any important additional information : .....

.....

.....

Palliative Performance Scale (PPSv2)

How to do the PPS:

The PPS score is determined by reading horizontally at each level to find the "best fit" for the patient. Leftward columns are "stronger" determinants, thereby taking precedence over others.

1. Begin at the left column until the appropriate ambulation level is found
2. Read across to the next column until the correct activity/evidence of disease is located
3. Read across to the self-care column, intake and conscious level columns before assigning the PPS score to the patient

Making "Best Fit" Decisions:

- Only use the PPS in 10% increments (e.g., cannot score 45%)
- Sometimes one or two columns seem easily placed at one level but one or two columns seem better at higher or lower levels. In these cases, use your clinical judgment and the leftward dominance rule to determine a more accurate score the patient.

PALLIATIVE PERFORMANCE SCALE (PPSv2)

PPS Level	Ambulation	Activity Level And Evidence of Disease	Self-Care	Intake	Level of Consciousness
100%	Full	Normal activity and work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity and 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	Can't do normal job or work Significant Disease	Full	Normal or reduced	Full
60%	Reduced	Can't do hobbies or housework Significant disease	Occasional Assistance Needed	Normal or reduced	Full or Confusion
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable Assistance Needed	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	Minimal or sips	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal or 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	-	-	-	--

Adopted from the Victoria Hospice Society, 2006.
www.victoriahospice.org/health-professionals/clinical-tools