POLICY & PROCEDURE NUMBER:
DEPARTMENT: *Nursing* **SUBJECT:** *Palliative and End-of-*Life *Care*

APPROVAL DATE: May 2014 REVISION DATE: Oct. 2019; April 2022; Nov. 2022
REVIEW DATE: Dec 2020; March 2023

PURPOSE:
To provide residents with quality palliative and end-of-life care in a manner that meets their assessed physical, emotional, psychosocial, social, cultural and spiritual needs.

To make available and/or provide, based on assessed needs and resident/Substitute Decision Maker (SDM) consent, palliative care options including, but not limited to:

- Quality of life improvements
- Symptom management
- Psychosocial support; and,
- End-of-life care, if appropriate

PROCEDURE: The brochure "Don't be surprised when we ask" will be included in the acceptance letter sent to all residents on the wait list for the home.
All new residents should have an assessment completed to determine their palliative care requirements, plan of care and symptom interventions. Assessment will include clinical indicators specifically related to declining health status (SPICT), the Palliative Performance Scale (PPS) and the Palliative and End-of-Life clinical support tool. When using the PPS and Edmonton Symptom Assessment Scale (ESAS) the score should be recorded within 7 days of admission, upon readmission from hospital or significant change in status. The ESAS should be completed, preferably, by the resident. If resident is not able to complete the ESAS it should be completed by a family caregiver or by the resident with assistance from the care provider. The Dementia Progression Tool - Functional Assessment Staging (FAST) is designed to evaluate residents at the more moderate-severe stages of dementia. For this resident population, the FAST tool would replace the PPS. PPS, ESAS and FAST scores should be entered into the resident PPS/ESAS/FAST Record Flow sheet. Refer to Palliative Performance and Edmonton Symptom Assessment Scale policy and procedures.

Palliative Care/End-of-Life Assessments should be reviewed on a regular basis as per policy.
The "TRC Palliative and End-of-Life CST (non-system)" assessment shall be completed for any resident who has a significant change in status, a new admission, or any resident who has a PPS score of 40% or less.

<u>Palliative Care:</u>

Palliative Care aims or strives to:

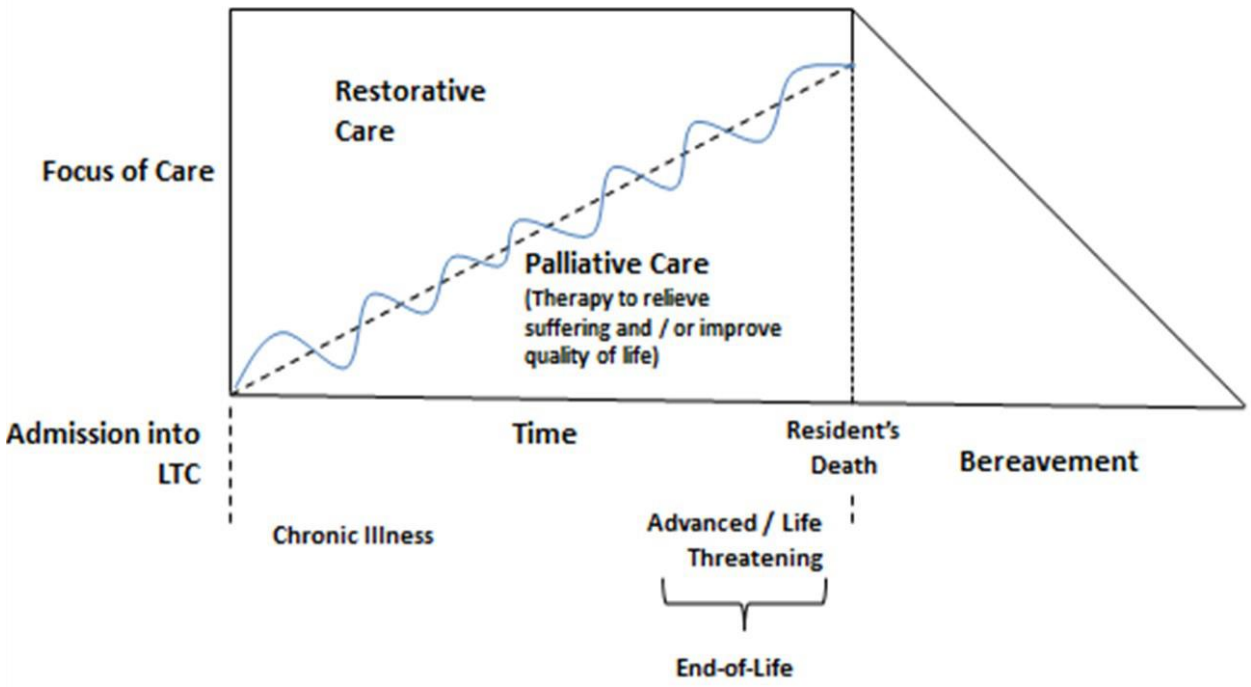
- Relieve suffering
- Improve the quality of living and dying

- Help residents and families to address holistic issues
- Address expectations, needs, hopes and fears
- Prepare for and manage self-determined life closure
- Prepare resident and family for the dying process
- Assist residents to cope with loss and grief during the illness and bereavement
- Treat all active issues and prevent new issues from occurring
- Promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization

Palliative Care: (continued)

- Complements and enhances restorative care and in later stages may become the total focus of care
- Appropriate for any resident and family living with, or at risk of developing a life-threatening illness due to any diagnosis, any prognosis, regardless of age, at any time they have unmet expectations and/or needs and are prepared to accept care
- Palliative care can complement restorative care
- Palliative care is appropriate only when the resident and/or family, however defined by the resident, are ready to accept this type of care
- Early communication to residents and families regarding palliative care and care goals is essential prior to introducing palliative care goals within the care plan. This supports

resident and family understanding of the resident's disease trajectory.



(Adapted from CHPCA, 2002)

- This picture was adapted from the Canadian Hospice Palliative Care Model to better depict the trajectory of residents living in long term care homes
- The bottom axis of the model shows the period of time a resident lives in long term care
- The side axis shows the focus of care through the resident's stay. When a resident moves into long term care, he/she may have palliative care goals of care but will primarily have restorative goals of care
- As the resident lives in long term care he/she will continue to change goals of care from restorative to palliative, however, these goals are complementary and do not take away from each other
- End-of-life care is the last phase section of palliative care before the resident dies
- After the death of a resident, there is a bereavement stage for families, residents and staff members

Palliative Approach Assessment:

1. Would you be surprised if the resident died within the next year?
2. Have there been hospital admissions recently?
3. Are there distressing physical or psychological symptoms?
4. What are the goals of care?
5. What is the resident's/family's understanding of the disease processes, prognosis, and treatment options?
6. Are there significant social or spiritual concerns affecting daily life? (Limited social support)
7. Has resuscitation been discussed?

Criteria:

- The "surprise question" has been answered "no" (Would you be surprised if the resident died within 12 months?)
- Difficult to control physical or psychological symptoms and more than one admission to hospital in the last several months
- Complex care requirements
- Decline in function, food and fluid intake, and unintended weight loss
- Cognitive impairment
- Disease specific markers (SPICT) and palliative performance scale

After completing the palliative approach assessment the team can determine if the resident can benefit from a palliative approach. If it is decided that, "yes the person would benefit", a conversation should take place with the team, family and resident (if possible). It is important to note that conversations with residents and families should be non-threatening. Residents and families must also agree that palliative care planning is appropriate or this approach should not continue.

Care planning is done around the resident's decisions for treatment options, with an emphasis on comfort and quality of living while maximizing medical management of the disease process.

Both non-pharmological options (e.g. equipment, supplies, devices, assistive aids or positioning aids) and pharmological options may be considered based on resident assessed needs/condition.

The care plan will be adjusted as there are changes in health status and in collaboration with all members of the resident's health care team, especially the resident and family/SDM. This approach will enable the team to respond to changes and health care crisis more proactively and affect a more acceptable transition to end-of-life care at the appropriate time.

Definition of End-of-Life Care

End-of-Life Care is the third stage of the Palliative Performance Scale (PPS) that categorizes a resident's functional level between 20-0% on the PPS scale. End of life care emphasizes the last days and hours of life. Level of functioning appears to be the most important indicator of prognosis.

End-of-Life Care

- Multidisciplinary, holistic, resident-centred
- Still focuses on symptom management
- Treatment goal to relieve suffering and maintain comfort
- The focus remains on supporting resident and family informed choices
- Recognizes and supports the grief process
- The resident's health status has changed to a stage where medical management is maximized and death has become inevitable and the PPS is 20% and declining

The palliative care program shall be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

References:
Canadian Hospice Palliative Care Association (CHPCA) – A Model to Guide Hospice Palliative Care
College of Nurses of Ontario (CNO) – Guiding Decisions about End-of-Life Care Practice Guideline
Pallium Pocket Guide (2013)
Administration Policy 4.8 Annual Program Evaluation
Fixing Long-Term Care Act, 2021; ON Reg. 246/22 Section 61