

**HOSPICE PALLIATIVE CARE/End-of-Life Care PROGRAM
FOR LONG TERM CARE
Generic**

The Hospice Palliative Care Program of _____ has adopted the Canadian Hospice Palliative Care Association's definition of palliative care. (March 2002) *

"Hospice palliative care aims to relieve suffering and improve the quality of living and dying.

Hospice palliative care strives to help residents and families:

- Address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears
- Prepare for and manage self-determined life closure and the dying process
- Cope with loss and grief during the illness and bereavement.

Hospice Palliative care aims to:

- Treat all active issues
- Prevent new issues from occurring
- Promote opportunities for meaningful and valuable experiences, personal and spiritual growth and self-actualization."

The Hospice Palliative Program of _____ believes:

- That the assessment, coordination and ongoing monitoring of terminally ill residents will be more intensive and specialized than for other individuals.
- That palliative care is best provided by an interdisciplinary team of healthcare providers who are both knowledgeable and skilled in all aspects of the caring process related to their discipline of practice.
- That the resident and family are part of the interdisciplinary team.

The Philosophy of the Hospice Palliative Care Program

In the provision of hospice palliative care services at _____, the staff recognizes and supports the following values:

1. The intrinsic value of each person is an autonomous and unique individual.
2. The value of life, the natural process of death, and the fact that both provide opportunities for personal growth and self-actualization.
3. The need to address residents' and families' suffering, expectations, needs, hopes and fears.
4. Care is only provided when the resident and/or family is prepared to accept it.
5. Care is guided by quality of life as defined by the individual.

6. Caregivers enter into a therapeutic relationship with residents and families based on dignity and integrity.
7. A unified response to suffering strengthens communities.

Goals of the Hospice Palliative Care Program

In meeting the needs of palliative residents and their families, the Hospice Palliative Care Program is striving to achieve the following goals:

1. Resident / Family Focused - The resident and family are treated as a unit. All aspects of care are provided in a manner that is sensitive to the resident's and family's personal, cultural, and religious values, beliefs and practices, their developmental state and preparedness to deal with the dying process.
2. High Quality - The palliative care program is guided by:
 - Ethical principles of autonomy, beneficence, nonmaleficence, justice, truth-telling and confidentiality
 - Standards of practice that are based on nationally-accepted principles and norms of practice, and standards of professional conduct for each discipline.
 - Policies and procedures that are based on the best available evidence or opinion-based preferred practice guidelines
 - Data collection/ documentation guidelines that are based on validated measurement tools.
3. Safe and Effective - The palliative care program is provided in a manner that:
 - Is collaborative
 - Ensures confidentiality and privacy
 - Is without coercion, discrimination, harassment or prejudice
 - Ensures safety and security for all participants
 - Ensures continuity and accountability
 - Aims to minimize unnecessary duplication and repetition
4. Accessible – All residents and families have equal access to palliative care services in a timely manner.
5. Adequately Resourced – All residents and families have sufficient support and resources to help them meet their goals through:
 - Other Community Agencies such as CCAC, Hospice, Community Mental Health, Support and Bereavement groups, etc.
6. Collaborative – The _____ works in partnership with other community organizations to improve the hospice palliative care available.
7. Knowledge-Based – _____ have knowledge and training in palliative care that is updated on a regular basis. The _____ is committed to the education of the community, agencies and other institutions and healthcare providers regarding palliative care.

8. Advocacy-Based – _____ staff advocate for individual clients and for the provision of palliative care services on an ongoing basis.

9. Research-Based - _____ bases all activities on best available evidence and practice and seeks opportunities to participate in research projects.

Admission Criteria

An individual and their family living with a life threatening illness (due to any diagnosis, with any prognosis, regardless of age) may be admitted to the Hospice Palliative Care Program if:

- Their physician is in agreement; and/or
- They are suffering pain or other symptoms and no one would be surprised if they died in the next six months.

Within a Long Term Care Home, a patient may never be diagnosed with a life threatening illness, yet will require symptom support before they die.

“Multiple Complex Issues”

“To be effective at relieving suffering and improving quality of life, caregivers must be able to identify and respond to all the complex/multiple issues that patients and families may face. If one or more issues are missed, they can compound one on another. This can lead to increased distress and further complications.

The issues commonly faced by patients and families can be categorized into 8 domains, each of which is of equal importance.” See diagram next page. The issues in each domain are meant as examples and not necessarily the complete list.

Multidisciplinary Process of Providing Care

The Model to Guide Hospice Palliative Care has identified a process of providing care that applies to all caregivers as they interact with patients and families. The therapeutic relationship develops with time as familiarity, trust and confidence are established. This relationship evolves through a series of therapeutic encounters between caregivers and the resident and families.

Similar to the nursing process, there are basic and essential steps in each therapeutic encounter. The steps are Assessment, Information sharing, Decision-making, Care Planning, Care Delivery and Confirmation. See diagram on pages 6 and 7.

*** References:**

“A Model to Guide Hospice Palliative Care: Based on National Principle and Norms of Practice” by the Canadian Hospice Palliative Care Association, March 2002

END-OF-LIFE POLICIES AND PROCEDURES

PROCEDURE:

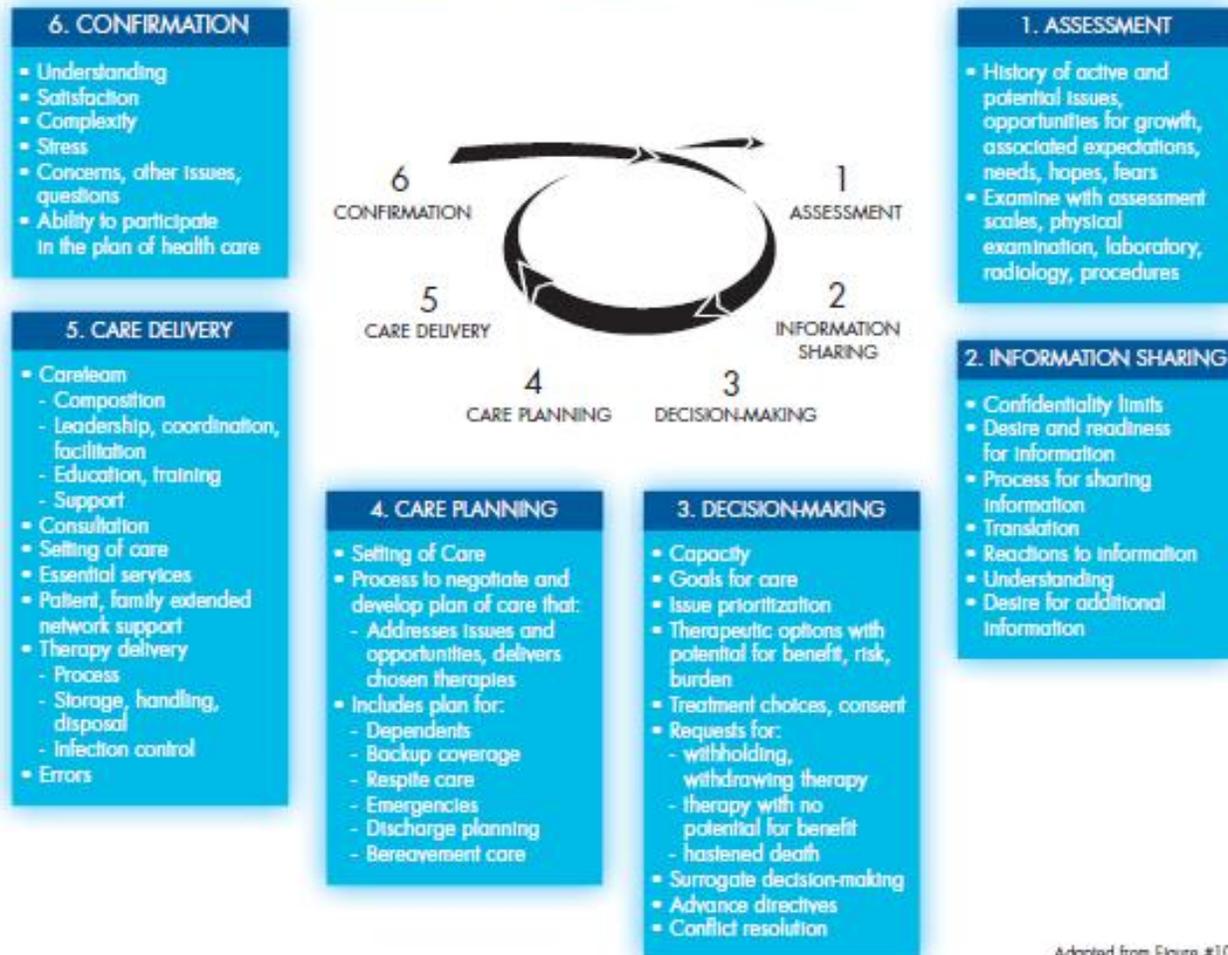
1. A Palliative Performance Scale, (PPS), and Edmonton Symptom Assessment Scale, (ESAS) will be completed on admission, quarterly and prn. (Where possible the Edmonton Symptom Assessment Scale will be completed by resident or family either independently, or with staff assist where necessary.)
2. A PPS of 30% or lower will result in completion of the Palliative Assessment Form and the initiation of an end-of-life care plan. Utilize the End-of-Life package to guide you through this process.
3. Registered nursing staff will ensure that family is apprised of resident's status and will be orientated to the services available.
4. The resources available in our Palliative Baskets will be left in room for family/resident use.
5. Comfort baskets can be made available on each Unit and include:
 - Kleenex / Gloves
 - Hand and Body Lotion
 - Family care kit – toothbrush, toothpaste, mouth wash, comb
 - Portable CD Player
 - Music CDs
 - Boxed set – 6
 - Spirit Wings
 - Celtic Whispering
 - Warm Breezes
 - Gentle Waters
 - Hugs and Kisses
 - Classic Comfort
 - Books;
 - Freddie the Leaf
 - Final Gifts
 - Love you Forever
 - Large print Word Seek Puzzles
 - Movie and T.V. Word Seeks
 - Booklets;
 - Booklets “When Someone ...What can I do? What can I expect?”
 - Hospice pamphlet
6. Registered staff to review Health Care Directives and donor status with resident/family and have appropriate consents signed. (i.e. organ donor consent)
7. Palliative care plan to be made available to all persons in the resident's circle of care.
8. Where ESAS scores are 4 and over a care plan will be activated with the most troublesome symptoms being addressed first.
9. Issues related to pain will be addressed according to the Pain Management Policies and Procedures. Algorithms to guide staff through this policy are available in each med room.

10. Once a plan to treat symptoms is in effect the ESAS will be completed daily, to monitor efficacy of treatment, until symptoms stabilize.
11. If the plan of care is found to be inadequate a referral to physician, dietician, PT, OT, Palliative Pain and Symptom Management Coordinator, etc. will be made to address issues.
12. A Palliative progress note will be generated q shift until PPS is above 30% or the resident's death.
13. At time of death the Dove symbol will be placed on door handle to notify all staff/residents/volunteers that resident has expired.
14. End-of-Life audits will be completed, in conjunction with family satisfaction survey within 1 month of resident's death.
15. A condolence card will be set out for staff signatures by the ward clerk.
16. Educational in-services and updates are offered initially and at least yearly to all staff.
17. Review and update policy and procedure, and resource binders at least annually as needed.

NORMS of PRACTICE

The Process of Providing Care

ESSENTIAL AND BASIC STEPS DURING A THERAPEUTIC ENCOUNTER



Adapted from Figure #10.

"While hospice palliative care has grown out of "care for the dying," the concepts can now be used to guide care at any point during an acute, chronic, or life-threatening illness, or bereavement." p.53

Source: A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice. Canadian Hospice Palliative Care Association (CHPCA). March 2002. 131C – 43 Bruyère Street, Ottawa, Ontario, Canada K1N 5C6.

Visit www.chpca.net to view this document in its entirety.

DOMAINS OF ISSUES ASSOCIATED WITH ILLNESS AND BEREAVEMENT



*Other common symptoms include, but are not limited to: **Cardio-respiratory:** breathlessness, cough, edema, hiccups, apnea, agonal breathing pattern. **Gastrointestinal:** nausea, vomiting, constipation, obstipation, bowel obstruction, diarrhea, bloating, dysphagia, dyspepsia. **Oral conditions:** dry mouth, mucositis. **Skin conditions:** dry skin, nodules, pruritus, rashes. **General:** agitation, anorexia, cachexia, fatigue, weakness, bleeding, drowsiness, effusions (pleural, peritoneal), fever/chills, incontinence, insomnia, lymphoedema, myocarditis, odor, prolapse, swells, syncope, vertigo.

Adapted from Figure #7.

Providing a Shared Vision

"so that patients and families can realize their full potential to live even when they are dying." p.87

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