CSPCP
Canadian Society of
Palliative Care Physicians

SCMSP
Société canadienne des
médecins de soins palliatifs

KEY MESSAGES:
Embedding a Palliative Approach to Care in Long Term Care Facilities
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Background

The vast majority of residents are admitted to long-term care (LTC) with advanced life-limiting illnesses including, but not limited to, end-stage dementia, frailty, heart and lung disease, and cancer. Consequently, residents of LTC facilities have a significant burden of morbidity and mortality. The annual mortality rate in LTC is estimated at 27%, with a median life expectancy of about two years.[1]

Access to high quality, evidence-based palliative care should be guaranteed for all residents in LTC - and yet, the Canadian Institute of Health Information (CIHI) finds that only 6% of all LTC residents are recorded as having received palliative care in the last year of life.[2]

The goal of this document is to clarify and define the role of palliative care in LTC, along with listing top priorities for improving access to and delivery of palliative care in LTC facilities.

Key Definitions

Integrated palliative approach to care/community-integrated palliative care – "Care that focuses on meeting a person's and family's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person's autonomy and right to be actively involved in their own care – and strives to give individuals and families a greater sense of control. It sees palliative care as less of a discrete service offered to dying persons when treatment is no longer effective and more of an approach to care that can enhance their quality of life throughout the course of their illness or the process of aging. It provides key aspects of palliative care at appropriate times during the person's illness, focusing particularly on open and sensitive communication about the person's prognosis and illness, advance care planning, psychosocial and spiritual support and pain/symptom management. As the person's illness progresses, it includes regular opportunities to review the person's goals and plan of care and referrals, if required, to expert palliative care services."[3]

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[1] Kaasalainen, S., Sussman, T., Durepos, P., McCleary, L., Ploeg, J., Thompson, G., & Team, t. S.-L. (2017). What Are Staff Perceptions About Their Current Use of Emergency Departments for Long-Term Care Residents at End of Life? *Clinical Nursing Research, 28*(6), 692-707. doi:10.1177/1054773817749125

[2] Canadian Institute for Health Information. (2018). *Access to Palliative Care in Canada.* Ottawa, ON: CIHI.

[3] Canadian Hospice Palliative Care Association, Lexicon, The Way Forward Initiative: An Integrated Palliative Approach to care, 2014

Quality care - The continuous striving by an interdisciplinary team/organization to meet the expectations and needs of the people and families it serves and the standards established by the organization, health authority, profession and accreditation bodies.[4]

Key Messages

1. All residents in LTC have a right to receive high-quality palliative care, based on resident needs and not just prognosis.

2. For most residents, the palliative care approach should be introduced before arrival at or upon admission to LTC.

3. LTC medical directors and attending physicians need adequate training and education to be comfortable providing a palliative approach to care as well as evidence-based end-of-life care for LTC residents.

4. The resident care team in LTC needs basic educational competencies in palliative care.

5. Advance care planning and goals of care discussions for LTC residents should occur upon admission, at annual reviews, at the request of a resident or their substitute decision maker(s) (SDMs) (see definition below), and at times of transition (i.e., changes in functional status, acute medical events, hospital transfers, or when approaching end of life).

6. Improving staffing ratios in LTC would allow more time to manage symptoms, support psychosocial and spiritual concerns, as well as participate in serious illness conversations.

7. LTC residents should have access to the support of palliative care specialist teams, when required.

8. Grief and bereavement support needs to be available for informal caregivers (often family members) as well as LTC staff.

9. The quality of palliative care provided in LTC should be tracked via standardized performance measures.

Role of palliative care

The CSPCP advocates for access to high quality, early integrated palliative care for all residents in LTC with life-limiting illness, along with support for their families and caregivers.

The CSPCP envisions palliative care in LTC as the following:

1. A holistic resident focused approach to care which ensures management of symptoms (physical, psychological, social and spiritual) and relief of suffering through proactive goal concordant assessment and management by the resident care team. The goal is to have residents be supported by healthcare professionals, administrators, family and friends, volunteers, and Compassionate Communities (see definition below).

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[4] Quality End of Life Coalition of Canada (QELCCC). (n.d.). *Blueprint for Action 2020 - 2025.* Retrieved 2021, from Quality End of Life Coalition of Canada (QELCCC): https://www.chpca.ca/projects/the-quality-end-of-life-care-coalition-of-canada

2. A focus on clearly documented advance care planning and goals of care discussions so residents receive goal-concordant care and can prepare for end of life.[5]

3. Provision of education, counseling, and support for families, SDMs and caregivers.

Glossary

Compassionate Communities – "Compassionate Communities respond to local community needs and empower individuals to provide important physical, emotional, social, spiritual, and practical support to patients, families, and caregivers.

At its core, a Compassionate Community is about improving the quality of life for people with a life-limiting illness and their families by encouraging people to advocate and provide assistance and practical support within their community."[6]

Goal Concordant Care – clinical care that helps reach a patient-identified goal, and respects any treatment limitations the patient has placed on clinical care.[3]

Resident Care Team – Attending Physicians, Nurse Practitioners, Nurses, Personal Support Workers (PSWs) as well as many other health care professionals, volunteers, and essential caregivers.

Substitute Decision-Maker (SDM)
Note: this term may vary from province to province/territory
A SDM are those (e.g., proxy, agent, attorney, etc.) who consent to treatment which most closely represents the preferences of the person they are representing, when the person is unable to direct their own care. Please see https://www.advancecareplanning.ca/wp-content/uploads/2020/06/Speak-Up-Public-Workbook-ENG-2.pdf.

[5] Turnbull, A. E., & Hartog, C. S. (2017). Goal-concordant care in the ICU: a conceptual framework for future research. *Intensive care medicine*, *43*(12), 1847–1849. https://doi.org/10.1007/s00134-017-4873-2

[6] Pallium Canada. (2021). Compassionate Community Fact Sheet. Retrieved from Compassionate Communities: https://www.pallium.ca/compassionate-communities/