Palliative Care Resource Package for Long-Term Care Homes

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Introduction

Home and Community Care Support Services Central and its health system partners – including hospitals, long-term care homes and nurse-led outreach teams – are working collaboratively to reduce hospital overcrowding, emergency department visits and move toward ending hallway medicine by strengthening palliative care capacity in long-term care homes through education and support.

Overseen by the Regional Palliative Care Network, the Long-Term Care Working Group's (Working Group) mandate is to develop and implement a long-term care palliative strategy. First steps included conducting a current state analysis with all 46 long-term care homes in the region to determine the resources necessary for homes to implement a palliative strategy. Based on the results of this research, the Working Group then engaged with key stakeholders, such as families, residents and staff, to inform and develop a Palliative Care Resource Package for the homes.

In fall 2018, the Working Group conducted a survey of the 46 homes to assess their knowledge and needs related to palliative care and as a result determined the content for this resource package.

Purpose

- To advance the government's priority to reduce hospital overcrowding by decreasing unnecessary Emergency Department (ED) transfers and admission to hospitals
- To reduce the number of patients being transferred from long-term care to hospital with palliative symptoms by standardizing palliative/ end–of-life care and sustainability in long-term care homes
- To help inform organizational policies and build capacity within long-term care

How to Use the Resource Package

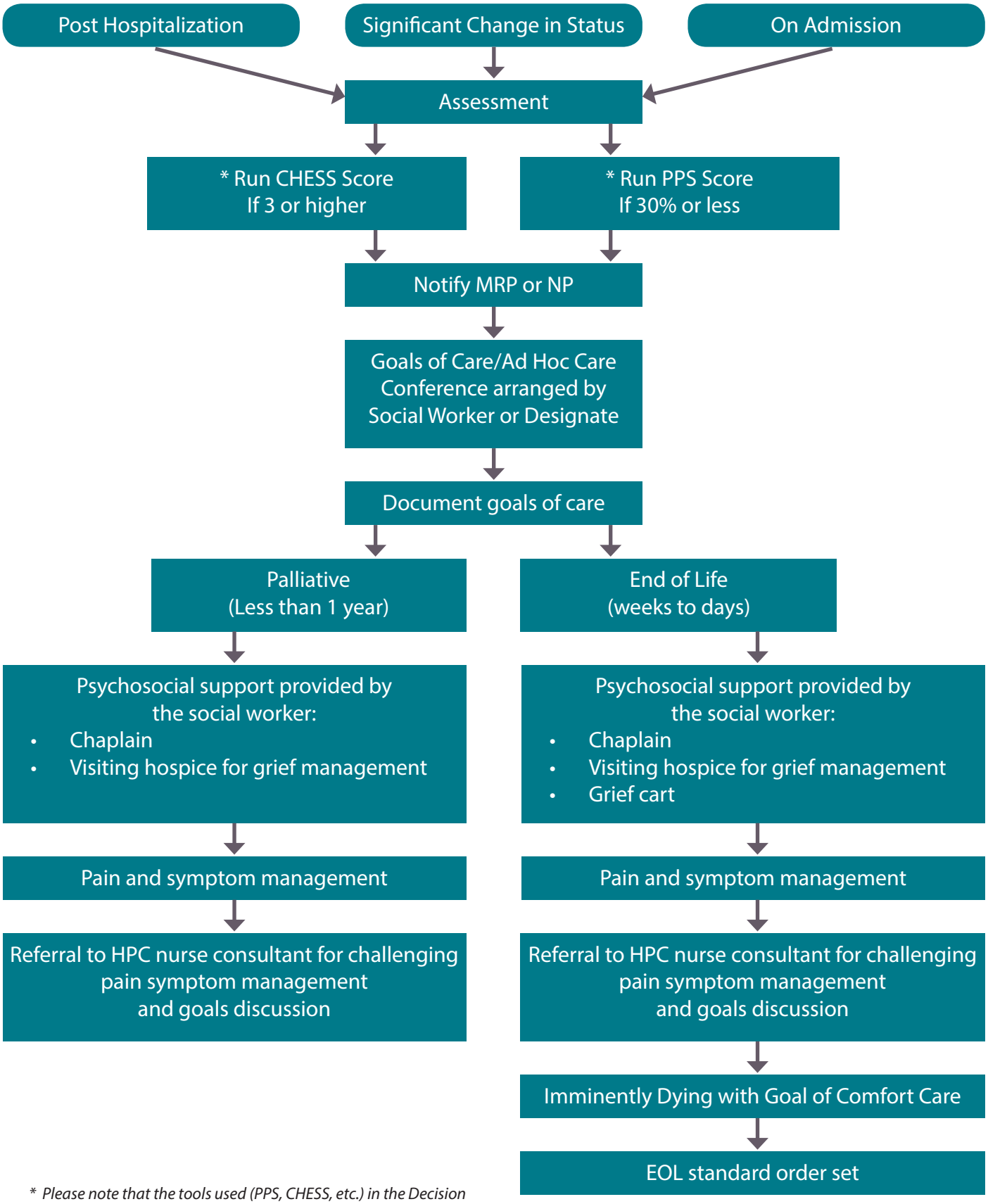
- This easy-to-use electronic toolkit has been created with hyperlinks embedded. Home and Community Care Support Services Central will review the document on an ongoing basis to ensure the hyperlinks are still relevant and working.
- Resource for long-term care home staff to assess and determine palliative and end-of-life and the necessary steps to meet resident's needs.
- Resource for your organization in the development of targets and specific actions pertaining to *HQO's Quality Priorities for the 2019/20 Quality Improvement Plan (QIP)*; early identification of palliative care needs for patients within your long-term care home

Identifying the Need

Links to Gap Analysis tools have been included below to aid your home in determining what process and outcome components related to palliative care are available in your long- term care home and potential areas for focus.

- *Palliative Alliance Gap Analysis Toolkit*
- *RNAO End of Life - Gap Analysis*

How to Identify – Decision Tree



* *Please note that the tools used (PPS, CHESS, etc.) in the Decision Tree can be customized based on the tools available in each long-term care home*

Palliative Approach to Care

STEP 1: Identify the need (Decision Tree)

*** Examples of assessment tools**

- ✓ CHESS
- ✓ PPS
- ✓ PSI
- ✓ Gold Standard Framework
- ✓ ESAS
- ✓ Comprehensive Geriatric Assessment/Frailty Index
- ✓ Pain assessment
- ✓ *Palliative and End of Life Clinical Support Tool* Password: CSTProgram
- ✓ Swallowing assessment

STEP 2: Management

Patient/Family education and support

- ✓ *Advance care planning, goals of care, and treatment decisions & informed Consent* (Ontario Palliative Care Network)
- ✓ *A Caregiver's guide* (Central HPC Network)
- ✓ Making decisions about your care (Ontario Palliative Care Network)
- ✓ *When someone close to you is dying* (National Initiative for the Care of the Elderly)

Symptom management

- ✓ *Hospice palliative care symptom guidelines* (Fraser Health Authority)
- ✓ *Managing Symptoms: Guidelines and Advice* (Cancer Care Ontario)

Staff conversation tools (tips/techniques for having conversations with families)

- ✓ *Advance Care Planning Module* (Palliative Alliance)
- ✓ *Advance Care Planning with Families and Residents* (Speak Up Ontario)
- ✓ *Grief Support for Staff*
- ✓ *Palliative care education resources* (Palliative Alliance)

End of Life (EOL) Approach to Care

STEP 1: Identify the need (Decision Tree)

*** Examples of assessment tools**

- ✓ ESAS
- ✓ Swallowing assessment
- ✓ Pain assessment
- ✓ *Palliative and End of Life Clinical Support Tool* Password: CSTProgram

STEP 2: Management

Access to appropriate medications

- ✓ *Example of Palliative Symptom relief kit* (Central HPC Network)
- ✓ *Example of end of life order sheet* (Palliative Alliance)
  - Discontinue P.O. medications or discontinue medications when unable to swallow
  - Discontinue vitals
  - Turn and position q2h and prn
  - Mouth care q2h and prn
  - Insert butterfly as needed for sc medications
  - Hydromorphone 0.5 mg sc q2h prn for pain and dyspnea
  - Scopolamine 0.4 mg sc q4h prn or Glycopyrrolate 0.2-0.4 mg sc prn
  - Midazolam 1.25 mg sc q2h prn for agitation
  - O^2 at 2L nasal prong prn for dyspnea
- ✓ *Ontario drug benefit formulary* (Ministry of Health)
- ✓ *Palliative Care Facilitated Access NP's* (RNAO)
  - *Eligibility Criteria for NP's – Palliative Care Facilitated Access* (Ministry of Health)
- ✓ *Request for an unlisted drug product* (Ministry of Health)

Comfort care rounds (Palliative Alliance)

Comfort feeding

- ✓ *Comfort feeding* (RNAO)
- ✓ *Food for thought* (Palliative Alliance)

End of life care during the last days and hours (RNAO)

End of life Doulas

Mouth care

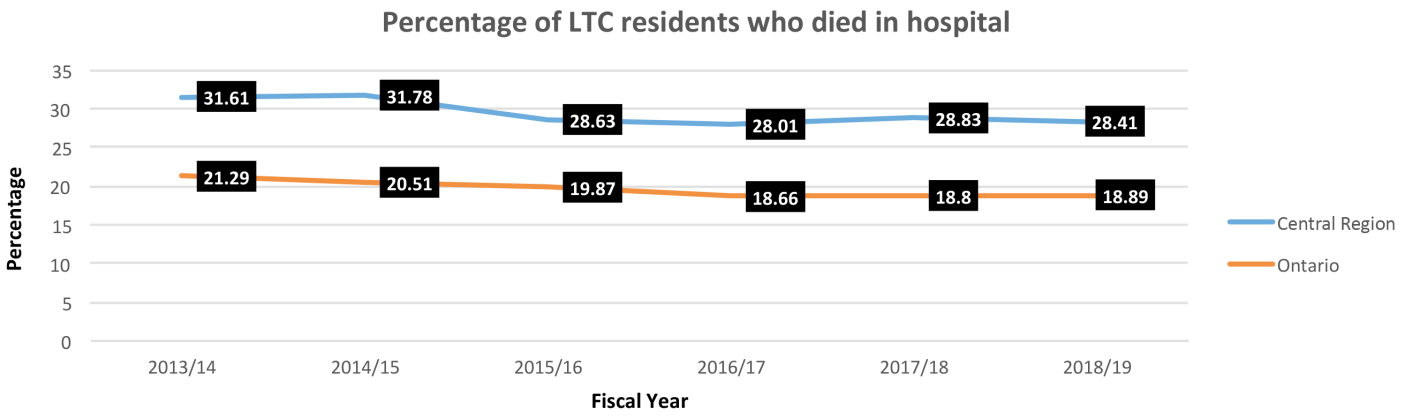
- ✓ *Oral Care* (Cancer Care Ontario)
- ✓ *Oral health* (RNAO)

Positioning techniques in long-term care (RNAO)

* *Please note these are examples of assessment tools but this is not an exhaustive list*

Long-Term Care Statistics

Percentage of LTC residents who died in hospital



Data Source: Ontario Palliative Care Network, Regional Profiles Tool, v.2.2, retrieved March 15, 2021

Central Area Long-Term Care at a Glance

- 46 long-term care homes
- Waitlist Demographics* (age and gender)
  - 64.2% are female
  - 35.8% are male
  - Median age: 86 years
- In the 2020/21 fiscal year:
  - 39% of patients admitted to a Central area long-term care home had a high MAPLe score
  - 43% of patients admitted to a Central area long-term care home had a Very High MAPLe score

* *Data Source: HSSO Placement Reports-Long Term Care Home Admission by Home and MAPLe Level - Long Stay Admissions, CPRO and CHRIS IDS*

Glossary of Terms

CHESS (The **Changes** in **Health**, **End**-Stage Disease, **Signs**, and **Symptoms** Scale)
Designed to identify individuals at risk of serious decline. It can serve as an outcome where the objective is to minimize problems related to declines in function, or as a pointer to identify persons whose conditions are unstable. CHESS, originally developed for use with nursing home residents, has been adapted for use with other instruments in the interRAI suite. It creates a 6-point scale from 0 = not at all unstable to 5 = highly unstable, with higher levels predictive of adverse outcomes such as mortality, hospitalization, pain, caregiver stress, and poor self-rated health.
Resource: *www.interrai.org/scales.html*

Comprehensive Geriatric Assessment
"is the gold standard in best practice for managing frailty in older adults"
Resource: *https://cgatoolkit.ca/*

Edmonton Symptom Assessment Tool (ESAS)
Valid and reliable assessment tool to assist in the assessment of nine common symptoms experienced by cancer patients
Resource: *Cancer Care Ontario*

Gold Standards Framework (GSF)
"a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. Through the GSF, palliative care skills for cancer patients can now be used to meet the needs of people with other life-limiting conditions,"
Resource: *www.goldstandardsframework.org.uk*

End of Life Care
"the final stage of the palliative approach. It is considered to be the final stage of the journey of life. The resident is expected to die within the near future (months, weeks, days). "

- when death is inevitable
- a short trajectory (months/weeks/hours)
- focused on supporting patient and family choices

Resource: *www.palliativealliance.ca*

MAPLe
"MAPLe is a decision-support tool that can be used to prioritize those needing community-or facility-based services and to help plan allocation of resources."
Resource: *www.cihi.ca/sites/default/files/document/interrai-hc-maple-job-aid-en-web.pdf*

Palliative Care
"Should be implemented when death of a resident would be expected within the next year. A plan of care that has a *palliative approach* would address the physical, psychological, social, spiritual and practical issues of both the resident and family and continues to provide support into bereavement."
Resource: *www.palliativealliance.ca*

Palliative Performance Scale (PPS)
"The Palliative Performance Scale (PPS) is a useful tool for measuring the progressive decline of a palliative resident. It has five functional dimensions: ambulation, activity level and evidence of disease, self-care, oral in-take, and level of consciousness. To score, there are 11 levels of PPS from 0% to 100% in 10 percent increments. Every decrease in 10% marks a fairly significant decrease in physical function. For example a resident with a score of 0% is deceased and a score of 100% is fully ambulatory and healthy."
Resource: *http://www.palliativealliance.ca/assets/files/Alliance_Reources/Physical_Care/PPS._edited_Jan_242013.pdf*

Personal Severity Index (PSI)
"presents a complex view of resident status. It incorporates factors that are most relevant to residents at the end of life. This score includes measures of functional, clinical and mood status in combination with other measures such as presence of end stage disease, a recent decline in or unstable health status, and delirium. The PSI can be a useful tool to help LTC providers identify residents who may be moving towards EOL and who may require changes to their current care plans. The PSI is rated from 0 to 18. Researchers who developed the PSI found that residents with a score of 9 or more are at a high risk of death or have a 35.7 percent death rate within 6 months."
Resource: *www.hpcconnection.ca*

Rockwood Clinical Frailty Scale
"A method of summarizing the overall level of fitness or frailty of an older adult after they had been evaluated by an experienced clinician; a judgement-based tool to screen for frailty and to broadly stratify degrees of fitness and frailty. It is not a questionnaire, but a way to summarize information from a clinical encounter with an older person, in a context in which it is useful to screen for and roughly quantify an individual's overall health status."
Resource: *https://docs.wixstatic.com/ugd/2a1cfa_e5e2c60f3d3d4449bbdd5e85aeb915f3.pdf*

References

- *Cancer Care Ontario*
  - *Palliative Care Toolkit for Indigenous Communities*
- *Hospice Palliative Care Resources – Central Region*
  - *Hospice Boundaries*
  - *Early Identification and Prognostic Indicator Guide*
  - *LEAP Training*
  - *Long Term Care Referral Form to HPC Teams*
  - *Palliative Care Common Referral Form*
- *Ontario Long-Term Care Association*
- *Ontario Palliative Care Network – Palliative Care Toolkit*
- *Palliative Alliance*
  - *Palliative Care Alliance-QPC-LTC Toolkit – Resource Directory*
  - *Palliative Care Definitions*
- *Speak Up Ontario*
- *Think Research - Ontario Long-Term Care Clinical Support Tools Program*

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