BC Centre for Palliative Care

SPA-LTC
Strengthening a Palliative Approach in Long-Term Care

Essential Elements of a Palliative Approach In Long Term Care

Long Term Care Palliative Approach Collaborative

February 2025

The BC Centre for Palliative Care (BCCPC) is a provincial organization funded by the BC Ministry of Health established to work with partners in the health system and community to accelerate the spread of innovations and best practices in palliative care.

Citation:

BC Centre for Palliative Care (2025). BC Centre for Palliative Care: Essential Elements Palliative Approach in Long-Term Care in BC. Copyright © BC Centre for Palliative Care. 2025. office@bc-cpc.ca.

Acknowledgement:

This work has been supported by the *'Strengthening a Palliative Approach in Long-Term Care' (SPA-LTC)* program, funded by a contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Financial contribution from

Health Canada Santé Canada

Background:

In February 2024, BCCPC with support of short-term funding from the Strengthening a Palliative Approach-Long-term Care project, convened a round table of experts from BC's long-term care (LTC) community to explore opportunities to work together to strengthen a palliative approach to care in LTC.

As an outcome of this meeting, leaders in LTC across the BC health authorities including the Ministry of Health Seniors Services Division lead by the BCCPC, formed a time limited collaborative to enhance the integration of a palliative approach happening in regional health authorities and contracted care long term care home and to generate new strategies to spread and deepen a palliative approach into LTC homes in BC. The Ministry of Health acknowledges a Palliative approach is a key component of LTC.

These essential elements of a palliative approach in Long-term Care are endorsed by the following Palliative Approach Collaborative Members;

Endorsed by:

Gita Rafiee, CNS Seniors Community & Complex Care, Fraser Health

Shannon Paul-Jost, CNS Gerontology Seniors Specialized Care Transformation, Interior Health

Vanda Urban, Director Long Term Care Services, Interior Health

Katie Hennessy, CNS Palliative & End of Life Care, Island Health

Stacey Joyce, Palliative Lead, Northern Health

Monica Kelly, Regional Approach to Palliative Care Education VCH

Jennifer Walker, Palliative Physician, VCH

Frances Wright, Palliative Clinician Long Term Care, Providence Health

Bhawan Brar, Regional Director Quality Care, BC Optima Living

Clara Dyck, SPA – LTC BC Lead

Heather Cook, Director Long Term Care & Assisted Living

Della Roberts, Consultant Strategic Initiatives, BC CPC

Purpose:

To inform policy in "all publicly funded Long-term Care (LTC) homes including health authority owned and operated facilities, contracted and affiliated providers with the exception of those providing only short-stay services." [1]

Approach:

This document is designed to influence LTC system change to ensure that a palliative approach to care is integrated into the care for Residents from moving in until their end of life or discharge and into LTC practices, processes and functions.

Challenge/Issue:

LTC has traditionally been known in society as a place where people go as they age, when they need more care. However, with these assumptions, there has not been a concerted effort to support and apply a systematic palliative approach within LTC. This is evident in the lack of standardization and integration of palliative approach practices, processes, routines, leadership and structures that support care practice in LTC.

Background:

People moving into LTC homes in BC are living with progressive, life limiting conditions including frailty and dementia as they age and inevitably have a change in their health condition that leads to death. In BC, the typical length of time that people live in a LTC home is approximately 480 days (16 months).[2]

All people moving into LTC will benefit from a palliative approach. A palliative approach in LTC means to adopt the principles of palliative care, adapt strategies to meet the person and family needs, and embed palliative practice into usual care.[3] Examples of these processes that would guide LTC are:

- On moving into LTC, conversations address goals of care conversations.
- Pain and symptom management and psychosocial care through to the end-of-life
- Identification and documentation of triggers of anticipatory care planning for when change happens and what to do next.
- Standardized integrated clinical education to build clinician confidence in applying a palliative approach.
- Consistent engagement of admitting family physicians, nurse practitioners and the allied care team in revisiting goals of care conversations and planning for anticipatory change.
- Standardized processes to engage the person and family to determine decisions regarding risk considering the wishes of the person and their specific goals.

Definitions:

Palliative Approach in LTC involves a holistic, person-centered approach aiming to improve the quality of life for individuals living in LTC with life-limiting health conditions including frailty and dementia. The approach integrates chronic disease management and palliative care principles including care of the whole person and their family, conversations about serious illness, identifying personal preferences and goals of care, understanding where the person is in the course of their journey including preparing for illness progression, while recognizing uncertain prognosis,[4] and supporting a peaceful and dignified death.[5]

> **Palliative Care** improves the quality of life of people facing problems associated with life-limiting health conditions and their families. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.[4]

Family is whoever the person identifies as being important, or identifies as being their chosen family, including blood relations, partners, neighbors, and/or friends.[5]

> **Family caregivers** are unpaid family members, friends, or other support for someone who needs care due to physical, intellectual, or developmental disabilities; medical conditions; mental health; or needs related to aging. Caregivers provide care because of a relationship, not as a job or a career. [6]

Life-limiting health condition describes an illness or condition where people who are actively living with their health conditions, often for lengthy periods of time, are not imminently dying but death is expected as a direct consequence of the condition.[4] When the health condition is advanced, death is expected though the timing is often uncertain.

> **Late stage** of a life limiting health condition is when decline & weight loss are expected due to the natural course of the illness trajectory. [7]
>
> **Last hours and days:** When the body is showing physical changes associated with dying and death is expected in the next hours or days.[8]

Advance Care Planning is the process of thinking about values, beliefs and wishes for future health and personal care and letting others know these future health and personal care preferences. It includes choosing who would make care decisions for them if they cannot.[4,9]

Person-centered care puts the person at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families, and health care services providers.[10]

Policy Key Elements

Funding and service delivery models support a **sustained palliative approach to care** in LTC homes.

Administrative leaders are engaged, knowledgeable about and supportive of a palliative approach, allocating resources to: [11,12]

- Staff education, mentorship, and peer support.
- Resources, standardized processes and tools for provision of a palliative approach; including available medications, equipment, technological capacity, and supplies to support persons, family members and family caregivers throughout their trajectory where change and decline are anticipated as part of the course of the life-limiting health condition.
- Staff wellness to support providing palliative care such as debriefing, rituals and farewells.
- Facilitate access to resources, space and services needed by persons and families for cultural, spiritual and/or religious practices.
- Formal linkages with community-based organizations to enable availability of supports including bereavement.
- Formal processes for bereavement support for family members, both external support and embedded bereavement support within the care home.

Interprofessional healthcare clinicians (nurses/allied health/health care assistants) **and volunteers** are engaged, equipped and supported:

- Clear roles and expectations for implementing a palliative approach appropriate to their scope of practice.
- Standardized education.
- Standardized processes that promote consistent and equitable integration of high-quality palliative care.
- Supported by palliative care specialists as needed.

Physicians & Nurse Practitioners practicing in LTC are engaged, equipped and supported:

- To enact their role (i.e.: serious illness conversations, establishing & revising goals of care, care plans and orders to address anticipated change and care aligned with the person's goals).
- Understand and contribute to development of the relevant palliative care education, standards, guidelines, and policies.
- Access consultative palliative care when needed, available 24/7.[4,14]

Quality monitoring and improvement initiatives related to a palliative approach.

- Implement identified quality indicators to assess processes and outcomes.
- Quality assurance monitoring and evaluation of practices.

Clinical Key Elements

Palliative approach is integrated into routine LTC processes, centralized documentation and clinical practice:

Effective goals of care conversations take place upon move-in, care conferences, and when there are indicators of decline or increased care needs, documented and translated into plans that direct clinician care.

- Build on and continue earlier advance care planning and serious illness conversations supported by standardized processes and documentation, to understand what is most important to the person & family, identify & revise goals of care, translate into the person's care plans, and inform treatment decisions.[8,15]
- Create a common understanding of the health condition now and expectations for future progression of the condition with the person, family and health care providers.

Optimize comfort and symptom management:

- Screen, assess and address needs and symptoms with standardized process, forms, assessment documents and care plans, and consultation when required.[8,11,13]
- Connect with symptom, psychological, spiritual, and bereavement support as appropriate.[8,11,13]

Care plan to support quality of life now and anticipate and prepare for change and decline:

- Explore, respect and address the unique needs & cultural practices of the person along with their family and family caregivers in providing and planning care including support for living with risk as aligned with their wishes.[8,11,13]
- Prepare for, recognize and respond to clinical indicators or signposts of health condition progression (e.g.: weight loss, decreasing function, poor response to treatment and hospitalization), communicate with the person and their family and team to revise the care plan if needed, including plans for further change.[8,11,13]

References

1. Long-Term Care Quality Framework Policy Directive, Ministry of Health, April 2024. page 2.
2. Office of the Seniors Advocate BC. Survey Report – Long-term care resident and visitor survey results 2023. https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2023/11/OSA-LTC-SURVEY-REPORT-RESULTS-2023.pdf
3. IPANEL. 2016. Infographic: Shift your thinking to a palliative approach.
4. Health Canada. Framework on Palliative Care in Canada. 2018. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html
5. Fraser Health, 2018, Clinical Practice Guideline, Integrating a palliative approach in LTC.
6. Canadian Centre for Caregiving Excellence. Caring in Canada: Survey insights from caregivers and care providers across Canada, May 2024.
7. Kootenay Boundary, Division of Family Practice & Interior Health. When your loved one has dementia: A road map for families. Accessed September 18, 2024 at https://divisionsbc.ca/sites/default/files/pedney/Dementia%20Booklet%20v23_FNL%20Aug_23_2018_electronic.pdf
8. Canadian Partnership Against Cancer & Health Canada. The Canadian Interdisciplinary Palliative Care Competency Framework. Toronto, ON: 2021. Canadian HPC Interprofessional Competencies
9. BC Centre for Palliative Care. Advance Care Planning. Accessed August 14, 2024 at https://www.bc-cpc.ca/acp/
10. Ministry of Health. The British Columbia Patient-Centered Care Framework, Feb 2015, Patient-Centred Care Framework
11. Covenant Health Palliative Institute. Alberta Interprofessional Palliative Care Competency Framework, Edmonton, AB: February 2023. Alberta HPC Interprofessional Competencies
12. Registered Nurses' Association of Ontario. A palliative approach to care in the last 12 months of life. Toronto (ON): Registered Nurses' Association of Ontario; 2020. Best Practice Guideline RNAO A Palliative Approach to Care in the Last 12 Months of Life
13. BC Center for Palliative Care 2019. Interdisciplinary Palliative Care Competency Framework. BC CPC HPC Interprofessional Competency Framework
14. Vancouver Coastal, Regional Palliative Care Standards 2024.
15. Kaasalainen, S. et al. Palliative Care Models in Long-Term Care: A Scoping Review, Nurs Leadership (Tor Ont) 2019 Sep;32(3):8-26. doi: 10.12927/cjnl.2019.25975.