Palliative Essentials in Long Term Care:
Foundations and Care Planning

Presenters:
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May 7th, 2026: 12:00pm-1pm PST

Agenda Item	Discussion
Introduction & Objectives	**Overview** • This ECHO session introduced palliative essentials in long-term care, focusing on foundational principles and care planning strategies. • The session emphasized that palliative care in long-term care is not limited to end-of-life care but should begin from the day a resident moves in. With an average length of stay in long-term care being approximately 16 months, most residents enter with life-limiting conditions such as dementia, frailty, or progressive chronic illnesses. • The session explored how a palliative approach integrates into everyday practice through symptom management, communication, care planning, and responding to changes over time, with the ultimate goal of supporting quality of life throughout the entire illness journey. **Objectives** • Understand the foundations of a palliative approach in long-term care. • Recognize opportunities for proactive care planning for current and future needs. • Identify resources and strategies to support palliative care practice.

Presentation Key points	**Key Learnings**
	Foundations of Palliative Care in Long-Term Care
	• The session reviewed the evolution of palliative care from the hospice movement led by Dame Cecily Saunders to the modern understanding of palliative care as both a specialty and an approach to care.
	• Historically associated with the final days of life, palliative care is now recognized as beneficial throughout the illness journey and alongside disease-directed treatments.
	• The bow tie model demonstrated how palliative care and active treatment can occur together, with palliative care providing symptom management, psychosocial support, communication, and alignment with resident goals.
	Essential Elements of Palliative Care in Long-Term Care
	• Three essential elements were emphasized for LTC practice.
	  ○ First, goals of care and advance care planning should begin at admission and continue as residents' conditions change. Conversations should explore values, wishes, and who should participate in decision-making.
	  ○ Second, optimizing comfort and symptom management requires regular assessment of physical, emotional, psychosocial, and spiritual needs. Care plans should be individualized to support what matters most to the resident.
	  ○ Third, healthcare teams must remain attentive to signs of decline, such as weight loss, reduced function, falls, worsening symptoms, and frequent hospitalizations. Recognizing these indicators early supports timely conversations and care plan adjustments.
	Care Planning with a Palliative Approach
	• The session emphasized that care planning should follow the 'Platinum Rule' by focusing on what matters most to the residents rather than what providers believe is best. One example involved a resident distressed by overnight turning schedules for pressure injury prevention. After discussing benefits and risks, the care team prioritized his wish to sleep

	comfortably through the night while still supporting wound healing through alternative measures.
	Understanding Illness Trajectories
	• Participants learned about three common illness trajectories: cancer, progressive chronic disease, and frailty/dementia.
	  o Cancer trajectories often involve stable functioning followed by rapid decline, while chronic illnesses such as COPD involve gradual decline with repeated exacerbations. Frailty and dementia are characterized by slow, progressive decline over months or years.
	  o Understanding these trajectories helps teams anticipate changes and prepare residents and families for future care needs.
	Recognizing Decline
	• Important indicators of decline include fatigue, reduced mobility, worsening symptoms, recurrent infections, falls, and weight loss.
	• The presenters emphasized that weight loss can be an expected part of decline rather than something to 'fix.' These changes should prompt meaningful conversations with residents and families about priorities, comfort, and quality of life.
	Balancing Autonomy and Risk
	• A major theme of the session was balancing resident autonomy with safety considerations. Examples included supporting residents who preferred independence despite risks of falls or choking. Creative and harm-reduction approaches, such as using hip protectors instead of restraints or allowing preferred routines while minimizing risk, were encouraged.
	• The discussion also highlighted the importance of ensuring staff safety and supporting staff when implementing individualized care plans.

Q&A Discussion	**<u>Case Study: Mr. N</u>** • The session explored the case of Mr. N, a resident with Lewy body dementia and COPD who had recently moved into long-term care. Mr. N experienced falls while attempting independent transfers and disliked alarms or restrictions that limited his autonomy. His husband, who had been his primary caregiver, struggled with seeing his decline and questioned whether long-term care placement had been the right decision. • Participants identified that Mr. N was experiencing both a dementia/frailty trajectory and a chronic illness trajectory related to COPD. Discussions focused on balancing safety, autonomy, symptom management, and family understanding of decline. The case reinforced the importance of proactive communication, individualized planning, and preparing families early for future changes. **Question & Answer Highlights** **Q: What are common barriers to proactive care planning?** A: Participants identified barriers such as lack of staff time, discomfort with difficult conversations, limited preparation, and families being resistant to discussing decline. Building trusting relationships with residents and families was identified as a major facilitator. **Q: When should palliative conversations begin in long-term care?** A: The presenters emphasized that palliative conversations should begin at admission and continue throughout the resident's stay as conditions and priorities change. **Q: What does it mean when families say a resident was 'doing fine before admission'?** A: The presenters explained that this often reflects difficulty understanding the resident's illness trajectory. In many cases, the move to hospital or LTC occurred because decline was already happening. **Q: How can teams balance resident autonomy with safety risks such as falls?** A: Participants discussed using harm-reduction strategies and creative solutions instead of restrictive measures whenever possible. Examples included hip protectors, environmental modifications, and individualized care plans that respect resident wishes while reducing risk. **Q: What should be included in future care planning for residents like Mr. N?** A: Suggestions included falls prevention measures, COPD symptom management, discussions about quality of life, support for family caregivers, plans for expected complications, and ensuring staff safety while respecting resident autonomy.

	Conclusion • Overall, the session reinforced that a palliative approach in long-term care is not limited to the end of life but is an ongoing philosophy of care centered on quality of life, communication, comfort, and respect for resident values. Early conversations, recognition of decline, proactive planning, and interdisciplinary collaboration are essential to supporting residents and families throughout the illness journey.
	Supplemental Resources Palliative Essentials in Long-Term Care course - Available in Learning Hub for British Columbia participants, featuring five short modules with links and resources developed by health authorities: LINK Clinical Frailty Scale - Tool to support recognition of decline in residents InterRAI CHESS scores - Assessment tool that can indicate increased health instability and prompt care planning conversations Illness trajectory models - Visual representations of cancer, progressive chronic disease, and frailty/dementia trajectories to help anticipate changes and plan care National Palliative Care Framework - Identifies 12 core competency areas, refined into three essential elements for long-term care practice.
Closing, Future Sessions	❖ Video recording ❖ **Upcoming Sessions:** **June 4th session: Aligning Care with What Matters** **Register** **June 18th session: Person-Centered Symptom Management Addressing Pain** **Register**