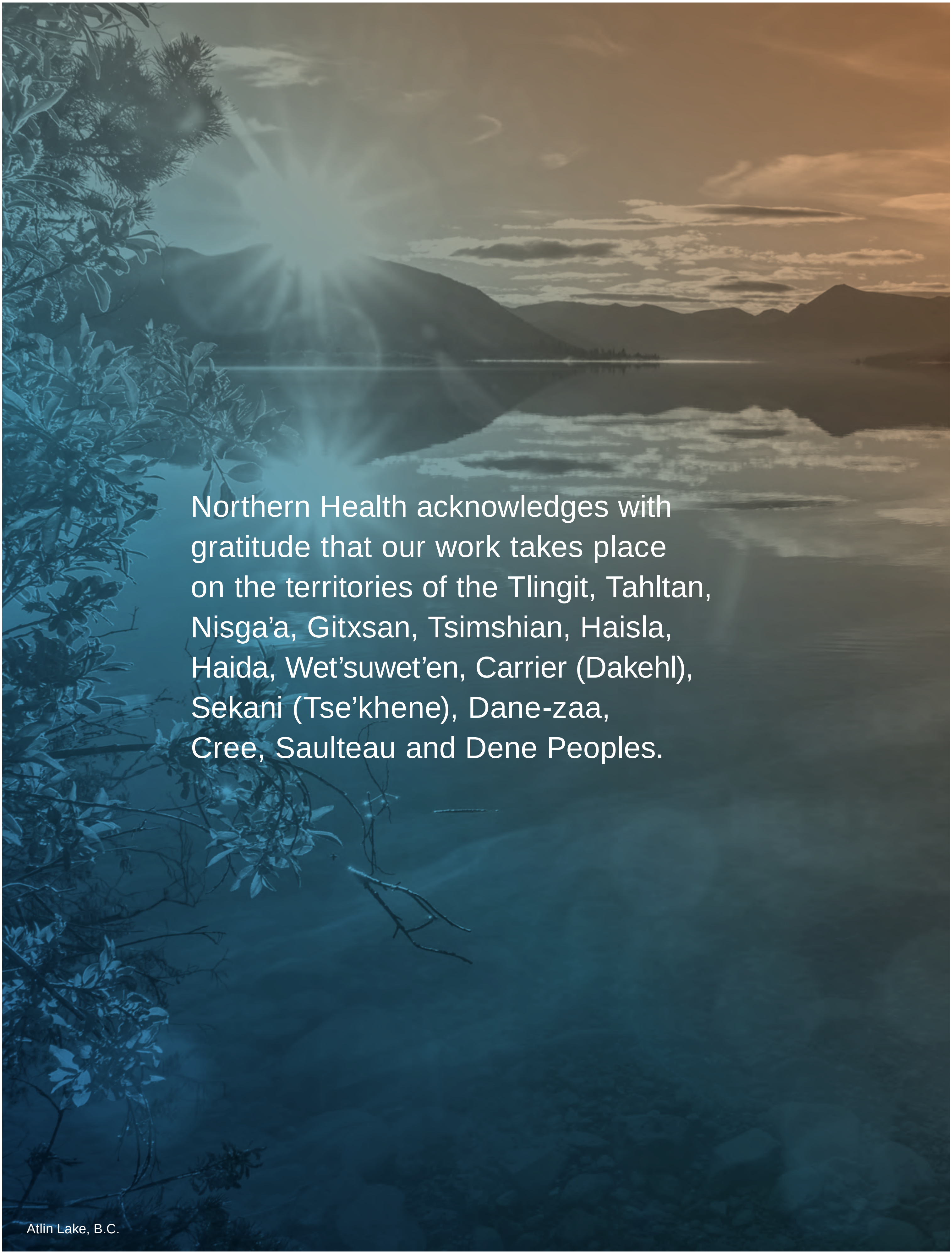
Muncho Lake, B.C.

Northern Health
Palliative Care Strategy

northern health
the northern way of caring



Northern Health acknowledges with gratitude that our work takes place on the territories of the Tlingit, Tahltan, Nisga’a, Gitxsan, Tsimshian, Haisla, Haida, Wet’suwet’en, Carrier (Dakehl), Sekani (Tse’khene), Dane-zaa, Cree, Saulteau and Dene Peoples.

Atlin Lake, B.C.

> “For society, a family’s suffering and the quality of their lives are a public health issue. By focusing on relieving suffering and improving quality of life, palliative care aims to promote health — physical, psychological, social and spiritual well-being — in everyone who is affected by illness and bereavement, including those who provide care. Our success will be a “determinant” of health in the 21st century.”
>
> *Lalonde, 1974*

Acknowledgements

Palliative Care in Northern BC is made possible through the dedicated efforts of health care providers, affiliated professionals, community members, families and friends — it is truly a collaborative effort. The Northern Health Palliative Care Team would like to acknowledge and thank everyone for their invaluable contributions to the development of the Northern Health Palliative Care Strategy and their continued dedication and support in promoting a happier, healthier Northern Population.

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Introduction

Dying is a part of life and a 'good death' is an important measure of the health of individuals, families, and communities. Recognizing this, Northern Health (NH) developed a Palliative Care Strategy (2015–2020) to guide and support a coordinated approach to care at the end of life. This document is an update to the 2015–2020 Strategy. While the principles and overarching goals expressed in the previous Strategy continue to be relevant, this document incorporates some important updates:

- Greater emphasis on a palliative approach to care in chronic disease and long-term care
- Greater alignment with Northern Health's commitment to truth and reconciliation
- Addition of self-care, well-being and psychological safety for individuals and teams providing palliative care

STRATEGIC ALIGNMENT:

> *"Northern Health leads the way in promoting health and providing health services for Northern, rural, and Indigenous populations."*
>
> *— Northern Health's Vision*

> *"Through the efforts of our dedicated staff and medical staff, in partnership with communities, organizations, and Indigenous peoples, we provide exceptional health services for Northerners."*
>
> *— Northern Health's Mission Statement*

The NH Palliative Care Strategy aligns with Northern Health's Strategic Plan and most closely reflects Coordinated and Accessible Services (priority 2), Quality (priority 3) and Communications, Technology and Infrastructure (priority 5). The Strategy is informed by Northern Health's commitment to truth and reconciliation and strives to narrow health disparities and ensure that all Indigenous people have access to high quality, culturally safe and respectful palliative care services.

The Strategy is embedded within the context of NH's Idealized System of Services (Appendix 1), which supports integration and coordination of care throughout NH, and is closely linked with Northern Health's Healthy Aging in the North Strategy. The NH Palliative Care Strategy is also informed by the Canadian Hospice Palliative Care Association and the BC Ministry of Health's Ptrovincial Framework for End-of-Life Care (2006) and Provincial End-of-Life Care Action Plan (2013).

Purpose and Vision

The purpose of the NH Palliative Care Strategy is to guide the delivery of palliative care services in Northern British Columbia and improve the outcomes and experiences of people needing palliative and end-of-life care. Three overarching goals express and support a vision of quality palliative and end-of-life care delivered to persons in the location of their choice, whenever possible, and in consideration of the rural, remote and Indigenous geographies of Northern Health:

1. Improve Patient and Family Outcomes and Experiences
2. Enhance Access to Palliative Care Services
3. Support Health Care Providers to Deliver Quality Palliative Care

This strategy is underpinned by the use of a palliative approach to care in seniors care, chronic disease care, and cancer care in all care settings, as well as culturally safe patient/family centered care planning processes that are developed with the person and their family and to anticipate the wishes and needs of persons requiring palliative care well before a health crisis occurs.

GUIDING PRINCIPLES

The following principles articulate how the vision — quality palliative and end-of-life care delivered to persons in the location of their choice — and accompanying goals will be achieved:

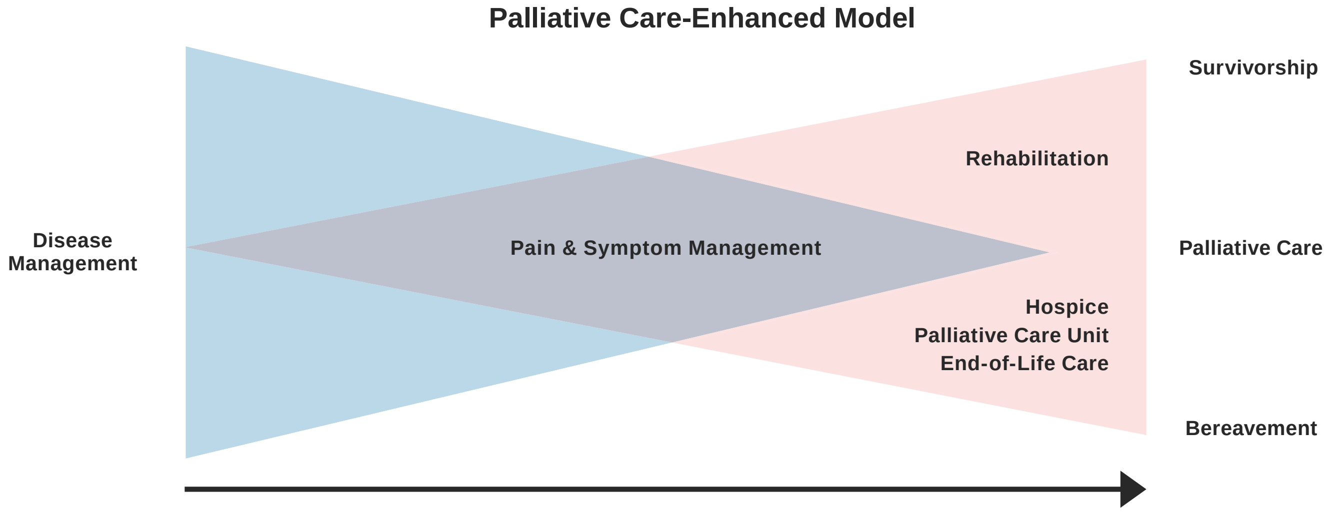
- Palliative care that is:
    - Person and family centred
    - Longitudinal
    - Team based
    - Culturally safe
- Palliative care that is in the location of the patient/family’s choosing, whenever possible
- Service delivery that considers a rural, remote, and Indigenous context
- A population health approach is used to guide upstream interventions
- Health care provider competencies are acknowledged as important in the various domains where palliative care occurs
- The toll that providing palliative care takes on the well-being of caregivers is recognized, and self-care is encouraged and supported

Palliative Care

The term “palliative care” is generally used in association with people who have an active, progressive and advanced disease with little or no prospect of cure. Palliative care aims to improve the quality of life of patients and their families facing the problems associated with life-threatening illness. It includes the specialized care of people who are dying — care aimed at alleviating suffering (physical, emotional, psychosocial or spiritual) rather than curing.

A population needs-based approach to palliative care “[r]ecognizes that individuals facing a serious illness have different needs, based on their unique health conditions, stage of disease and complexity of symptoms. Health care services and supports should therefore vary in type and intensity to most effectively meet the needs of the individual” *(BC Ministry of Health, 2013)*.

Figure 1
The continuum of palliative care includes care provided early in a disease trajectory, regardless of whether disease modifying treatments are in progress. As the disease progresses and treatments are reduced, palliative care support increases, although it is important to note that both active treatment and palliative care can happen at the same time.



Source: Hawley P (2014) *The bow tie model of 21st century palliative care.* J Pain Symptom Manag 47(1):e2–e5. https://www.jpsmjournal.com/article/S0885-3924(13)00609-X/fulltext. Accessed 5 June 2020

Palliative care is delivered across services areas (e.g., in primary and community care, long term care, residential and home care, acute care, and hospice) and by multiple roles (e.g., physicians, nurse practitioners, nurses, allied health care providers, support workers, volunteers, and family and friends). Good palliative care is a continuum of services provided in accordance with a care plan developed collaboratively between the person with a life limiting illness, the person's primary care provider and members of the person's care team.

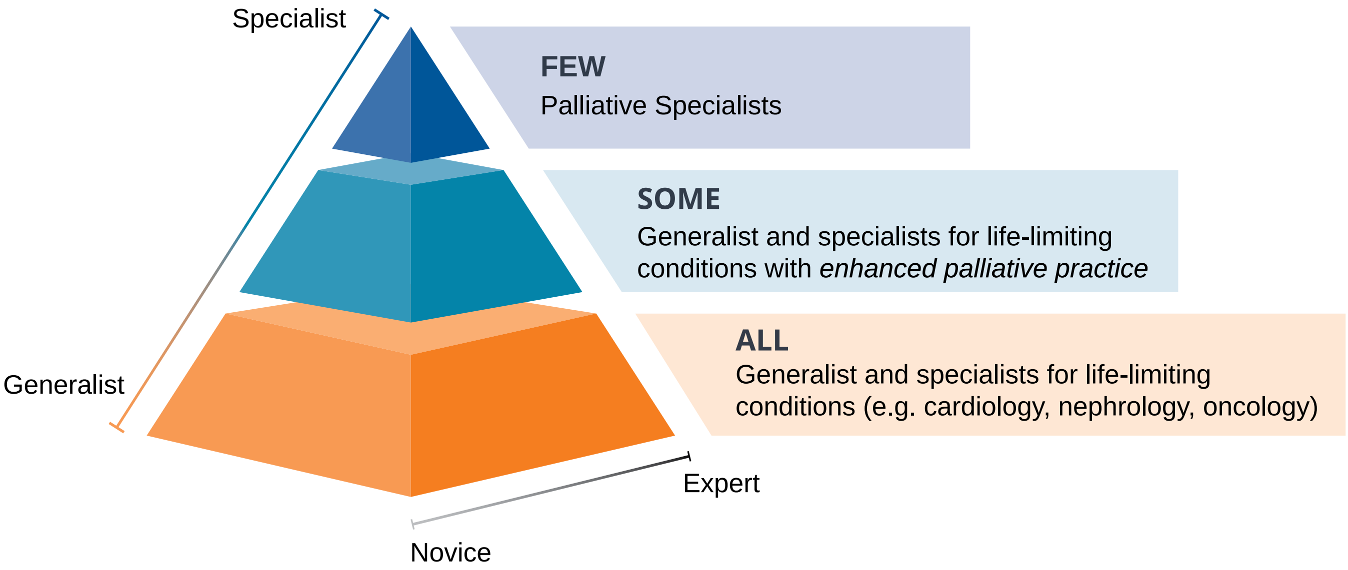
- Community — Patients in community are supported by their primary care providers and community nursing.
- Long Term Care — Residents of LTC facilities often have complex care needs and may require palliative care or be nearing end of life (EOL). In line with the patient's wishes and the support of family and staff, the patient will remain in the LTC facility until death.
- Hospice Care — Hospice care generally refers to EOL care. Typically, the patient's prognosis is 3 months or less.
- Acute Care — Palliative care patients are cared for on inpatient medical/surgical units, ICU and sometimes off-service beds.
- Tertiary Care — This level of service provides for complex care needs, such as high flow oxygen and intravenous antibiotics, that preclude palliative patients from being cared for in hospice beds.

Hospice Societies provide emotional, social, practical, spiritual, grief, and bereavement support and care. Hospice Societies aim to enhance quality of life and maintain dignity for people living with life-limiting illness and those at the end of life, their family, friends and others affected by their illness or death, as well as people who are grieving *(BCCPC, 2024)*.

The BC Centre for Palliative Care describes the relationship between levels of specialization within different health care provider categories and the capacity expected at each level.

Figure 2

The larger portion of the triangle is ALL, which is the largest group moving up to SOME and FEW at the top. There are fewer health care providers in the FEW category. Each level builds on the competencies below them and practitioners can move up levels.



Adapted from the *BC Centre for Palliative Care Inter-Professional Palliative Care Competency Framework*.

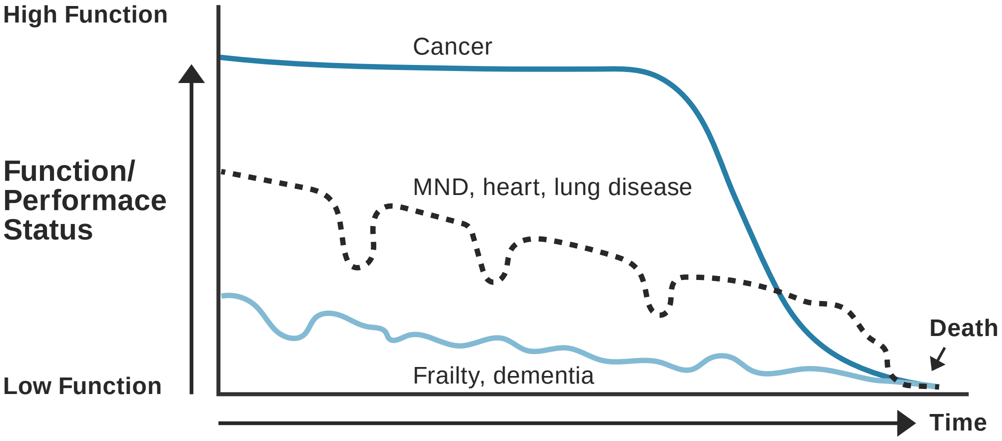
Improve Patient and Family Outcomes and Experiences

Ninety percent of persons who die may benefit from receiving palliative care services. This includes persons diagnosed with both malignant and non-malignant disease. With the exception of the approximately 10% of deaths that are sudden, deaths resulting from a broad range of causes — such as terminal illness, organ failure, and frailty — would benefit from access to palliative care *(Carstairs, 2010).*

Figure 3 shows disease trajectories for malignant and chronic disease. In the malignant disease trajectory, early palliative care is stable and minimal, yet in the last stages of illness, palliative care needs intensify for a short period of time. The chronic disease trajectory is less predictable, and it is difficult to determine if a dip in function may result in death. In dementia, the decline is slow, with smaller and more gradual dips in function. A palliative approach initiated by a primary care provider and inter-professional team early in the disease trajectory, allows for more timely response to changing needs and allows more effective management of patient transitions.

Figure 3
Disease Trajectories and Palliative Care

The three most common illness trajectories requiring a palliative approach to care are cancer, organ failure, and frailty/dementia. In all three trajectories, palliative approach can be used along the trajectory, regardless of the level of function. If we wait until the end of the trajectory to provide end of life care, we miss opportunities to plan and to improve quality of life and life expectancy. Palliative approach can be used, even in conjunction with active treatments.



Source: Lancaster University Medical School (2017). *Immunotherapy and Palliative Care Trajectories (IMPACT)*
https://chicas.lancaster-university.uk/projects/impact.html

PERSON AND FAMILY CENTERED CARE

Northern Health uses a person and family centered care approach to its health service delivery. Person and family centered care is an approach to the planning, delivery, and evaluation of health services grounded in mutually beneficial partnerships among health care providers, patients/clients, and families. It redefines the relationships in health care and leads to better health outcomes, wiser allocation of resources, and greater individual and family satisfaction (*Northern Health, 2018)*. More specifically, the approach seeks to:

1. Promote a Culture of Person and Family Centered Care within NH
2. Improve Experience of Care
3. Enhance All Forms of Person/Provider Relationships
4. Optimize Access to the Health System and Health Information

The person and family centered care approach's underlying values of inclusion, commitment to positive relationships and increased access merge nicely with the goals of culturally safe health care. This is a strength upon which to build the relationships and partnerships needed to improve Indigenous patient and family outcomes and experiences. The Regional Palliative Care Program actively participates in NH's Indigenous Health Engagement Strategy and will collaborate with First Nations Health Authority and Métis Nation BC in the development of resources and planning for services.

A PALLIATIVE APPROACH TO CARE

When considering who would benefit from palliative care, a palliative approach to care is the current best practice. This ensures that key aspects of palliative care are available to patients and families at appropriate times throughout the illness trajectory. After diagnosis and in the early stages of the illness the palliative approach to care focuses primarily on:

- Open and sensitive communication about prognosis and illness trajectory;
- Advanced care planning;
- Psychosocial and spiritual support; and,
- Pain and symptom management as required.

Later in the illness focuses on:

- Review of goals of care, and adjusting care strategies to reflect changes;
- On-going psychosocial support;
- Pain and symptom management; and,
- Engagement of specialized palliative care providers as needed to address complex physical, psychosocial or spiritual symptoms *(BC Ministry of Health, 2013).*

A palliative approach to care requires upstream orientation to care delivery, adapts specialized palliative care knowledge and expertise, and embeds it in care delivery, care processes and necessitates integration of care delivery *(iPanel, 2014)*. A palliative approach to care is not limited to measures taken in the last hours or days of life, but rather addresses care needs throughout the entire illness trajectory. It should be viewed as the requirement for care and services that form part of the continuum from the point of diagnosis and can and should overlap with active treatment.

Being diagnosed as needing palliative care or a palliative approach to care in the days, weeks or months before death can no longer be the impetus for providing palliative care as people living with chronic or life-ending illnesses have fluctuating disease trajectories and outcomes. Moving forward, a palliative approach should be integrated into care for all people with chronic, life-limiting conditions across all care settings and should be provided by primary care practitioners early in the course of a chronic, terminal disease to address patient's needs *(Canadian Hospice Palliative Care Association, 2015; iPanel, 2014)*.

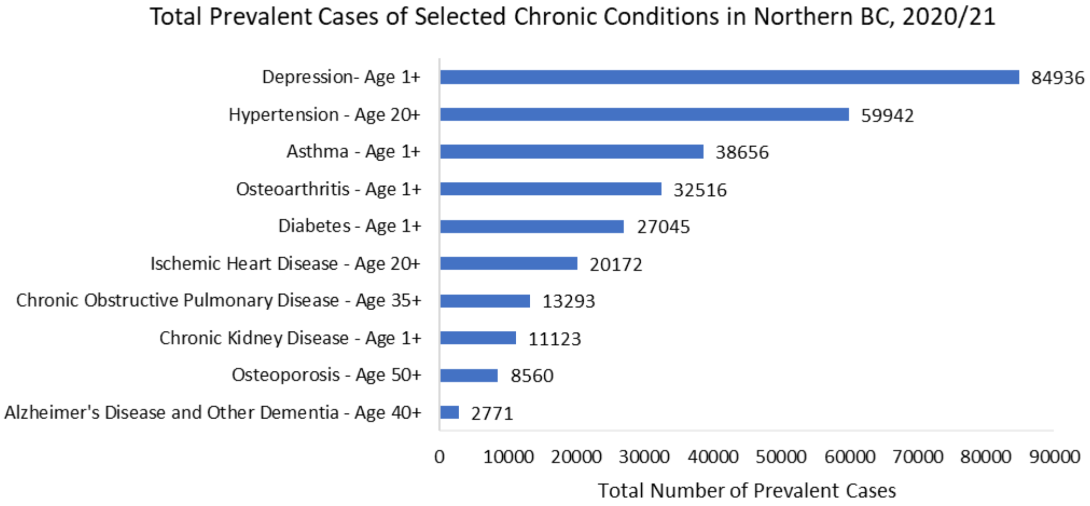
A RISING BURDEN OF CHRONIC DISEASE: A PALLIATIVE APPROACH TO CARE

Chronic diseases are prolonged conditions that may be terminal and eventually end the patient's life. These conditions include diabetes, heart failure and other heart disease, chronic obstructive pulmonary disease, kidney disease, and dementia. The success of our health care system has created a situation in which we now manage chronic diseases longer and more effectively than ever before. Because of advances in medical technologies and interventions, it is not unusual for a person to live long enough to develop multiple chronic, deteriorating conditions. As of 2019, 44% of Canadians report having been diagnosed with at least 1 of the 10 most common chronic diseases *(Centre for Surveillance and Applied Research, 2021).* In 2015/16, it was estimated the overall prevalence of multimorbidity (having 3 or more chronic conditions) in BC was 17%, rising to an estimated 38% for individuals over the age of 80 *(Basham, 2020)*.

The evidence shows that once these chronic conditions are diagnosed, taking a palliative care approach to care not only helps improve quality of life through symptom management, it can also increase life expectancy *(Canadian Hospice Palliative Care Association, 2015)*. The evidence also shows that there are opportunities to better manage these conditions and to improve outcomes through integrated approaches that include patient self-management strategies and integrated, interdisciplinary team support with specialist involvement when necessary. to better manage these conditions and to improve outcomes through integrated approaches that include patient self-management strategies and integrated, interdisciplinary team support with specialist involvement when necessary.

Figure 4 below shows the total number of prevalent cases for the most common chronic conditions that may require a palliative approach to care. In 2020/21, these select conditions represented 26,654 newly diagnosed cases and 465,028 total prevalent cases in Northern Health. Combined, these conditions constitute an enormous burden on the population of Northern British Columbia and on its health service system.

Figure 4.
Total number of prevalent cases of selected chronic conditions, 2020/21.



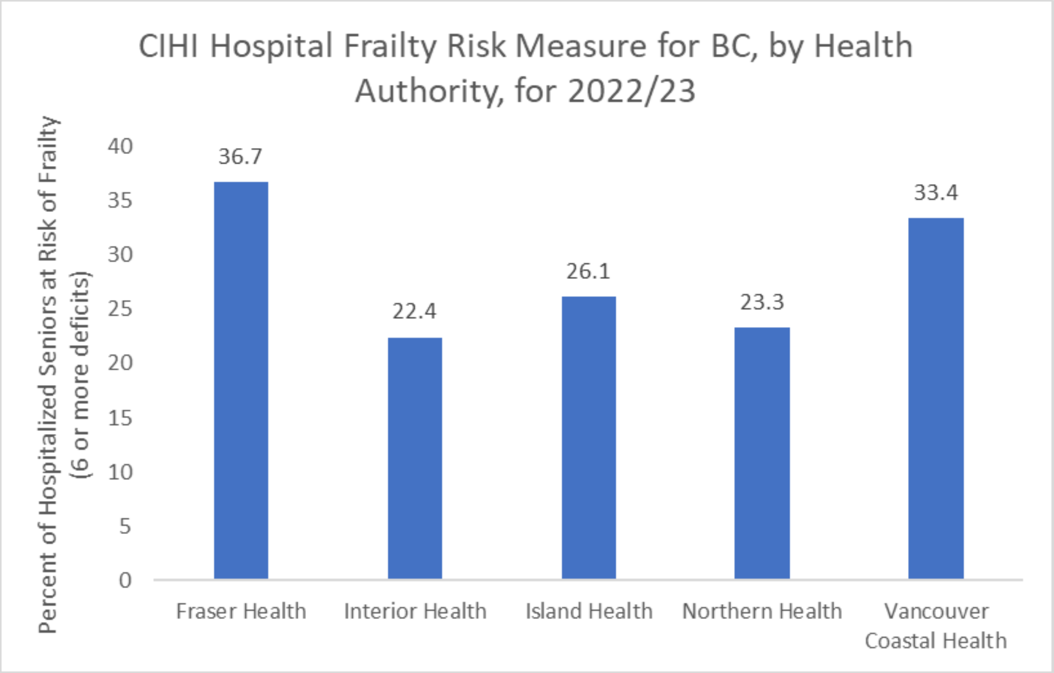
Source: British Columbia Ministry of Health [data provider]. *BC Observatory for Population and Public Health* [publisher]. Chronic Disease Dashboard.

A RISING BURDEN OF FRAILTY AND DEMENTIA: PALLIATIVE APPROACH

Frailty is a general term reflecting weakness, susceptibility to illness, injury, and prolonged recovery times. Elderly frail individuals are often the highest users of healthcare services; when in care they face significant risk of developing infections and depression, experiencing falls and have a poorer prognosis. Dementia is a condition where cognitive ability declines in a manner beyond that associated with normal aging. Dementia most frequently occurs in those aged 75 years and above. Individuals with dementia often need a variety of supports; either at home or in conjunction with residential care *(Northern Health, 2014)*.

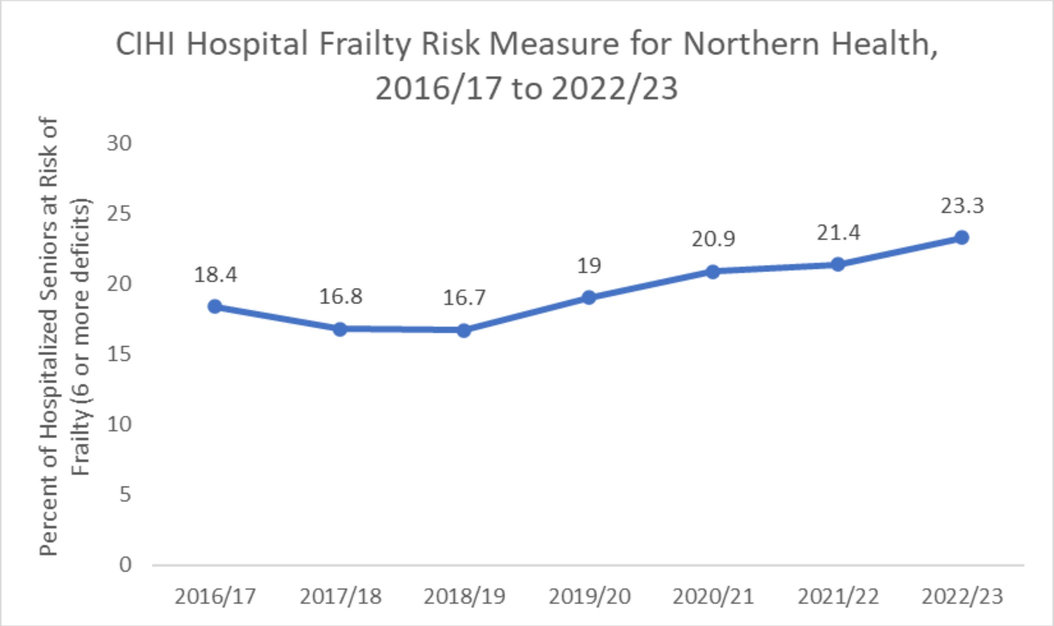
The Canadian Institute for Health Information has developed a contextual measure to characterize the risk of frailty among seniors in hospitals across Canada. The Hospital Frailty Risk Measure assesses 36 frailty condition categories and diagnoses to calculate an individual patient's risk of frailty *(Canadian Institute for Health Information, n.d.).* In the 2022/23 fiscal year, Northern Health has the second lowest proportion of hospitalized patients aged 65 years and older at risk of frailty in BC (Figure 5). However, the percent of hospitalized seniors at risk for frailty in Northern Health has been steadily increasing, from a low of 16.7% in 2018/19 to a high of 23.3% in 2022/23 (Figure 6).

Figure 5.
Percent of hospitalized seniors in BC at risk for frailty, by health authority, for 2022/23.



Data source: Canadian Institute for Health Information. (2023). *CIHI Hospital Frailty Risk Measure* — Data Tables. Ottawa, ON: CIHI.

Figure 6.
Percent of hospitalized seniors in Northern Health at risk for frailty, 2016/17 to 2022/23.



Data source: Canadian Institute for Health Information. (2023). *CIHI Hospital Frailty Risk Measure* — Data Tables. Ottawa, ON: CIHI.

Dementia is estimated using the Cognitive Performance Scale (CPS) which is part of the assessment for home care and residential care services. Table 1 below provides the 2023 population for Northern British Columbia residents aged 75+, along with a projection to 2033, and the number of aged 75+ active clients in Northern Health screened using the CPS. Projecting assessed clients with mild, moderate and severe dementia forward to 2033, it can be anticipated that if NH experiences the same rates of dementia among active clients, NH will see a roughly 70% increase in the number of individuals who experience dementia over the next ten years. This increase will place a significant burden on primary, acute and long term care services unless new ways of managing dementia and/or serving individuals with dementia can be found *(Northern Health, 2014)*. Taking a palliative approach to care with persons with frailty and dementia will significantly improve the impact health care demand moving forward, as the number of patients with frailty and dementia are expected to rise.

Table 1.
Estimates of total Northern Health population aged 75+ and the Cognitive Performance Scale rating of active Northern Health clients age 75+ for 2023, and estimated projections to 2033.

YEAR	POPULATION AGE 75+	CPS 1–2: MILD		CPS 3–4: MODERATE		CPS 5–6: SEVERE	
		# of Screened 75+ Clients	# of Total 75+ Population	# of Screened 75+ Clients	# of Total 75+ Population	# of Screened 75+ Clients	# of Total 75+ Population
2023	19,436	1,197	6.2%	683	3.5%	255	1.3%
2033	33,740	2,092	6.2%	1,181	3.5%	439	1.3%

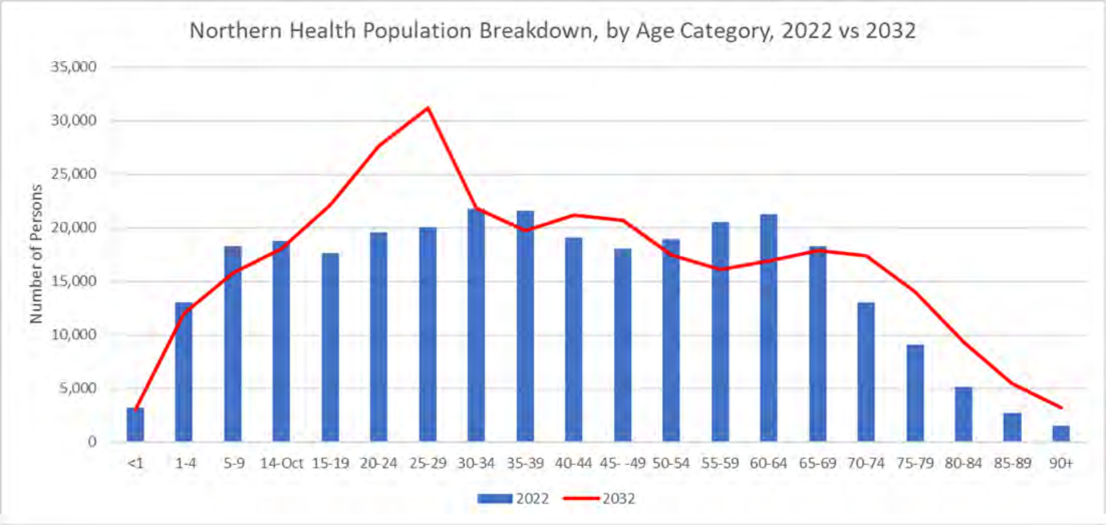
Data source: *RAI-HC, RAI 2.0, Med e-Care for Simon Fraser Lodge (SFL) and P.E.O.P.L.E. 2020*
Data extraction date: NH data extracted on Dec 21, 2023

Boreal Forest, B.C.

POPULATION PROJECTIONS AND SENIORS: INCREASED NEED FOR PALLIATIVE APPROACH

Between 2022 and 2032 the total BC population is expected to increase by 21% from 5,319,324 to 6,447,858 individuals *(BC Stats, 2023)*. In Northern BC, the projected increase from 2022 to 2032 is 10%. As seen in Figure 7 below, by 2032 the majority of this increase is projected to occur within the young adult and 70+ populations.

Figure 7.
Northern Health regional population breakdown for the years 2022 and 2032, by age category.



Source: BC Stats. (2023). *BC Population Estimates and Projections*.

For many years, Canada has faced a fast-growing elderly population, with the population of seniors aged 85+ growing at over twice the rate of the general population since 2016 *(Government of Canada, 2022).* BC is among the provinces with the highest proportion of people aged 85 years and older *(2022).* The aging population is a significant driver of health care demand, as the need for services rises dramatically with age. While many elderly British Columbians enjoy good health, aging continues to be associated with a variety of complex health challenges necessitating a wide range of health services and family supports from acute through to palliative care. A rising burden of chronic disease, frailty and dementia are three of these age-related challenges that will drive a significant demand for health services.

NH will be significantly challenged by the projected growth of the northern British Columbia seniors' population. Although the percentage of seniors aged 65 and over in the region's general population is currently one of the smallest of all the health regions at 17% *(BC Stats, 2023)*, the seniors' population is expected to continue to increase through to 2028. During this period, the population of people aged 65 years and over is expected to grow by 23%, the second highest projected percent change in BC *(Table 2)*.

Table 2.
Projected counts and percent increase for population aged 65+ in BC and regional health authorities, 2022 to 2028.

HEALTH AUTHORITY	POPULATION AGED 65 AND OVER IN 2022	PROJECTED POPULATION AGED 65 AND OVER IN 2028	PERCENT CHANGE
Fraser	344,530	436,458	27%
Interior	209,472	253,405	21%
Northern	49,778	61,256	23%
Vancouver Coastal	229,308	272,837	19%
Vancouver Island	225,374	270,802	20%
British Columbia	**1,058,462**	**1,294,758**	**22%**

Source: BC Stats. (2023). *BC Population Estimates and Projections*.

Enhance Access to Palliative Care Services

Northern Health's 7,000 staff members provide a full range of health care services across a vast landscape that comprises two-thirds of the province. As the largest (geographically) health authority in British Columbia, NH covers an area of approximately 592,116 square kilometers *(Northern Health, 2014)*. Approximately 300,000 people reside in northern British Columbia where approximately 2700 people die each year *(BC Ministry of Health, 2023)*. Of those persons who die each year, 90% would benefit from palliative care services and/or a palliative approach to their care *(Carstairs, 2010).*

Indigenous peoples in British Columbia include Métis, Inuit and First Nations peoples residing both off reserve and on-reserve. There are approximately 200,000 Indigenous peoples in the province of BC, which is close to 5% of the population. However, the Northern regions have the greatest proportions of Indigenous peoples in the province, ranging from approximately 13% in the Northeast and Northern Interior regions to 30% in the Northwest region. It is critical that palliative care services acknowledge the diversity within the Indigenous population and work towards improving access, availability, and cultural safety for all Indigenous peoples regardless of where they live or call home.

Northern Health acknowledges the harms experienced by Indigenous peoples accessing the health system. We are committed to new ways of being through building healthy and trusting relationships with Indigenous communities, families, individuals, and employees. These commitments are interwoven throughout the strategic priorities and integral to the success of Northern Health.

PALLIATIVE CARE IN NORTHERN HEALTH

Palliative care is provided in all communities, and in multiple settings (e.g., acute care):

- Community — Patients who choose to receive care at home are supported by their primary care providers, primary care inter-professional teams, and home and community care services (such as registered nurses, dieticians, social workers), home support services, medical supplies and equipment, BC Palliative Care Drug Program, home oxygen service, symptom management kit and planned death resources.
- NH has an obligation to provide 24/7 access to palliative care services for community patients. After hours palliative care nursing advice is available by phone and intended to support to community patients registered with the Northern Health Palliative Care Registry and BC Palliative Benefits and who are receiving community nursing services. However, additional in-person after-hours and weekend support are needed.
- Residential and Long Term Care (LTC) — Residents of LTC facilities often have complex care needs and a palliative approach to care should be taken at admission to the LTC facility, if not prior. Residents are able to receive palliative care/EOL care in the LTC facility, and if it is in line with the patient's wishes and with the support of family and staff, the patient will remain in the LTC facility until death. Registration with the Palliative Care Registry is not necessary on admission to LTC, however, early identification as the patient nears EOL is recommended to facilitate quality care and provide timely access to resources.
- Hospice Care — The only *dedicated*[1] hospice beds in Northern Health are located in Prince George at the Rotary Hospice House. Northern Health funds 7 of these beds. Approximately 22% of palliative care patients in Prince George are dying at Rotary Hospice House. *Designated*[2] palliative care beds (D-beds) are NH's approach to providing hospice care in communities that do not have dedicated hospice beds. D-beds are located in a number of NH long term and acute care facilities as a means to improve the quality, access and integration of palliative care for patients who have a palliative designation. EOL patients are a priority for these beds.
- Acute Care — Palliative care patients are cared for on inpatient medical/surgical units, ICU and sometimes off-service beds. Approximately 26% of palliative care patients in Prince George are dying at UHNBC.
- Tertiary Care — According to the Catalonia formula[3], 2 tertiary level palliative care unit beds are needed per 100,000 population. Northern Health is the only health authority in British Columbia without a tertiary palliative care unit. This level of service provides interventional palliative procedures, high flow oxygen, intravenous medications, and other care needs that preclude palliative patients from being cared for in alternate facilities such as hospices.
- Virtual Care — The use of technology to support patients both within PG and in other communities across the North.

Additional resources and services are available in all care settings and include:

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[1] Dedicated beds: provides protected access for a single purpose only. Require stringent admission criteria as part of reserving access.

[2] Designated beds: provides priority access for a target population but may be used for alternate purpose or populations.

[3] Catalonia formula: 10 inpatient palliative care beds/100,000 population. Of these 2 should be tertiary palliative care unit beds and 8 hospice level beds (as cited in the Canadian Atlas of Palliative Care, Pallium Canada, 2023).

- Consultation, mentorship and education resources
- Clinical rounds resources
- Pain and symptom management resources
- Best practice guidelines
- Ethical guidelines for clinical decision making in palliative care
- Adult palliative care order sets
- Clinical decision tools
- Advanced care planning
- Caregiver support
- Volunteer programs
- Bereavement and wellness support

To access palliative care services, supplies and equipment at no daily charge, patients must be registered in the NH Palliative Care Registry and with BC Palliative Care Benefits. The Registry supports earlier identification of palliative patients and coordinated and timely access to services and symptom management. Registration may be initiated by any healthcare provider with written confirmation by a physician. There are several criteria for registration for the program including:

- The patient is living with a life limiting or progressive illness;
- Curative treatment is not the primary focus of care;
- The patient or representative has agreed to accept palliative care services and;
- The patient has a life expectancy of less than six months.

A central data base is maintained for all people registered with palliative status and this is maintained by the NH PC Consultation Team. This data is collected in order to monitor, evaluate and improve palliative care outcomes and services. There has been an overall trend upwards in the number of patients on the Registry.

Lake Boya, B.C.

Support Health Care Providers to Deliver Quality Palliative Care

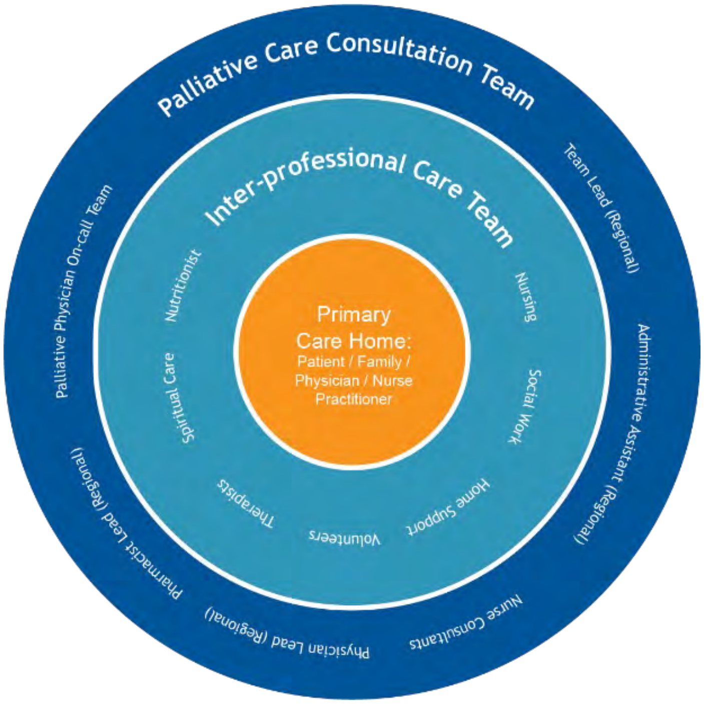
PALLIATIVE CARE FRAMEWORK

NH's Palliative Care Framework provides guidance and a structure for all service areas that offer palliative care. It supports NH to meet standards, guidelines and competencies as outlined by the Ministry of Health and the BC Center for Palliative Care and strives to ensure that palliative patients are provided similar care regardless of where they chose to live, especially with the unique challenges of rural and remote communities.

The NH Palliative Care Framework, which was developed in 2011, places the patient and family at the centre of care, which continues after the death of the patient with bereavement/support services for family and caregivers (see Figure 8).

The Northern Health Palliative Care Framework Manual is a guide for all care settings providing palliative care and is the responsibility of all care providers. The Framework outlines a consistent and standardized approach that all care settings and clinicians within these care settings will take to provide best practice palliative care.

Figure 8.
NH Palliative Care Program Framework of Care



REGIONAL PALLIATIVE CARE CONSULTATIVE TEAM

In NH, the delivery of palliative care is provided by inter-professional teams led by the family physician or a nurse practitioner. These professionals identify the issues, manage the disease, and provide fundamental palliative care in the patient's own community. To support this local team, NH has adopted a consultative model of care. In this secondary level of care, a Regional Palliative Care Consultation Team, an interdisciplinary team of palliative care experts, supports and mentors health care providers in every care setting where patients and families receive palliative care.

For every community, the Regional Palliative Care Consultation Team provides nurse consultant, pharmacist and Palliative Care Physician support. Leadership is provided by the Program and Physician Leads. All members of the Consultation Team work together to provide leadership and to contribute to all aspects of program development, including the development of clinical palliative care resources for care, educational programs, and quality improvement projects. The Palliative Care Consultation Team also collaborates with hospice societies in the provision of education to the public regarding palliative care issues, as well as providing leadership and education to hospice society volunteers and staff.

PALLIATIVE CARE EDUCATION AND COMPETENCIES

In order to support patients throughout their journeys, it is important that core competencies of palliative care be supported in all practice settings for all disciplines. Specialist palliative care teams, such as NH’s Regional Palliative Care Consultative Team, are best positioned to provide education and mentoring so that all care providers, whether professionals, volunteers or family members, can deliver integrated palliative care. In BC, Palliative Care competencies have been developed by the BC Centre for Palliative Care. The Regional Palliative Care Consultative Team delivers education to support health care providers to meet these competencies.

In addition to the palliative care education provided to all health care providers, cultural safety education is encouraged across Northern Health and is incorporated into palliative care education whenever possible. The Regional Palliative Care Program also promotes the Northern Health resources regarding cultural practices around illness and death.

HUMAN RESOURCE CONSIDERATIONS

Palliative care is best delivered by inter-professional teams that include nurses, physicians and allied health care providers. Volunteers, pharmacists, spiritual care providers, program managers, administrative assistants, as well as friends and family members, also play important roles in the provision of palliative care.

Adequate staffing is a necessary element of providing the quality care that patients need when facing serious illness. This includes supporting physicians, nurses and other health care providers to have the time they need to provide palliative care. Human resource planning should also take into consideration the requirement to provide 24/7 access to palliative care services for community patients and adequate staffing and support for designated beds across the North..

SELF-CARE, WELL-BEING, AND PSYCHOLOGICAL SAFETY

Health professionals may experience a variety of psychosocial risk factors, including heavy workload during periods of staff shortages, shift work and working on call, job demands, insufficient time for patient interaction, and lack of resources to meet patient needs. Providing palliative care is particularly demanding work that involves complex, sensitive issues that may make it difficult for providers to “turn off work” and achieve healthy balance between personal and professional life. Managing all of the clinical, emotional and ethical challenges that arise at the end of life often result in health care providers experiencing moral distress and psychological depletion.

Supporting the psychological health and well-being of health care workers promotes capacity to deliver quality patient care and helps to retain caregivers in their roles, which is important to continuity of care and stabilization of the workforce. Working with teams to develop coordinated and coherent plans to promote self-care and address issues in the work environment will support psychological well-being among palliative care providers.

Conclusion

Palliative care is an important domain of care that reduces suffering and improves the quality of life of patients and their families who are faced with life-limiting illness and will touch the majority of the population either directly or indirectly. Through its guiding principles, this document supports a vision of palliative care services in Northern British Columbia that improves the outcomes and experiences of people needing palliative and end-of-life care. The strength of this Strategy will be evident in its implementation. A robust Action Plan, updated every 3 years, accompanies this document to provide a clear road map to achieve its goals to improve patient and family outcomes and experiences; enhance access to palliative care services; and, support health care providers to deliver quality palliative care.

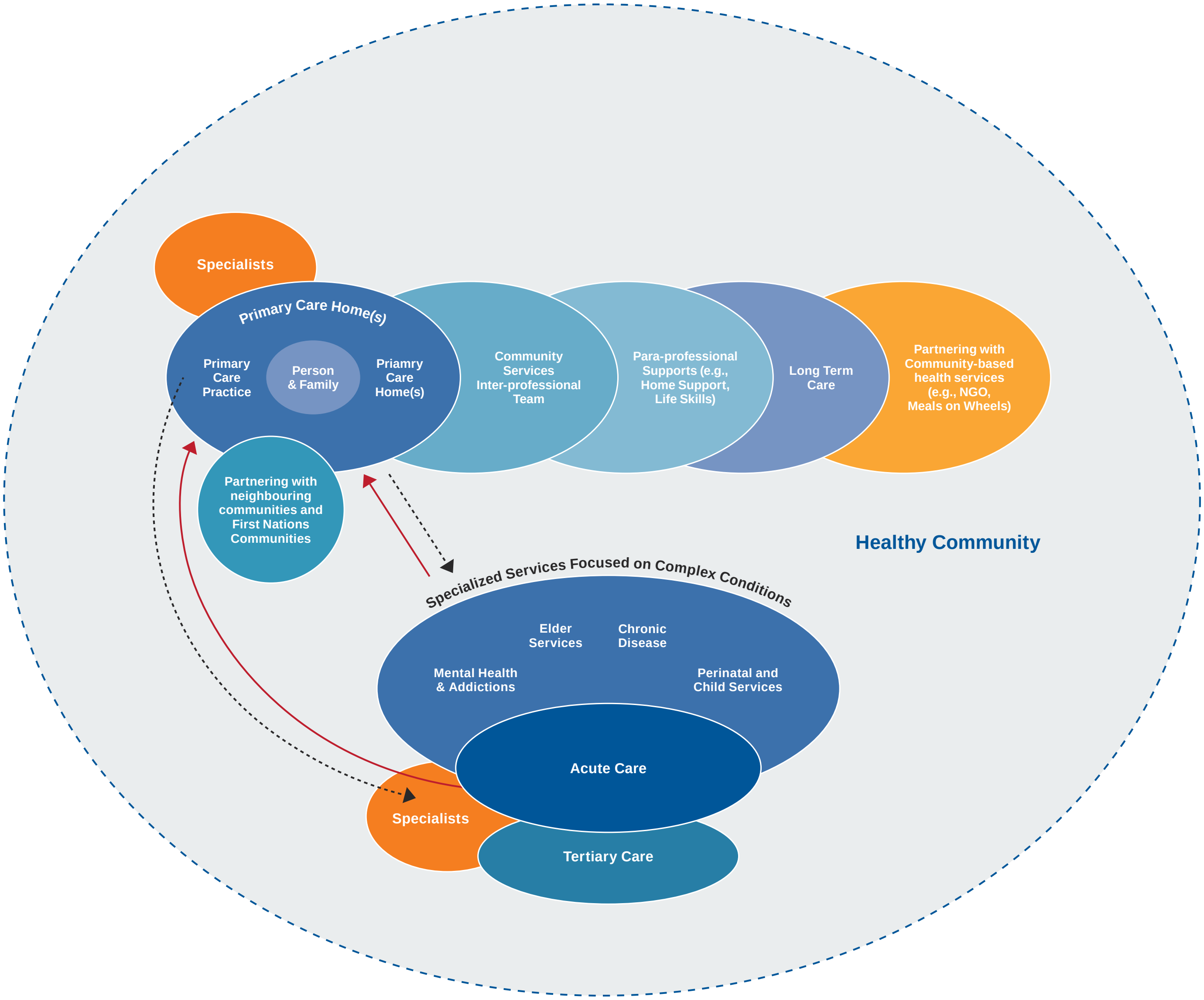
Definitions

Palliative Care	Palliative care means the specialized care of people who are dying — care aimed at alleviating suffering (physical, emotional, psychosocial or spiritual), rather than curing. The term “palliative care” is generally used in association with people who have an active, progressive and advanced disease, with little or no prospect of cure” *(BC Ministry of Health, 2006).*
Hospice Palliative Care	“Hospice palliative care” is a philosophy of care that stresses the relief of suffering and improvement of the quality of living and dying. It helps patients and families to: • 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; and • Cope with loss and grief during illness and bereavement *(BC Ministry of Health, 2006)*
End of Life Care	“End of life care is associated with advanced, life-limiting illnesses, and focuses on comfort, quality of life, respect for personal health care treatment decisions, support for the family, psychological and spiritual concerns” *(BC Ministry of Health, 2013).*
Palliative Care Competencies	Performance of critical work functions using related knowledge, skills, and abilities *(BC Centre for Palliative Care, 2019)*
Designated Bed/ Space or Service	A designated bed/space or service means that a target population is given priority access, but the bed/space or service may be used for alternate purposes or populations *(BC Ministry of Health, 2015).*
Dedicated Bed/ Space or Service	A dedicated bed/space or service means that the access is reserved for a single purpose only. Dedicated spaces require stringent admission criteria as part of reserving access *(BC Ministry of Health, 2015).*
Cultural safety	The goal of cultural safety is for all people to feel respected and safe when they interact with the health care system. Culturally safe health care services are free of racism and discrimination. People are supported to draw strengths from their identity, culture and community.

Appendix 1.
Northern Health's Idealized System of Services Framework for Larger Community

Partnering to Build a Healthy Community

- Municipalities, Regional Districts, First Nations, School Districts
- Healthy communities, healthy families, healthy schools, healthy workplaces, healthy public policy
- Partnered initiatives with communities, industries, workplaces, school districts, etc.



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