



# Palliative Care Framework (Program) Manual

---

October 2020

Reorder # 1745



**northern health**  
the northern way of caring

# Table of Contents

<b>Introduction .....</b>	<b>1</b>
<b>Palliative Care Definitions.....</b>	<b>1</b>
<b>Northern Health Palliative Care Program.....</b>	<b>2</b>
Goals of the Northern Health Palliative Care Program .....	3
Values of the Northern Health Palliative Care Program.....	3
<b>Northern Health Palliative Care Framework.....</b>	<b>3</b>
<b>Principles of the Northern Health Palliative Care Program Framework of Care .....</b>	<b>4</b>
Unit of Care - Patient and Families.....	4
Primary Care Providers: Family Physicians/Nurse Practitioners .....	5
Primary Care Interprofessional Team (IPT).....	6
Regional Palliative Care Consultation Team .....	6
<b>NH Palliative Care Framework – Organization and Functions.....</b>	<b>7</b>
How Is It Organized? .....	7
Leadership and Governance .....	7
Operationally in each HSDA.....	7
Strategic Direction.....	7
How Does It Work?.....	8
Registration Based.....	8
Palliative Care Registry .....	8
<b>Northern Health Services Providing Palliative Care .....</b>	<b>9</b>
Community-Based Care .....	9
Professional Services .....	9
Home Support Services.....	9
Supplies & Equipment Resource.....	9
BC Palliative Care Benefits Resource.....	9
Home Oxygen Program (HOP).....	10
Symptom Management Kit (SMK) Resource .....	10
Planned Home Death Resources.....	11

- Acute/Hospital-Based Services..... 11
- Long-Term Care (LTC) Services..... 11
- Designated Palliative Care Beds Resource (D-beds) ..... 11
- Rotary Hospice House - Prince George ..... 11
- Additional Services/Resources Available in All Care Settings ..... 12
  - Palliative Care Consultation Service ..... 12
  - Clinical Rounds Resource ..... 12
  - 24/7 Response Service..... 12
  - Assessment Tools..... 13
  - BC Inter-Professional Palliative Symptom Management Guidelines (2019) and Northern Health Palliative Care Symptom Guidelines (4th ed.) ..... 14
  - Clinical Ethics..... 14
  - NH Adult Palliative Care Orders for Outpatients, D Beds and Symptom Management Kits..... 14
  - Advance Care Planning ..... 15
  - Caregivers' Support ..... 15
  - Volunteers ..... 15
  - Bereavement..... 15
  - Education ..... 16
  - Self-Care ..... 16

## Introduction

Palliative care is an approach to care which applies when supporting people who have an active, progressive, and advanced disease; who have little or no prospect of cure; and the goal is to improve quality of life for both the patient and family.

The support, operation and evaluation of the palliative care program is the responsibility of senior decision makers in each Health Service Delivery Area (HSDA) (e.g. Chief Operating Officers, Health Services Administrators, Acute Care Managers, Residential Care Managers and Community Services Managers).

The vision for palliative care aligns with the Northern Health (NH) Vision – “Northern Health leads the way in promoting health and providing health services for Northern and rural populations” – and reflects the NH Mission – “Through the efforts of our dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners” – by integrating and coordinating equitable access to high quality palliative care services for patients living with a life-limiting illness and their families.

Dying is a part of life and a ‘good death’ is a measure of the health of individuals, families and communities. Recognizing this and the efficiencies resulting from a coordinated approach to care at the end of life, NH developed a regional Palliative Care Program. This program continues to evolve, plan and provide direction for the provision of palliative care in Northern British Columbia.

In 2013, the Government of British Columbia released *The Provincial End of Life Action Plan for British Columbia*, which outlines priority actions for end-of-life care. Work has been underway within NH for several years to align with these priorities. The NH Palliative Care Strategy is a key element of NH Senior’s Strategy and is part of the health authority’s primary and community care integration work, contemplating how to best provide services within a rural context.

## Palliative Care Definitions

The NH Palliative Care Program defines palliative care as a type of health care for people who are living with active, progressive and life-limiting illness. Palliative care is holistic care aimed at alleviating suffering, whether physical, emotional, psychosocial, or spiritual. Palliative care is provided by a multidisciplinary team and may occur alongside treatments that control or manage illness. Palliative care is about promoting the best possible quality of life for patients living with a life-limiting illness and their family/loved ones as defined by the individuals.

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.

**Palliative care:** 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:** 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.
- Cope with loss and grief during illness and bereavement (BC Ministry of Health, 2006).

**Palliative Approach:** makes certain aspects of palliative care available to patients and families at appropriate times throughout the illness trajectory. After diagnosis, and in the early stages of the illness, the Palliative Care Approach focuses primarily on:

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

Later in the illness the Palliative Approach focuses on:

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

Palliative Approach 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).

**End-of-life (EOL) 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, and psychological and spiritual concerns” (BC Ministry of Health, 2013).

## Northern Health Palliative Care Program

The NH Palliative Care Program provides the framework for all services in NH offering palliative care to ensure standardized “best practice guidelines” are followed when providing palliative care in any setting (e.g. acute care, community, residential). It ensures that dying patients are provided the same care regardless of where they choose to die.

## Goals of the Northern Health Palliative Care Program

NH palliative care provides the framework to:

- Improve access to palliative care.
- Standardize the quality of palliative care.
- Promote the integration and coordination of care throughout NH. Ultimately, the goal is to provide quality palliative and EOL care to persons in the location of their choice, considering the rural and remote context that exists in the health authority.

## Values of the Northern Health Palliative Care Program

The NH Palliative Care Program reflects the [Values of Northern Health](#) and the [Canadian Hospice Palliative Care Association](#).

## Northern Health Palliative Care Framework

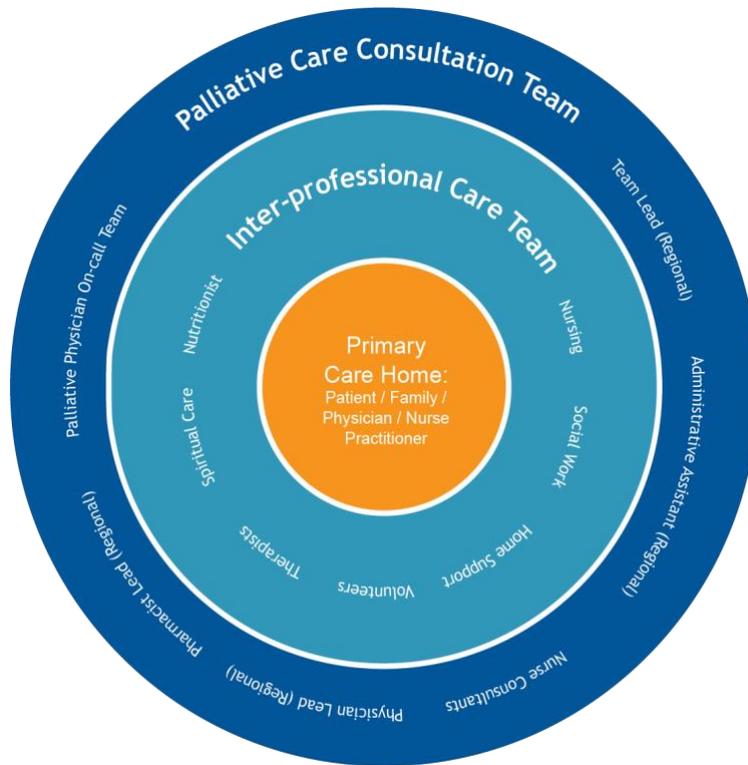
The NH Palliative Care Framework supports both the patient and family as the unit and center of care. Care continues after the death of the patient with bereavement/support services for family and caregivers.

In NH, the delivery of palliative care is provided by local primary care interprofessional teams, made up of health care providers, and led by the family physician or a nurse practitioner. These teams identify issues, manage the disease and provide fundamental palliative care in the patient's own community. NH primary care interprofessional teams are made up of professionals from many disciplines including: physicians, nurse practitioners, nurses, social workers, occupational therapists etc. who work collaboratively with volunteers, support workers, family members or friends to provide palliative care to patients and their families.

To support this local team, NH has adopted a consultative model of care. In this specialized tertiary level of care, an interdisciplinary team of palliative care experts (NH Palliative Care Consultation Team) support and mentor primary care providers in every care setting where patients/families receive care.

The Palliative Care Consultation Team provides Physician Lead, Pharmacist Lead and Nurse Consultant support across the NH region.

All members of the consultation team work together to provide leadership and contribute to all aspects of program development. This includes the development of clinical palliative care resources for care.



**Figure 1** Illustrates the Northern Health Palliative Care Program Framework of Care.

## Principles of the Northern Health Palliative Care Program Framework of Care

### Unit of Care: Patient and Families

NH palliative care places the person and family at the centre of care, and recognizes the unit of care to be both the patient and the family as defined below:

*Patient:* The person living with an acute, chronic, or advanced illness. The term patient, as opposed to client, is used in recognition of the individual’s potential vulnerability at any time during the illness. The word patient derives from the Latin ‘*patiens*’, to suffer, to undergo, to bear. <sup>1</sup>

*Family:* Those closest to the patient in knowledge, care and affection. These may include the biological family, the family of acquisition (related by marriage/contract) or the family of choice and friends (including pets). The patient identifies who will be involved in his/her care and/or be present at the bedside. <sup>2</sup>

<sup>1</sup> CHPCA, *A model to guide hospice palliative care: Based on national principles and norms of practice.* (Ottawa: CHPCA, 2002).

<sup>2</sup> CHPCA, *A model to guide hospice palliative care: Based on national principles and norms of practice.* (Ottawa: CHPCA, 2002).

Patients and families have the responsibility to:

- When ready, engage in pre-planning for EOL care and issues (e.g. choose a preferred place of care and death, consider an advanced directive, attend to legal/will issues, make funeral arrangements, and inform their health care team of decisions).
- Ask questions (if they wish to know) until they clearly understand their health condition, treatments, or method of care.
- Tell the health care team when they are experiencing pain, other symptoms, or have concerns/questions.

## **Primary Care Providers: Family Physicians/Nurse Practitioners**

Family physicians and nurse practitioners (NP) are primary care providers but have a unique role on the team. In addition to the primary care provider responsibilities listed below, the family physician and NP will:

- Initiate the EOL Practice Support Program (PSP) module/algorithm in the primary care home; this includes taking the lead with decision making and advanced care planning. Discuss resuscitation issues and choices with the patient and family, sign the No CPR/MOST form, and obtain signatures from the patient or Substitute Decision Maker (SDM) as appropriate.
- Confirm, by signing the NH palliative care registration form, that the patient meets the Palliative Care Program criteria (see registration criteria).
- Register the patient with [BC Palliative Care Benefits](#) as appropriate.
- Request provision of community nursing services as early as possible in the palliative process.
- Maintain the responsibility for the day-to-day medical management of the palliative patient in all care settings, which may include home visits.
- Ensure care plans are in place for predictable challenges at end-of-life including appropriate medications and supplies in discussion with the primary care nurse. Patients followed by the primary care interprofessional team (IPT) can also be referred to the Palliative Care Consultation Team.
- For an expected death at home ([planned home death resources](#)):
  - Discuss arrangements for actions at the time of death with patient, family and community nursing.
  - Complete Notification of Expected Death in the home form as per joint protocol for expected/planned home death.
  - Complete adult palliative care orders for outpatients, D Beds, Symptom Management Kits (SMK) and any prescriptions for other anticipated medications.

## Primary Care Interprofessional Team (IPT)

IPT will work with the primary care home to:

- Provide early identification of patients who meet palliative care status.
- Assist with the transitions identified in the [End of Life Practice Support Program module/algorithm](#).
- Provide ongoing assessment of palliative care patients and their families using standardized and validated assessment tools.
- Provide timely pain and symptom management based on approved clinical guidelines.
- Collaborate and communicate with other primary care providers to ensure the needs and expectations of the patient and family have been addressed.
- Participate in local palliative care interdisciplinary teams and work collaboratively with the interdisciplinary primary care providers.
- Develop, plan, and evaluate individual care plans while acknowledging the diversity of individuals and of services available in communities within each HSDA.
- Request consultation with members of the Palliative Care Consultation Team as needed.
- Assure continuity of care across the continuum and within each health care setting using detailed discharge planning and information sharing.
- Provide teaching and support to assist the patient and family in making informed decisions about care options that are based on ethical principles.
- Educate family members/informal caregivers about how to provide care and comfort measures for the patient and for themselves.
- Provide or refer to bereavement support services.

## Regional Palliative Care Consultation Team

Consultants as a specialized level of service will:

- Be an advocate for the NH Palliative Care Program.
- Provide education, support, and mentorship to build capacity among primary care providers, residents, and students.
- Provide consultation and clinical expertise for primary care providers and staff in all care settings.
- Participate in program development at the regional and local level.
- Help to establish and promote an interdisciplinary approach to care by participating in and/or promoting the activities of local palliative care clinical rounds.
- Be responsible for statistical data as required and for the maintenance of the Palliative Care Registry in each HSDA.

- Identify situations in which clinical care does not meet acceptable standards, despite consultative support provided, and reports through the appropriate channel.
- Collaborate with non-NH caregivers (e.g. volunteers, end-of-life doulas, hospice societies).
- Participate in research and evaluation activities.

## **NH Palliative Care Framework – Organization and Functions**

The Palliative Care Framework Manual serves as a framework to all care settings providing palliative care. Providing palliative care services is the responsibility of all managers in all care settings providing end-of-life care. 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.

### **How Is It Organized?**

#### **Leadership and Governance**

Operational leadership on the NH Palliative Care Program is the responsibility of the Chief Operating Officers in each HSDA to ensure operational success.

#### **Operationally in each HSDA**

Each operational manager within the care setting (acute care hospitals, residential care, designated beds in residential care, community care) is responsible to ensure quality palliative care provision and that the policies and best practice resources are followed, gaps in service identified and resolved in an integrative approach across all sectors. These operational managers' report to their respective managers.

#### **Strategic Direction**

Strategic direction is provided regionally by the NH Executive ensuring that NH Palliative Care Program aligns with the Vision and Mission of Northern Health, NH's Idealized System of Services and other strategic planning processes (including Senior's Strategy and Chronic Disease Strategy etc.).

The responsibility and interpretation of the strategic alignment is the responsibility of the Executive Lead Elder Program and the Lead for NH Palliative Care.

The program will integrate information received through data collection and quality management to develop regional strategies and supporting policies to ensure competent and timely health care team involvement with the person/family through to death.

## How Does It Work?

### Registration Based

To access identified palliative care services a patient must be registered in the NH Palliative Care Registry to allow a broader set of services to be provided. Registration may be initiated by any health care provider with written confirmation by a physician or nurse practitioner.

The purpose of registration is to:

- Support earlier identification of palliative patients resulting in more appropriately coordinated care and timely access to services and symptom management.
- Provide quantitative data in order to direct future program development.

There are several criteria for registration 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.
- The patient has a life expectancy of less than 6 months.

### Palliative Care Registry

A registry of all patients identified as having met the criteria for palliative status will be maintained.

The NH Palliative Care Registry is maintained to:

- Provide a central database of all patients designated as palliative in NH.
- Confirm patient eligibility for select supplies, services and equipment at no daily charge.
- Provide quantitative data in order to monitor current program activity and direct future program development.

The Palliative Care Consultation Team will be responsible for entering and updating client information from the NH Palliative Care Registration Form.

Data will be collected at the local, HSDA and regional level in order to monitor, evaluate and improve palliative care clinical outcomes and services. The data will be collected primarily from the Palliative Care Registry of patients.

## Northern Health Services Providing Palliative Care

The following are services that palliative patients can receive.

### Community-Based Care

Palliative care patients who choose to receive care at home can receive community-based care as follows.

#### Professional Services

Primary care interprofessional teams provide professional services that support people and their families who are nearing EOL at home or in long-term care facilities. Services may be provided by Primary Care Nurses, Occupational Therapists, Physiotherapists, and Social Workers. Details on the various home-based services offered can be found under Home & Community Care at: <https://www.northernhealth.ca/services>.

#### Home Support Services

Community health workers provide assistance with personal care, activities of daily living and respite care. This service is provided in accordance with NH guidelines that determine the provision of all home support. The hours and services provided are determined, monitored and reviewed by NH Primary and Community Care service providers. If a client is currently referred to Primary and Community Care and registered with the NH Palliative Care Program, there is no per diem charge for NH home support service.

#### Supplies & Equipment Resource

For patients registered with the NH Palliative Care Program, selected medical supplies are necessary to facilitate home care. Wound dressing supplies, incontinence supplies, injection/infusion equipment, and other supplies are provided free of charge following assessment by a Primary Care Nurse who will determine what is necessary.

Loans of equipment to facilitate care at home (e.g. hospital bed, pressure relieving/reducing mattresses and cushions, commodes, wheelchairs, mobility and safety aids, etc.) are provided free of charge following assessment by Northern Health primary care interprofessional teams. In some communities this equipment is provided in partnership with other organizations (e.g. Red Cross, Hospice Societies).

#### BC Palliative Care Benefits Resource

The BC Palliative Care Benefits (sometimes referred to as “Plan P”) is provided by the BC Ministry of Health.

Plan P provides coverage (free of charge to the patient) for select prescription and non-prescription medications that support symptom management and quality of life. These medications are listed in the [‘Palliative Care Drug Plan Formulary’](#). Any patient, living at home or in a designated hospice bed is eligible for BC Palliative Care Benefits. Excluded are those living in a long-term care residence, covered under PharmaCare Plan B, members of the

Canadian Forces, and RCMP. The BC Palliative Care Benefits Registration form is completed by the physician or nurse practitioner, faxed to PharmaCare, and a copy sent to the [relevant local community](#) services office.

Registration with the NH Palliative Care Program is not required for Plan P, but is recommended.

Further information, the drug plan formulary, and application forms are available at the following sites:

- [PharmaCare](#)
- [Northern Health Palliative Care/End-of-life registration](#)

### **Home Oxygen Program (HOP)**

A palliative diagnosis does not ensure a home oxygen subsidy. Palliative patients must qualify by meeting specific HOP criteria to be considered. The Palliative Care Benefits Program does not provide oxygen coverage.

### **Symptom Management Kit (SMK) Resource**

[\(Clinical Practice Standard: Symptom Management Kit for Community Palliative care\)](#)

In partnership with select community pharmacies, NH provides a readily accessible kit of medications and supplies required to manage symptoms in adults who are cared for in their own home. The medications are for use on a short-term basis, until arrangements can be made for the patient's own supply of the medication.

The patient must be:

- Registered with the NH Palliative Care
- Registered with the BC Palliative Benefit
- Referred to nursing services

In communities where kits are not available, the nurse can assess the patient and the physician/nurse practitioner would then order specific medications for the patient, anticipating the most common symptoms. The Palliative Care Adult Order Sets are available on the OurNH palliative care site and can be used to guide the physician/NP and assist them with appropriate medications and dosages based on the BC Inter-professional Palliative Symptom Management Guidelines. The medications would be dispensed from the pharmacy and kept in the patient's home in a safe and secure manner. The nurse then needs to incorporate teaching for proper medication administration and use. Teaching would be instituted and then assessed on an ongoing basis by community nursing staff with regular visits, and medication use evaluated.

## Planned Home Death Resources

- [No CPR](#) or [MOST form](#): patients who know they have a terminal illness or are considered to be at the end of their natural lives can request beforehand that no active resuscitation be started on their behalf if they are dying.
- [Joint Protocol for Expected/Planned Home Deaths in British Columbia Service](#): clarifies the process and procedures involved in managing anticipated natural home deaths in the context of a terminal illness and outlines the roles and responsibilities of health professionals and agencies involved in a home death.

## Acute/Hospital-Based Services

Acute care/hospital-based palliative care services are available if the patient and family desires this, or if the patient care needs exceed what can be provided in the community.

## Long-Term Care (LTC) Services

Patients admitted to LTC beds have complex care needs and are acknowledged as being near the end of life or requiring palliative care. In line with the patient's wishes and 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. Interdisciplinary Palliative Care Consultation Team with specialized skills is available to support the individual, family, and staff as needed.

## Designated Palliative Care Beds Resource (D-beds)

Designated palliative care 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. Please check the NH website for an updated list of where these beds are located.

## Rotary Hospice House - Prince George

In partnership with NH, the Prince George Hospice Palliative Care Society operates Rotary Hospice House, a ten-bed facility in Prince George designed to provide EOL care to anyone who is suffering with an advanced chronic or life-limiting illness. NH partners with, and provides consultation and support for, the Rotary Hospice House staff to further develop their level of expertise. Further information can be found at: <http://www.hospiceprincegeorge.ca>

## **Additional Services/Resources Available in All Care Settings**

### **Palliative Care Consultation Service**

The Palliative Care Consultation Team supports and mentors primary care providers in every care setting where patients or families receive palliative care. The team consists of physicians, a team lead, a pharmacist, and nurses.

The palliative care consultation service is available for:

- Education sessions to build the capacity among primary care providers in all care settings.
- Consults on clinically complex palliative care patients.
- Counselling on physical, psychological, social, spiritual, death management, loss/grief services and resources.
- The development of evidence-based best practice palliative care resources.

Criteria for Consultation:

- The patient should be registered with the NH Palliative Care Registry (unless patient is a permanent resident in LTC).
- The family physician/nurse practitioner is aware of the consultation request.
- The individual has complex symptom management and/or psychosocial issues.
- The individual or designated decision maker has agreed to the referral.
- Note: A request for consultation can be made by any member of the clinical team.

### **Clinical Rounds Resource**

Clinical rounds support quality palliative care because the issues faced by patients at the EOL are complex and multi-dimensional requiring teamwork from individuals with diverse skills and knowledge who share the goal of improving the quality of life for the patient.

**Interdisciplinary clinical rounds may be established to:**

- Review palliative cases in order to support palliative best practice.
- Promote palliative care knowledge exchange among members of the interdisciplinary team.
- Identify and refer any issues or concerns regarding policies, procedures, and resources.

### **24/7 Response Service**

The goal of the NH Palliative Care Program is to provide a 24/7 response service for patients, families and primary care providers.

- Patients and families – Patients and their families can contact their primary care provider during regular office hours as needed. After hours, they can access the After-

Hours Palliative Nurse Services (AHPNS). The AHPNS is a specialized phone service offered through HealthLink BC for after-hours palliative inquiries regarding symptom management and other palliative concerns.

- Nurses and team members – during business hours, nurses can contact the patient’s primary care provider or the consultation team by telephone.
- Physicians/Nurse Practitioner - The Palliative Care Nurse Consultants and Palliative Care Physicians offer consultation and clinical support to physicians and NPs by telephone, or if able, in person. Outside of regular office hours primary care providers may contact the on-call Palliative Care Physician for advice on symptom management by calling UHNBC switchboard at 250-565-2000. Care providers can also contact the BC Physician Palliative Care Consultation line at 1-877-711-5757. This line offers 24/7 access for physicians to a palliative care physician for symptom management advice.

### **Assessment Tools**

An assessment which includes the physical, emotional, social, and spiritual aspects of the patient will be completed by health care providers using appropriate and validated assessment tools.

- The goals of assessment in palliative care are to:
  - Obtain a history, current symptoms, treatments and impact illness has on the patient’s quality of life.
  - Establish goals of care.
  - Identify symptoms experienced by the individual.
  - Include the patient’s perspective as to the severity of the symptoms, which will direct the management of the symptoms.
  - Provide on-going assessment to determine the effectiveness of interventions/treatments.
  - Enhance the communication about the needs of the patient/family between various health care providers.
- The choice of the most appropriate tool requires an awareness of the assessment goals and the verbal competency of the patient/family.
- Good assessment technique requires an appropriate environment, sufficient time, attentive listening skills, and appropriate training in the use of approved assessment tools.
- A wide variety of appropriate and validated assessment tools have been developed and may be used.

The following are the tools selected and provided in NH:

- [Braden-Pressure Ulcer Risk Assessment Tool](#)
- [Edmonton Symptom Assessment System – Revised \(ESAS-r\) Graph](#)
- [Edmonton Symptom Assessment System – Revised \(ESAS-r\) Numerical Scale](#)
- [Mini Mental State Examination \(MMSE\) \(FOLSTEIN\)](#)
- [Pain Assessment](#) (O-V)
- [Pain Assessment in Advanced Dementia \(PAINAD\) Scale](#)
- [Palliative Performance Scale \(PPS\)](#)
- [Supportive and Palliative Indicators Tool \(SPICT\)](#)
- [Symptom Assessment](#) (O-V)

### **BC Inter-Professional Palliative Symptom Management Guidelines (2019) and Northern Health Palliative Care Symptom Guidelines (4th ed.)**

The guidelines are intended to provide general advice to clinicians, physicians, and nurses involved in palliative care support. They provide practical and easy-to-follow advice to health care providers for effective patient care.

The guidelines are not an all-inclusive list of symptom guidelines. Rather, they are intended to be a resource for some of the more common symptoms experienced by adult patients ( $\geq 19$  years of age) who are living with advanced life-limiting illness. As they are symptom guidelines only, they do not replace individual patient assessment and/or clinical judgment within the scope of the professional. Access to the guidelines can be found here: [BC Centre for Palliative care BC Inter-Professional Palliative Symptom Management Guidelines](#) and [NH Palliative care Symptom Guidelines \(4<sup>th</sup> Edition\)](#).

### **Clinical Ethics**

Health ethics is about making decisions – both by people who receive health care and for people who provide health care – that respect everyone's beliefs, values and knowledge. These decisions, which occasionally may be difficult and complex, need to be made within the ethical parameters of beneficence, non-maleficence, fidelity, justice and respect for the patient's autonomy and wishes. Assistance with making ethical decisions can be provided by the [Northern Health Ethics Committee](#).

### **NH Adult Palliative Care Orders for Outpatients, D Beds and Symptom Management Kits**

Palliative care medication order sets are approved by the NH Medication Safety and Quality Committee and the NH Medical Advisory Committee (NHMAC) and are reviewed every three years. They provide adult palliative patient specific physician orders for symptom management and crisis events which enable nurses to begin managing care prior to contacting the physician. The order sets integrate and coordinate care by communicating best practices. This helps reduce variation, unintentional oversight, and unnecessary calls to physicians for

clarifications and questions regarding orders. The orders are consistent, legible and allow for timely symptom management. More information can be found in the [Symptom Management Kit for Community Palliative Care Clinical Practice Standard](#). For questions or individualized support in accessing the order sets e-mail: [Palliative.Care.Consult.Team@northernhealth.ca](mailto:Palliative.Care.Consult.Team@northernhealth.ca).

### **Advance Care Planning**

Advance Care Planning (ACP) gives patients the opportunity to make choices about their future health care decisions. It helps capable adults to prepare if the time comes when they are unable to make decisions and speak on their own behalf. Through ACP, family members and health care providers are made aware of the person's wishes for further health care treatment options and EOL care. ACP allows for understanding and respect of the person's choices based on their values and beliefs. NH will collaborate and partner with hospice societies and volunteers across the North to promote ACP and provide leadership and education for the public and staff. Further information can be obtained from [Speak Up BC](#), [Advance Care Planning](#) or [B.C. ACP](#).

### **Caregivers' Support**

Informal caregivers are fundamental in providing palliative care and assisting patients in remaining in their home longer. The increasing emphasis on providing care in the home means family caregivers often take on a greater burden of care. Recognizing the increased family caregiver responsibilities, primary care providers facilitate support for caregivers by:

- Providing information and resources related to caregiver support groups.
- Assisting with applications for financial support to those who have taken a leave of absence from paid work to care for a terminally ill family member.
- Providing respite through home support services.
- Further information can be obtained by contacting the Hospice Society in your community or area.
- Providing the *Palliative Care at Home Binder*.

### **Volunteers**

Palliative care volunteers provide support and are fundamental to the palliative care philosophy. The most common volunteer role is working with the patient and family through companionship, listening and sitting at the patient's bedside during the dying process. Specialized volunteers may provide bereavement support to family and friends. Further information can be found by contacting the Hospice Society in your community or area.

### **Bereavement**

Bereavement and grieving are normal processes following loss. Support and counselling does not always need to be provided by professionals. In many communities, support is provided by religious/spiritual leaders, volunteers and informal groups.

Grief counselling, professional support groups or educational classes with peer-led support groups are available to the bereaved. Further information on specific grief and bereavement resources in your area are available through the BC Bereavement Helpline: <http://www.bcbereavementhelpline.com/> or through your local Hospice Society.

### **Education**

All care providers have a responsibility to maintain their palliative care competencies through ongoing education and learning. For any education or mentorship needs, contact the Northern Health Palliative Care Consultation Team at [Palliative.Care.Consult.Team@northernhealth.ca](mailto:Palliative.Care.Consult.Team@northernhealth.ca).

### **Self-Care**

Providing palliative care may contribute to health care providers to experiencing burnout or compassion fatigue with ongoing demands for compassion and care. The impact of this work is often profound. Support for and access to individual counselling sessions provided by professional counsellors is available. NH provides these and other services through the [Employee and Family Assistance Program \(EFAP\)](#) who can be reached at: 1-844-880-9142.



Northern Health Palliative Care  
101 – 155 McDermid Drive  
Prince George, BC V2M 4T8  
Tel: 250-645-6030 • Fax: 250-565-5596  
Email: [Palliative.Care.Consult.Team@northernhealth.ca](mailto:Palliative.Care.Consult.Team@northernhealth.ca)



#healthynorth

[northernhealth.ca](http://northernhealth.ca)