NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

**Purpose**

- To identify and promote accessible and consistent access to palliative and end-of-life care for Continuing Care residents and their families.

- To support publicly funded Continuing Care programs and settings to achieve compliance with the Continuing Care Health Service Standards (CCHSS).

**Policy Statement**

Compassionate, effective and timely palliative care is fundamentally important to the delivery of quality health care. As a Catholic, faith based system, Covenant Health is committed to being “leaders and advocates for robust Palliative and End of Life Care (PEOLC)” (Covenant Strategic Framework, April 2018).

**Applicability**

This policy and procedure applies to all Covenant Health Continuing Care facilities, staff, medical staff, volunteers, students and any other persons acting on behalf of Covenant Health.

**Responsibility**

Covenant Health’s Continuing Care staff will ensure appropriate PEOLC services are provided and/or made available to all persons with a life limiting illness, and their family(ies).

**Principles**

The Palliative and End-of-Life Care (PEOLC) Provincial Steering Committee compiled and developed principles for the *Palliative and End-of-Life Care Alberta Provincial Framework* (Appendix 1: *Principles of Palliative Care*).

Palliative Care, including end-of-life care, is both a philosophy and an approach to care that enables all individuals with a life-limiting illness to receive integrated and coordinated care across the continuum. This care incorporates the values, preferences, and goals of care and spans the disease process from early diagnosis of a life-limiting illness to end of life, including bereavement.

Palliative and/or end-of-life care residents are not defined by age, diagnosis or the length of time they may require service, but by their need for care.

A palliative approach to care can occur simultaneously with a curative approach or during treatment. Palliative care improves the quality of life for individuals of any age and at any stage of a life-limiting illness by helping to manage both symptoms and the side effects of treatment.
Palliative and End of Life Care

Palliative care is an approach to improve the quality of life of persons and their families who are facing the problems associated with a life-limiting illness through the prevention and relief of suffering by means of early identification, comprehensive interdisciplinary assessments and appropriate interventions.

End-of-life-care is care provided to individuals and their families when the person is approaching a period of time closer to death. This care may be exemplified by an intensification of inter-disciplinary services and assessments such as anticipatory grief support, and pain and symptom management.

Policy Elements

1. Assessment

1.1 All residents in Continuing Care shall be assessed by a health care professional using a standardized assessment tool for the care setting. Refer to Appendix 2: PEOLC Standardized Assessment Tools.

   a) Assessment shall occur upon resident admission to a care setting and change in level of care.

   b) Reassessment shall be performed as per recommended frequency in accordance with the care setting requirements, individual resident need, and when there is a significant change in the resident’s health status.

1.2 Secondary assessment tools shall be evidence based to support accurate assessment and communication amongst the interdisciplinary team. Refer to Symptom Assessment Tools accessible online (see policy resources section).

   a) Secondary assessment tools may vary based on:

      (i) individualized needs of each resident and their family; and

      (ii) specific tool(s) used within the care setting.

   b) Secondary assessments shall be performed in a timely manner that is responsive to the resident’s needs and include members of the interdisciplinary team as required.

2. Palliative Care and End-of-Life Care Services

2.1 Residents and their family (when involved) shall be offered care and services provided in the location best suited for the resident’s care needs, in accordance with the resident’s choice, to the greatest extent possible.

2.2 Residents and their family (when involved) shall be engaged and included in care decisions in a sensitive, open and timely manner.
2.3 Palliative and end-of-life care and services shall be provided by the most appropriate health care provider working within their role, scope and competencies within the practice setting.

2.4 Care interventions are based on the resident’s assessed unmet needs. Palliative and end-of-life care services should include, but are not limited to:

- a) pain and symptom management;
- b) psychosocial care;
- c) grief, loss and bereavement supports; and
- d) respect for residents diversity and culture; and
- e) spiritually sensitive care that maintains residents dignity

2.5 Residents and their family shall be informed of and provided access to relevant care and services available, which may include, but not be limited to:

- a) Consultation with health care professionals as required (i.e., Palliative Care Nurse, Palliative Physician, Social Worker, Spiritual care provider, etc.);
- b) Emergency Medical Services (EMS), Palliative and End-of-Life Care Assess, Treat and Refer (ATR) program;
- c) Hospice or designated Palliative and End-of-Life beds in an Acute Care or Continuing Care setting;
- d) services and supports provided by community agencies or programs;
- e) specialized services (e.g., Respiratory Care);
- f) volunteer resources;
- g) palliative and end-of-life care resources and education materials accessible online at My Health Alberta - Palliative Care via https://myhealth.alberta.ca/palliative-care;
- h) brochures and printed education materials, as available in each care setting; and
- i) resources and education materials in print and accessible online at www.conversationsmatter.ca
3. Care Planning

3.1 Advance care planning shall be conducted in accordance with the Covenant Health policy #VII-B-350, *Advance Care Planning and Goals of Care Designation*.

3.2 The resident’s Goals of Care Designation Order shall be accessible to the interdisciplinary team and any other involved health care providers to ensure the resident’s choices are respected.

3.3 Each resident shall have an individualized care plan, developed by a health care professional, and accessible to the interdisciplinary team that:

a) addresses their physical, psychosocial and emotional needs;

b) aligns with their Goals of Care Designation Order;

c) contains other relevant wishes or instructions pertaining to the resident’s palliative and end-of-life care goals (e.g., Personal Directive);

d) incorporates resident diversity, culture and spiritual beliefs and practices; and

e) identifies the health care provider responsible to perform interventions.

3.4 The interdisciplinary team shall review the resident’s care plan for effectiveness based on resident assessment(s), resident goals or changes in Goals of Care Designation Order, and then revise the care plan to reflect the resident’s current status and choices.

4. Points of Emphasis

4.1 Medical assistance in dying events do not fall within the scope of this policy. Refer to the “Covenant Health’s Position and Policy on Medical Assistance in Dying (MAID)” page on CompassionNet for information related to this topic.

4.2 Care of the resident after death does not fall within the scope of this policy. Refer to the established practices in the care setting, and the Covenant Health policy #VII-B-410, *Death*.

Definitions

Advance Care Planning means a process which encourages people to reflect and think about their values regarding clinically indicated current and future health care choices; explore medical information that is relevant to their health concerns; communicate wishes and values to those important to them, their alternate decision-maker and their health care team; and record those choices.
Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. This may include a minor’s legal representative, a guardian, a ‘nearest relative, in accordance with the Mental Health Act, an agent in accordance with a personal directive, a co-decision maker, a specific decision-maker or a person designated in accordance with the Human Tissue and Organ Donation Act.

Assessed unmet needs means the care requirements that remain after the strengths and resources of the patient and family and of the community have been considered in relation to the functional deficits identified on assessment. The assessment includes the patient’s ability to learn the skills necessary for self-care and the willingness, ability and availability of the family and community to participate or learn.

Continuing Care means an integrated range of services supporting the health and wellbeing of individuals living in their own home, a supportive living or long-term care setting. Continuing care clients are not defined by age, diagnosis or the length of time they may require service, but by their need for care.

End-of-life care means, for the purposes of this policy, care provided to an individual and their family when they are approaching a period of time closer to death, which may be exemplified by an intensification of services and assessments.

Family(ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Goals of Care Designation means a codified instruction that provides direction regarding general care intentions, specific health interventions, transfer decisions and locations of care, for a patient as established after consultation between the most responsible health practitioner, patient and when appropriate, alternate decision-maker.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Covenant Health.

Hospice means, for the purposes of this policy, a designated non-tertiary space specifically providing End of Life Care.

Palliative care means, for the purposes of this policy, an approach to improve the quality of life for patients and families facing the problems associated with a life-limiting illness through the prevention and relief of suffering by means of early identification, comprehensive interdisciplinary assessments and appropriate interventions.

Appendix

Appendix 1: Principles of Palliative Care
Appendix 2: PEOLC Standardized Assessment Tools
Appendix 3: Canadian Hospice Palliative Care Association Model of Hospice Palliative Care
Related Documents
- Covenant Health Policies/Procedures available on-line @ http://www.compassionnet.ca/Page2099.aspx
  - Advance Care Planning and Goals of Care Designations, #VII-B-350
  - Death, #VII-B-410
  - Move-In, VII-C-60
  - Palliative Care Pathway, #VII-C-20
  - Responding to Request for Medical Assistance in Dying, #VII-B-440
  - Standard Assessment, Care Planning and Care Conference, VII-C-80

References/Resources
- Covenant Strategic Plan, April 2018
- Palliative Symptom Assessment Tools accessible online: https://www.albertahealthservices.ca/info/Page14559.aspx.
- Alberta Health Services Resources:
  - Advance Care Planning/Goals of Care Designation (ACP/GCD) Frequently Asked Question (FAQ) for the Health Care Professional
  - Provincial Palliative and End-of-Life Care Project Charter - EMS Assess, Treat and Refer
  - Palliative and End-of-Life Care Alberta Provincial Framework 2014
- My Health Alberta: Palliative and End of Life Care: https://myhealth.alberta.ca/palliative-care

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Appendix 1: Principles of Palliative Care

1. **Patient & Family Centered:** It is important that patients and families are placed at the centre of their care to foster participation and collaboration. They will be empowered to make informed choices, and their needs, culture, values, religion, language and preferences are respected and honored. The patient and family’s capacity to cope will be recognized allowing a flexible approach to care.

2. **Equitable & Accessible:** All Albertans should have equitable and timely access to quality interdisciplinary PEOLC services despite illness or geography. It is not the intention that the same services will necessarily be provided in all settings but that the access to expertise will be equitable across Alberta. Timely access to PEOLC services and programs will be facilitated by system processes for patients and providers at all levels of health care.

3. **Collaborative & Integrated Team Service Delivery:** In order to meet the individual needs of patients and families comprehensive interdisciplinary teams with varying skills and knowledge are required to safely and effectively care for Albertans who are palliative or are at the end of life. The systems of care including providers, policy makers, educators and organizations that can influence programming need to share information about practices that promote the best possible outcomes for patients and families.

4. **Communication and Information Sharing:** There is a need for improved structured options including information technology for knowledge transfer at all levels (patient and family, service delivery and system) and the use of common tools, language, and utilization of the most appropriate documentation to support seamless transitions of patients, to convey appropriate information, and, to safely manage patient and family issues.

5. **Safe, Ethical & Quality Care:** Comprehensive assessments by adequately skilled professionals and providers are at the heart of quality and ethical care delivery. The provision of care that is appropriate to all domains including physical, psychological, emotional, social and spiritual requires knowledge and tools related to assessment in these areas. Practice that promotes consistency, coordinated activities, and collaborative approaches with minimal duplication will foster best outcomes.

6. **Sustainable & Accountable:** Adequate and appropriate resources will be available for PEOLC programs and services for both cancer and non-cancer patients, their families and their health care providers with the goal of providing the right care at the right place at the right time. A mixture of structure, process and outcome indicators established for PEOLC services are needed to measure symptom improvement, accessibility of services and equitable distribution of services across Alberta.

7. **Governance and Administration:** Clearly defined governance and administration models are required to ensure accountability and to support the development of PEOLC programs. Exploring palliative care from a public health, health promotion perspective and aligning palliative care with a population needs approach is important for future planning. Broad-based governance includes community representatives, caregivers, service providers, patients and families.

8. **Research, Education and Advocacy:** High quality PEOLC that is supported by the best available evidence positively impacts quality of life. Continued learning and education should work toward information, research and advocacy for the development and maintenance of public policy, palliative care standards and resources to improve the delivery of palliative care. Clearly defined programs and activities will help support providers and improve patient outcomes.

Source: *Palliative and End-of-Life Care Alberta Provincial Framework 2014*
Appendix 2: PEOLC Standardized Assessment Tools

The following standardized assessment tools are used in one or more Continuing Care and Hospice setting, but are not limited to those listed here.

**Adult Tools – Specific to Clinical Care Area**

- Victoria Hospice Palliative Performance Scale (PPS)
- Edmonton Symptom Assessment Scale-Revised (ESAS-R)
- Palliative Outcome Scale (POS)
- Palliative Outcome Scale (POS)-modified
- Home Care End of Life (EOL) Comprehensive Assessment
- Agape Hospice Family Survey
- Bereavement Risk Assessment Tool (Victoria Hospice Society 2008)
- Complexity Tool (Grief Assessment)
- Eastern Cooperative Oncology Group Performance Status (ECOG)
- Edmonton Classification System for Cancer Pain (ECS-CP)
- Palliative Prognostic Index (PPI)
- Palliative General Physical Assessment (Meditech)
- Death at Home: Expected (Meditech)
- End of Life Prearrangements (Meditech)
- Palliative Care Intake (Meditech)
- Palliative Psychosocial Assessment (Meditech)

**Pediatric Tools – Specific to Clinical Care Area**

- Pediatric Client Comprehensive (Meditech)
- Palliative General Physical Assessment (Meditech)
- End of Life Prearrangements (Meditech)
Appendix 3: Canadian Hospice Palliative Care Association Model of Hospice Palliative Care