Palliative Care

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PRA-BC
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I would like to acknowledge that the land on which we gather and learn today is the traditional, ancestral, and unceded territory of the Coast Salish Peoples, including the territories of the xwməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Stó:lō and Sə̓lílwətaʔ/Selilwitulh (Tsleil- Waututh) Nations.

Disclosure Statement

- I receive honoraria as a delegate for Section of Palliative Medicine at the Doctors of BC Representative Assembly.

- I have no relationships with commercial interests, no commercial support.

Objectives

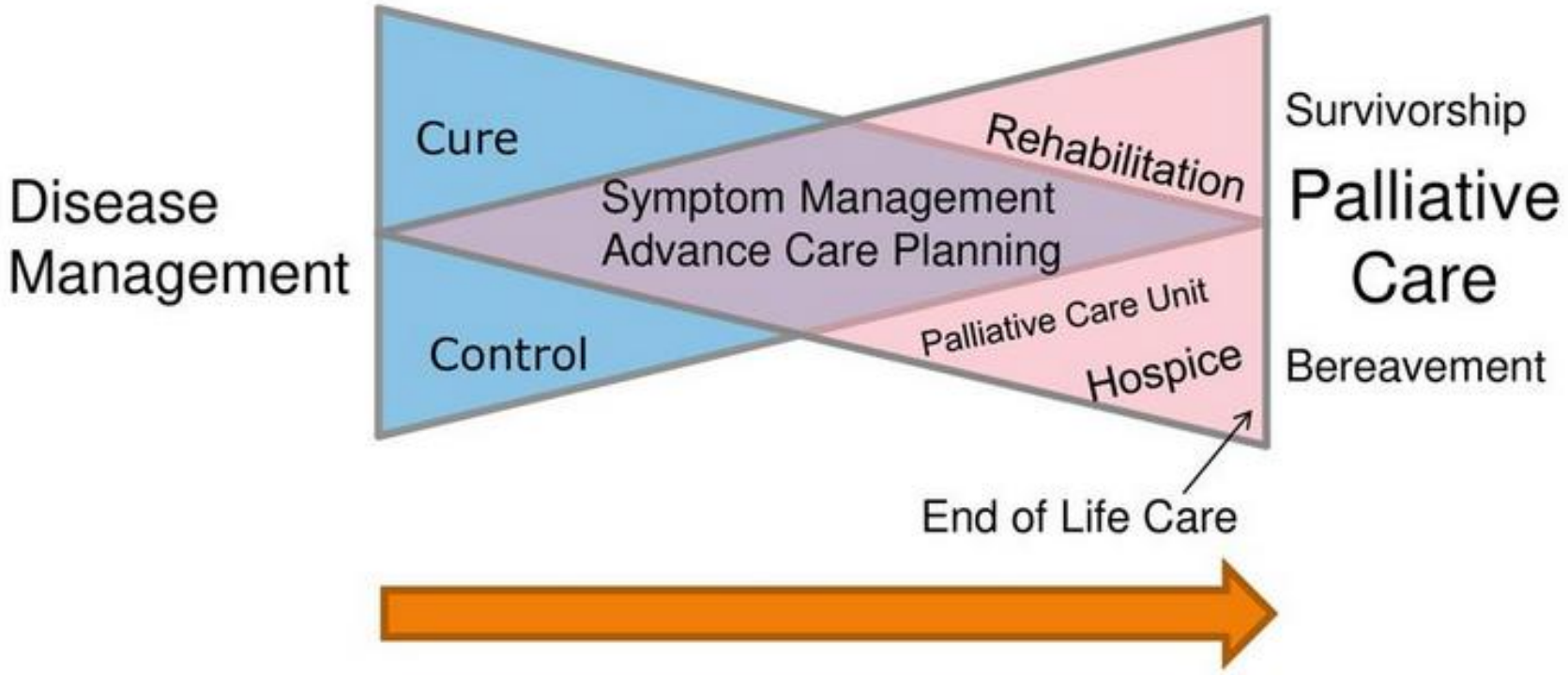
1. Identify who might benefit from a palliative approach to care
2. Review goals of care planning
3. Be aware of different services and programs in BC for patients receiving palliative care
4. Be aware of common symptoms in palliative care
5. Basic approach to opioid prescribing
6. Palliative care resources

WHAT IS PALLIATIVE CARE

What is a Palliative Care

- Care that aims to improves the **quality of life** of patients with **life-threatening illness**
- Care that focuses on alleviating the intensity of the symptoms of disease
- Integrates psychosocial and spiritual aspects of care important to the patient/family.
- Can be offered in conjunction with other therapies intended to prolong life
- Care is not limited to end of life
- Not the same as Medical Assistance in Dying

A Palliative Approach Care

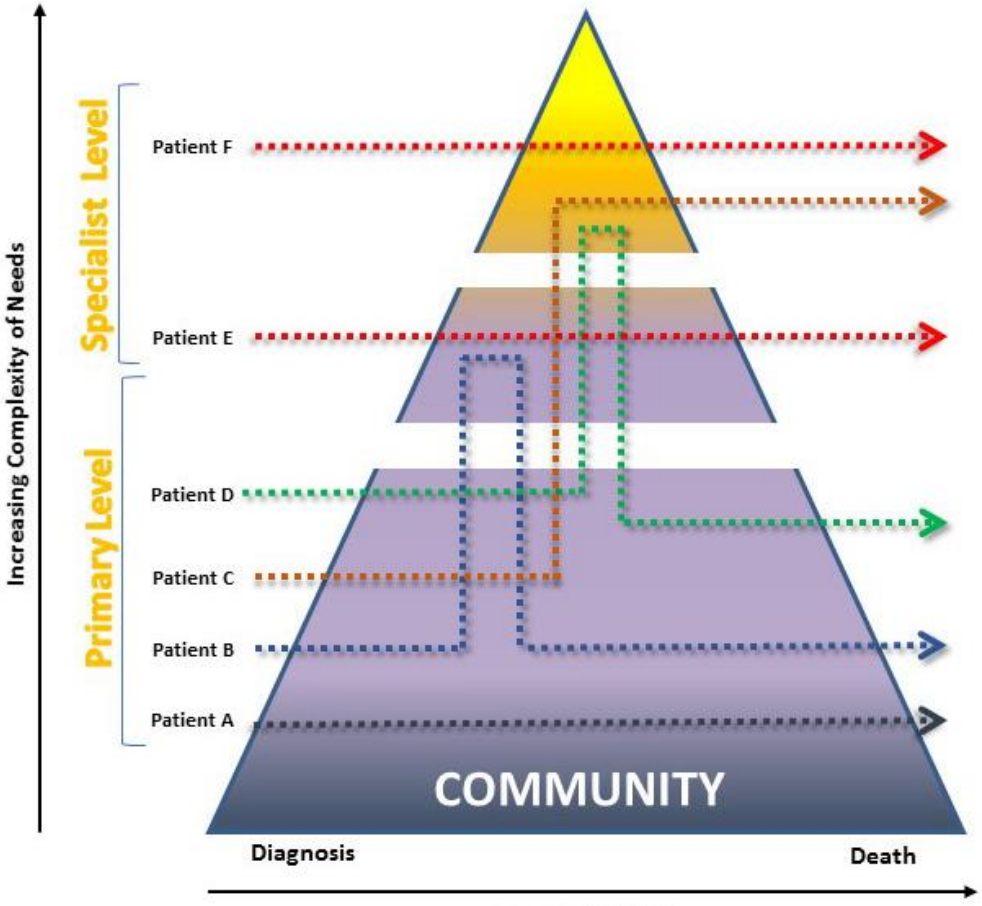


Dr. Pippa Hawley **The Bow Tie Model of 21st Century Palliative Care**

Where can a patient access a palliative approach to care?

Everywhere!

Who provides palliative care?



- **A small number of patients with complex needs require transfer of care to specialist palliative care services**
- **Some patients may occasionally require assistance of a specialist palliative team (a consultation or shared care support)**
- **Most patients require only primary-level Palliative Care (Palliative Care Approach)**
  - Family medicine clinic
  - Oncology team
  - Internal med clinics
  - Cardiology clinics
  - COPD clinics

Pallium, Canada

Specialist Palliative Care

Acute Care

- Palliative Care Unit - short stay
- Specialist Consult Teams - support to MRP

Outpatient

- BCCA Pain and Symptom Management Clinic
- Local specialist palliative clinic

Community

- Hospice - last weeks-months, no life-prolonging interventions

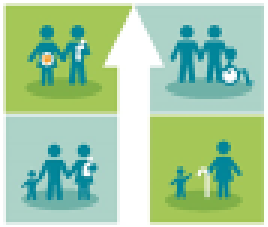
Palliative Care Resources

BC Provincial Palliative Care Consultation Line

For those who do not have access to a local palliative care service, for advice or support, call 1-877-711-5757. In ongoing partnership with the Doctors of BC, the toll-free Provincial Palliative Care Consultation Phone Line is staffed by Vancouver Home Hospice Palliative Care physicians 24 hours per day, 7 days per week to assist physicians and nurse practitioners with advice about symptom management, psychosocial issues, or difficult end-of-life decision making.

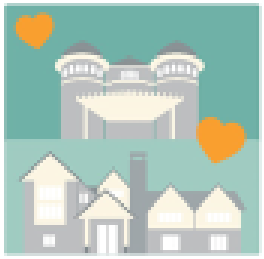
Canuck Place

- Canuck Place Children's Hospice is BC & Yukon's pediatric palliative care provider.
- We support children and youth with **life-threatening and/or life-limiting illnesses** and their families.
- On average, a child is on the program for 7 years and their parents and siblings are in bereavement for an average of 3 years following the death of their child.



Through all stages of a child's illness: Designed to meet the needs of each family:

- Family Support & Respite Care (21 days a year)
- Pain & Symptom Management
- End-of-Life Care
- Nursing & Medical Care
- Counselling & Expressive Therapies
- Consultative Services – 24-hour/day
- Clinics (Hospital & Community)
- Community care (home visits, phone/virtual visits)
- Grief & Bereavement



Families can self-refer to our program (clinical or bereavement)

Canuck Place is:

where memories are made.

canuckplace.org

Canuck Place CHILDREN'S HOSPICE

The Role of Family Physicians in Palliative Care

- Identifying patients who might benefit from a palliative approach to care
- Exploring goals of care/advanced care planning
- Helping patients and families to navigate and refer to to community palliative care resources
- Basic symptom management

WHO MIGHT BENEFIT FROM A PALLIATIVE APPROACH TO CARE?

H.L.	S.S.
• 80 M with congestive heart failure and CKD • Recent discharge from hospital for volume overload, 2nd admission this year • Despite optimization of cardiac and diuretic medication, still feels short of breath at rest • Renal function declining and he does not want dialysis	• 55 F with metastatic ovarian cancer on third line anti-cancer therapy • Recurrent ascites requiring paracentesis • Recent CT scan showing further progression • Worse nausea and pain
L.B.	**M. M.**
• 78 F with COPD, and diabetes • Oxygen dependent at home • Last admission to hospital required brief ICU stay, she never wants this again • She lives alone but finding it more challenging to complete her ADLs	• 60 M with a history of alcohol related cirrhosis and opioid use disorder • Multiple admissions to hospital with decompensated liver failure • Significant functional decline, decreased oral intake, weight loss

The ‘Surprise’ Question

Would you be surprised if this patient died in the next 12 months?

If NO, then they may benefit from a palliative approach to their care!

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

NHS SCOTLAND

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems. The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

Other conditions

Deteriorating with other conditions, multiple conditions and/or complications that are not reversible; best available treatment has a poor outcome.

Review current care and care planning.

- Review current treatment and medication to make sure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family/people close to them. Support carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, share, and review care plans.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™ 2022

S.S.

- 55 F with metastatic ovarian cancer on third line anti-cancer therapy
- Recent CT scan showing further progression
- No further systemic anti-cancer treatments
- Live with her husband (still working), no children
- Becoming increasingly house bound, difficult completing some of her ADLs
- She comes to your office with worsening nausea, hoping for a medication to try

Thoughts?

Prognosis

Symptom Management

Equipment

Physical Care

Caregivers

Spiritual Health

Financial Concerns

Goals and Values

Community Palliative Care Checklist

- ✓ Advance Care Planning
  - Goals of Care
  - Substitute Decision Maker
  - Provincial No CPR form
  - MOST
  - Notice of Expected Death

- ✓ Referral to Home Health Services
  - Community Health Nurse
  - Home Support Worker
  - Allied Health

- ✓ Palliative Care Benefits (prognosis <6mo)
  - Medication (oral, subcutaneous)
  - Equipment

- ✓ Caregivers benefits if applicable, other supports (e.g. volunteer)

- ✓ Referral to specialist palliative care (PCU, consultant)
  - Outpatient consultation
  - Palliative Care Unit
  - Hospice

Advance Care Planning

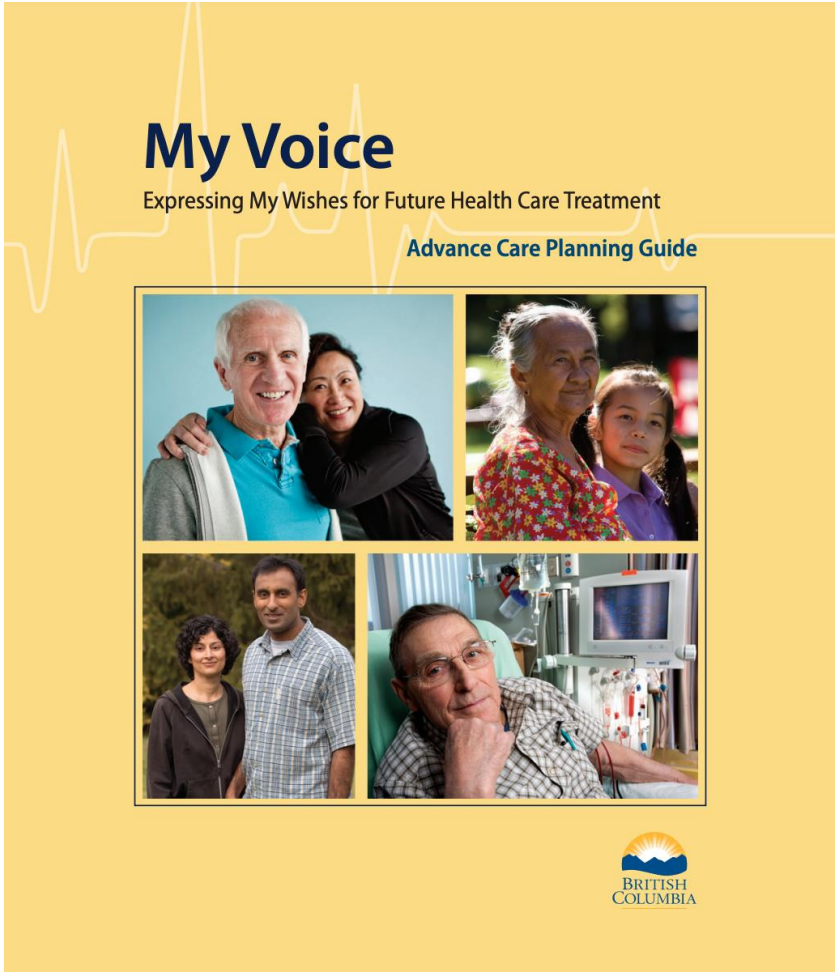
- Values, beliefs and wishes regarding future healthcare treatment
- Sharing with family/healthcare team
- Guides decision making
- Allows MD to make individual patient-centered recommendations
- Shared responsibility among health care team

More than just a ‘code status’ or ‘No CPR’.

BC's Advance Care Planning Guide

Outlines:

- Advance Directive
- Power of Attorney
- SDM
- Representation Agreement



- https://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning

Serious Illness Conversation Guide

Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. *Set up the conversation* · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. *Assess understanding and preferences*	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. *Share prognosis* · Share prognosis · Frame as a "wish…worry", "hope…worry" statement · Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness…" *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*." OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. *Explore key topics* · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. *Close the conversation* · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. *Document your conversation*	
7. *Communicate with key clinicians*	

ARIADNE LABS

S.S.

You use the Serious Illness Conversation Guide:

- she understands her cancer is progressing
- she does not want to die ‘like my dad’
- wants to go to hospital if she needs a paracentesis or bad pain, does not want CPR or ICU admission
- ‘I’m not scared to die’
- she hopes for a home death

S.S.

Who else needs to know her wishes?

What documentation does she need?

Substitute Decision Maker

- A capable person with the authority to make health care treatment decisions on behalf of an incapable adult.
- Includes a representative (Representation Agreement) and temporary substitute decision maker
- It is important that your Substitute Decision Maker knows about the care you want.

Representation Agreement

- Appointing a specific person to make certain types of decisions on their behalf

- Section 9 agreement:
  - personal care
  - health care treatments, including decisions about accepting or refusing life support and life-prolonging medical interventions
  - **NOT financial decisions**

Substitute Decision Maker

- Temporary SDM List
  - Your spouse
  - A child
  - A parent
  - A sibling
  - Grandparent
  - Grandchild
  - Anyone else related by birth or adoption
  - A close friend
  - A person immediately related to you by marriage
  - Public Guardian and Trustee

Common Documentation

- **Representation Agreement** - health and personal care, +/- finances
- **Enduring Power of Attorney** - finances, property
- **Advance Directive** - legal documentation with instructions for care
- **Provincial No CPR Form** - at home, first responders
- **Medical Order for Scope of Treatment (MOST)** - physician order in acute care, long term care, hospice
- **Expected Death in the Home** - direct to funeral home
- **Medical Certificate of Death** - completed by family doctor (or MRP in hospital) within 48h of death

BC No CPR Form

NO CARDIOPULMONARY RESUSCITATION – MEDICAL ORDER

Capable patients may request that no cardiopulmonary resuscitation be started on their behalf. This should be done after discussions with their doctor or nurse practitioner. "No cardiopulmonary resuscitation" is defined as no cardiopulmonary resuscitation (no CPR) in the event of a respiratory and/or cardiac arrest.

This form is provided to you or your substitute decision maker to acknowledge that you have had a conversation with a physician or nurse practitioner about a No CPR Order, and understand that no CPR will be provided in circumstances where you can no longer make decisions for yourself. It instructs people such as first responders, paramedics and health care providers not to start CPR on your behalf whether you are at home, in the community or in a residential care facility. The personal information collected on this form assists the health professionals noted above to carry out your wishes. If you have any questions about the collection of this information contact **HealthLink BC at 8-1-1** or go to www.gov.bc.ca/expectedhomedeath.

You or someone at your location should have the form available to show to emergency help if they come to your aid. It is desirable that you wear a MedicAlert® no CPR bracelet or necklet to enable quick verification that you have a No CPR Order in place. To obtain a free No CPR bracelet/necklet, please:

1. Complete the form below
2. Fill out the MedicAlert Registration form which can be printed from: https://www.medicalert.ca/nocpr/resources/MedicAlert_Application_BC_NOCPR.pdf
3. Mail both of the forms to: MedicAlert Foundation Canada, Morneau Shepell Centre II, 895 Don Mills Road, Suite 600, Toronto ON, M3C 1W3

If you change your wishes about your no CPR preference, then please inform your doctor, nurse practitioner or residential care facility nurse, tear up the No CPR form, and contact MedicAlert if you enrolled with them for a No CPR bracelet or necklet.

PATIENT IDENTIFICATION	Patient Last Name	Birthdate (YYYY / MM / DD)
	Patient First and Middle Name(s)	Personal Health Number (PHN)
	Patient Address	Telephone Number

WITNESSED BY THE PATIENT, OR BY THE PATIENT'S SUBSTITUTE DECISION MAKER (SDM) WHEN THE PATIENT IS INCAPABLE	I, _____ *(patient's name or patient's substitute decision maker if patient is incapable)* have had a conversation with the undersigned physician/nurse practitioner about this No CPR Order in the event of cardiac or respiratory arrest. I understand that in the event of a cardiac or respiratory arrest, no cardiopulmonary resuscitation is to be undertaken.	
	Patient's Signature	Date Signed
	Signature of the Patient's Substitute Decision Maker	Date Signed
	Relationship of the Patient's Substitute Decision Maker to the Patient *(e.g. representative, committee of person, or temporary substitute decision maker)*	

SECTION TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER

STATUS OF MEDICAL ORDER ☐ Patient (or SDM) agrees and has signed this form ☐ Patient (or SDM) agrees but has declined signing this form	The above identified patient has expressed wishes to not have CPR in the event of cardiac or respiratory arrest. I have discussed the patient's health status, life expectancy, and expressed wishes with the patient/patient's substitute decision maker. Based on this discussion, I order that in the event of a respiratory and/or cardiac arrest no cardiopulmonary resuscitation is to be undertaken. This order shall be in effect until cancelled or repealed.		Date
	ATTENDING PHYSICIAN/NURSE PRACTITIONER		**ALTERNATE PHYSICIAN/NURSE PRACTITIONER**
	Name of Attending Physician / Nurse Practitioner		Name (Print)
	License Number of Physician / Nurse Practitioner	Phone Number	Phone Number
	Address	Signature	

https://www.healthlinkbc.ca/health-feature/no-cpr-form

MOST

- **M**edical **O**rder for **S**cope of **T**reatment
- Physician order about CPR and other interventions
- Based on goals of care
- Acute care, long term care, hospice

Code status and MOST designations:

	Symptom Control	CPR	Intubation	ICU	Site Transfer	Treat Reversible Conditions
Option 1	✓	✗	✗	✗	✗	✗
Option 2	✓	✗	✗	✗	✗	✓
Option 3	✓	✗	✗	✗	✓	✓
Option 4	✓	✗	✗	✓	✓	✓
Option 5	✓	✗	✓	✓	✓	✓
Attempt CPR	✓	✓	✓	✓	✓	✓

Option 1 (M1)	No CPR. Supportive care such as nursing care, relief of pain, control of fever, provision of fluids and continued management of standing chronic conditions.
Option 2 (M2)	No CPR. Option 1 plus therapeutic measure and medications to manage acute conditions within the limits of residential or other facility or program to which the patient/ resident is admitted.
Option 3 (M3)	No CPR. Option 2 plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to critical care.
Option 4 (C1)	No CPR. Maximum therapeutic effort as Option 3 (M3) including referral to critical care but not including intubation and ventilation.
Option 5 (C2)	No CPR. Maximum therapeutic effort as Option 4 (C1) including referral to critical care and including intubation and ventilation.
Attempt CPR	In the event of acute medical event, maximum therapeutic effort including referral to Critical Care and Intubation.

Vancouver Coastal Health Authority

MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

ADULTS, AGE 19 AND ABOVE

IDENTIFICATION LABEL

A **I anticipate CPR to be of clear benefit and medically appropriate for the patient in the event of a medical crisis. I have not discussed this with the patient/SDM:**

☐ **Attempt CPR and refer to Critical Care -** _____ _____
Responsible Provider Signature Date

B **I have had a discussion with patient and / or substitute decision maker:**

Patient/Resident: ☐ is at this time capable to make own medical decisions
☐ is NOT currently capable to make own medical decisions

Patient / Resident / Substitute Decision Maker (SDM) consulted in development of Order / advised of Order:

_____ _____
Printed name Date

☐ Patient / Resident ☐ TSDM
☐ Representative ☐ Personal Guardian
☐ Other (explain below) ☐ None (explain below)
Explain:

☐ Client / SDM disagrees with Order

_____
Optional space for signature of Client or SDM aware of Order, intended for use in residential care. Order valid with or without signature.

☐ **Attempt Cardiopulmonary Resuscitation (CPR)**
In the event of acute medical event, maximum therapeutic effort.

☐ **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR: No chest compressions or other direct means of restarting the heart)**

IN THE EVENT OF SERIOUS ACUTE MEDICAL EVENT:

☐ **Option 1 (M1)*** No CPR. Supportive care, symptom management, and comfort measures. Allow natural death.

☐ **Option 2 (M2)** No CPR. Option 1 (M1) plus therapeutic measures and medications to manage acute conditions within the current setting. If in residential care or hospice, transfer to acute care will not occur except in special circumstances (eg fracture).

☐ **Option 3 (M3)** No CPR. Option 2 (M2) plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to Critical Care.

☐ **Option 4 (C1)** No CPR. Maximum therapeutic effort as in Option 3 (M3) including referral to Critical Care but **not including** intubation and ventilation.

☐ **Option 5 (C2)** No CPR. Maximum therapeutic effort as in Option 4 (C1) including referral to Critical Care and **including** intubation and ventilation.

Specific comments on Order / Goals of Care to aid interpretation:

DNACPR as detailed on this MOST will automatically be suspended for surgery and other procedures involving anesthesia or procedural sedation and treatment will be provided at the discretion of the Most Responsible Provider, unless specific direction is provided below:

_____
Provider detailing circumstances of suspension of DNACPR / MOST

SUPPORTING DOCUMENTATION: *Ask each patient / family if patient has expressed or documented wishes about future care*

☐ Previous DNACPR / MOST ☐ Provincial No CPR	☐ VCH ACP Record ☐ Advance Directive	☐ Representation Agreement ☐ *Section 9* ☐ *Section 7*	☐ Other:

This MOST Order first documented	_____ Date (dd/mm/yr)	Print Name:	**Signature,** **Most Responsible Provider**
	_____ College #	Contact #:	
MOST Order Reviewed - no change **If changed, prepare new MOST form and strike through this one**	_____ Date (dd/mm/yr)	Print Name:	**Signature,** **Most Responsible Provider**

* M1-C2 codes reflect codes used in Fraser and other health authorities

S.S.

- S.S. identifies her husband is her SDM.
- You encourage her to make an appointment to do a POA with her husband
- You fill out a No CPR form with her and give her a copy to keep on her fridge.
- She is needing more care at home, her husband wants to take leave from work to support her.

- What palliative care services and supports are available for this patient and family?
- Can she stay at home for end of life?
- Does she need referral to palliative care specialist?

Community Palliative Care Checklist

- ✓ Advance Care Planning
  - Goals of Care
  - Provincial No CPR form
  - MOST
  - Substitute Decision Maker

- ✓ Referral to Home Health Services
  - Community Health Nurse
  - Home Support Worker
  - Allied Health

- ✓ Palliative Care Benefits (prognosis <6mo)
  - Medication (oral, subcutaneous)
  - Equipment

- ✓ Caregivers benefits if applicable, other supports (e.g. volunteer)

- ✓ Referral to specialist palliative care (PCU, consultant)
  - Outpatient consultation
  - Palliative Care Unit
  - Hospice

Home Health Services

- Government funded care
- Community nursing and allied health resources
- Referral process depends on Health Authority

https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/how-to-arrange-for-care

Home Health Services

- **Community Health Nurse** - wound care, symptom management, sc butterflies, abdominal/chest drain management
- **Home Support Workers** - personal care, dressing
- **Occupational Therapy** - equipment
- **Respiratory Therapy** - home oxygen
- **Speech Language Pathology** - swallowing assessment
- **Dietitian**

BC Palliative Care Benefits

- Provincial program to cover cost of common medications and equipment at end of life
- Prognosis < 6 months
- Palliative approach to treatment (not curative)
- Commonly filled out by family physician, palliative care physician, specialist (oncologist, cardiologist)

https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/prescribers/plan-p-bc-palliative-care-benefits-program

BRITISH COLUMBIA | Ministry of Health

BC PALLIATIVE CARE BENEFITS REGISTRATION

For PharmaCare Plan P drug coverage and assessment for medical supplies/equipment

1. Complete every section of pages 1 and 2. See page 3 for general information.
2. Have a care plan conversation with your patient. The My Voice Advance Care Planning Guide is available in several languages and as a video at: www.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning
3. Give your patient this information sheet: www.gov.bc.ca/pharmacare/palliativecarebenefitspatientinfo.pdf

◯ **New patient** ◯ **Reassessment (required after 12 months)** ◯ **Cancellation (patient no longer qualifies) – *complete Step 1 and Step 3 only***

STEP 1 - PATIENT INFORMATION

Last Name	First Name	Middle Name (Optional)

Personal Health Number (PHN)	Date of Birth (yyyy / mm / dd)	Gender
		◯ Male ◯ Female ◯ _____

Telephone Number (include area code)	Mailing Address

STEP 2 - CHECK 2 OR MORE GENERAL INDICATORS OF POOR OR DETERIORATING HEALTH

Source: www.spict.org.uk/

- ☐ Unplanned hospital admission(s)
- ☐ Performance status is poor or deteriorating, with limited reversibility (e.g., stays in bed or a chair half the day or more)
- ☐ Depends on others for care due to increasing physical and/or mental health problems
- ☐ The person's carer needs more help and support
- ☐ Progressive weight loss; remains underweight; low muscle mass
- ☐ Persistent symptoms despite optimal treatment of underlying condition(s)
- ☐ Person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life

STEP 3 - CHECK 1 OR MORE CLINICAL INDICATORS OF LIFE-LIMITING CONDITIONS

Cancer (source: www.spict.org.uk/)

- ☐ Functional ability deteriorating due to progressive cancer
- ☐ Too frail for cancer treatment or treatment is for symptom control

Heart/Vascular Disease

- ☐ Heart failure or extensive, untreatable coronary artery disease, with breathlessness or chest pain at rest or on minimal effort
- ☐ Severe, inoperable peripheral vascular disease

Neurological Disease

- ☐ Progressive deterioration in physical and/or cognitive function despite optimal therapy
- ☐ Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing
- ☐ Recurrent aspiration pneumonia; breathless or respiratory failure
- ☐ Persistent paralysis after stroke with significant loss of function and ongoing disability

Respiratory Disease

- ☐ Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations
- ☐ Persistent hypoxia needing long-term oxygen therapy
- ☐ Has needed ventilation for respiratory failure, or ventilation is contraindicated

Dementia/Frailty

- ☐ Unable to dress, walk or eat without help
- ☐ Eating and drinking less; difficulty with swallowing
- ☐ Urinary or fecal incontinence
- ☐ Not able to communicate by speaking; little social interaction
- ☐ Frequent falls; fractured femur
- ☐ Recurrent febrile episodes or infections; aspiration pneumonia

Kidney Disease

- ☐ Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health
- ☐ Kidney failure complicating other life-limiting conditions or treatments
- ☐ Stopping or not starting dialysis

Liver Disease

- ☐ Cirrhosis with one or more of these complications in the past year: diuretic resistant ascites; hepatic encephalopathy; hepatorenal syndrome; bacterial peritonitis; recurrent variceal bleeds
- ☐ Liver transplant is not possible

Other Conditions

- ☐ Deteriorating with other conditions, multiple conditions and/or complications that are not reversible; best available treatment has a poor outcome

Compassionate Care Benefit

Employment Insurance (EI) benefits paid to people who have to be away from work temporarily to provide care or support to a family member who is gravely ill and who has a significant risk of death within 26 weeks (six months).

Physician fills out one page attestation.

https://catalogue.servicecanada.gc.ca/content/EForms/en/Detail.html?Form=INS5216B

S.S.

- Refer to Home Health Services
  - Home Care Nurse for symptom management
  - Community OT for hospital bed, walker, commode
  - Home Support for weekly bathing

- Husband applies for caregiver benefits, takes time off work
- She is supported at home by her family
- You prescribe some hydromorphone and metoclopramide for pain and nausea

S.S.

- The Home Care Nurse informs you that S.S. is not eating, spends most day asleep, and is now restless
- You identify that she is actively dying, and speak with her husband
- You order some subcutaneous medications and the home care nurses insert a butterfly and teaches the family to administer the medication
- Her husband asks you what to do after she dies?

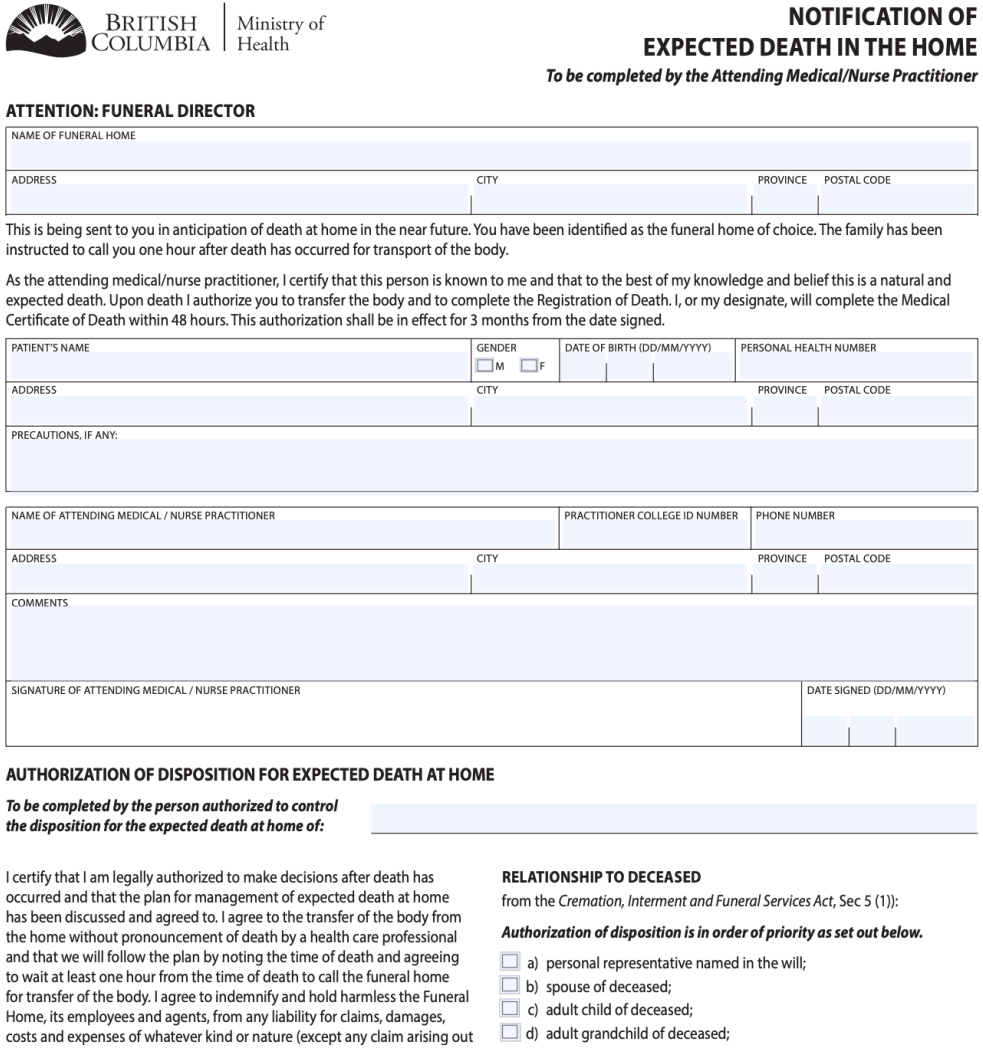
Home Death

- Discuss plans with nursing team
- Pre-arrangements with funeral home
- Notice of Expected Death at Home (EDITH)

At time of death:

- Do not call 911
- No EDITH - call nursing team/physician to pronounce death
- Yes EDITH - call funeral home after one hour or more has passed

Notification of Expected Death in the Home (EDITH)



BRITISH COLUMBIA | Ministry of Health

NOTIFICATION OF EXPECTED DEATH IN THE HOME

To be completed by the Attending Medical/Nurse Practitioner

ATTENTION: FUNERAL DIRECTOR

NAME OF FUNERAL HOME			
ADDRESS	CITY	PROVINCE	POSTAL CODE

This is being sent to you in anticipation of death at home in the near future. You have been identified as the funeral home of choice. The family has been instructed to call you one hour after death has occurred for transport of the body.

As the attending medical/nurse practitioner, I certify that this person is known to me and that to the best of my knowledge and belief this is a natural and expected death. Upon death I authorize you to transfer the body and to complete the Registration of Death. I, or my designate, will complete the Medical Certificate of Death within 48 hours. This authorization shall be in effect for 3 months from the date signed.

PATIENT'S NAME	GENDER ☐ M ☐ F	DATE OF BIRTH (DD/MM/YYYY)	PERSONAL HEALTH NUMBER
ADDRESS	CITY	PROVINCE	POSTAL CODE
PRECAUTIONS, IF ANY:			

NAME OF ATTENDING MEDICAL / NURSE PRACTITIONER	PRACTITIONER COLLEGE ID NUMBER	PHONE NUMBER
ADDRESS	CITY	PROVINCE / POSTAL CODE
COMMENTS		
SIGNATURE OF ATTENDING MEDICAL / NURSE PRACTITIONER		DATE SIGNED (DD/MM/YYYY)

AUTHORIZATION OF DISPOSITION FOR EXPECTED DEATH AT HOME

To be completed by the person authorized to control the disposition for the expected death at home of:

I certify that I am legally authorized to make decisions after death has occurred and that the plan for management of expected death at home has been discussed and agreed to. I agree to the transfer of the body from the home without pronouncement of death by a health care professional and that we will follow the plan by noting the time of death and agreeing to wait at least one hour from the time of death to call the funeral home for transfer of the body. I agree to indemnify and hold harmless the Funeral Home, its employees and agents, from any liability for claims, damages, costs and expenses of whatever kind or nature (except any claim arising out

RELATIONSHIP TO DECEASED

from the *Cremation, Interment and Funeral Services Act*, Sec 5 (1)):

Authorization of disposition is in order of priority as set out below.

- ☐ a) personal representative named in the will;
- ☐ b) spouse of deceased;
- ☐ c) adult child of deceased;
- ☐ d) adult grandchild of deceased;

Medical Certificate of Death

- Must be completed within 48h death
- Family MD will fill out for patient who has a home death

https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/vsa051.pdf

Community Palliative Care Checklist

- ✓ Referral to Home Health Services
  - Community Health Nurse
  - Home Support Worker
  - Allied Health

- ✓ Palliative Care Benefits (prognosis <6mo)
  - Medication (oral, subcutaneous)
  - Equipment

- ✓ Caregivers benefits if applicable, other supports (e.g. volunteer)

- ✓ Referral to specialist palliative care (PCU, consultant)
  - Outpatient consultation
  - Palliative Care Unit
  - Hospice
- ✓ Advance Care Planning
  - Goals of Care
  - Provincial No CPR form
  - MOST
  - Substitute Decision Maker

SYMPTOM MANAGEMENT

Common Symptoms

- Pain
- Nausea and vomiting
- Dyspnea
- Fatigue
- Decreased appetite
- Constipation
- Anxiety/depression

- Symptoms at end of life: secretions, agitation/delirium, bleeding

Symptom Management Guidelines

https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/palliative-care

https://www.bc-cpc.ca/publications/symptom-management-guidelines/

Use of Opioids in Palliative Care

Mr. O

- 50 M with locally advanced pancreatic cancer, coming to see you with significant constant epigastric pain
- Acetaminophen, ibuprofen of minimal help
- You want to start an opioid medication for his malignant pain

Common Palliative Indications for Opioids

- Pain (cancer, ESRD, CHF)
- Dyspnea (cancer, ESRD, CHF, COPD)

Common Opioids used in Palliative Care in BC

Drug	Formulations Available	Routes available	Common Starting Dose
Morphine	Short acting Long acting	Oral, sc, IV	2.5 mg
Hydromorphone	Short acting Long acting	Oral, sc, IV	0.5 mg po
Oxycodone	Short acting Long acting	Oral	2.5-5mg po
Fentanyl Patch	Long acting	Transdermal, sc, IV	Do not start in opioid naïve patients 12 mcg/hr lowest patch
Sufentanil	Short acting	SL	Do not start in opioid naïve patients
Methadone	Long acting	Oral, buccal, rectal	Do not start on opioid naïve patients

Approach to opioid in palliative care

WHO ~~Cancer~~ Palliative Pain Management - Guiding Principles

1. **By mouth** - when possible, drugs should be given orally.

1. **By the clock** - regular doses over 24 hours
- start with short acting q4h (q6h if renal impairment)
- Additional "breakthrough" medication should be available on an as needed (PRN) basis.
- titrate gradually until symptoms improve
- switch to long acting once symptom stable

1. **For the individual** - there is no standard dose of strong opioids. The right dose is the dose that relieves pain without causing unacceptable side effects.

1. **With attention to detail** - pain changes over time, thus there is a need for constant assessment and reassessment.

https://www.ncbi.nlm.nih.gov/books/NBK537492/

Mr. O

After a history and physical exam, you want to start Mr. O on a regular dose of morphine 2.5mg po q4h, with 2.5mg po q1h prn. You ask him to keep a record of his prn use and follow up next week.

- How do you prescribe his opioid?
- What else should you prescribe at the same time?

----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.

PRESCRIBING DATE DAY | MONTH | YEAR

PATIENT NAME FIRST (GIVEN) | MIDDLE / INITIAL | LAST (SURNAME)

PATIENT ADDRESS STREET

CITY | PROVINCE

DATE OF BIRTH DAY | MONTH | YEAR

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM

VOID IF ALTERED

QUANTITY (IN UNITS) NUMERIC | ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: ____ DAY ____ MONTH ____ YEAR

END DATE: ____ DAY ____ MONTH ____ YEAR

TOTAL DAILY DOSE NUMERIC | ALPHA **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION NUMERIC | ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
DR. THE-QUICK-BROWN-FOX-JUMPED-OVER-THE
123SUPERCALAFRAGILISTICEX
IFYOUSAYITFASTENOUGHITSOU
KUALALAMPURDUBAIPARISDUBL BC
ABC1234567 234-456-7890

11551 91
PRESCRIBER ID

000001
FOLIO

PHARMACY USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE

SIGNATURE OF DISPENSING PHARMACIST

PHARMACY COPY - PRESS HARD YOU ARE MAKING 2 COPIES

PRINTED IN BRITISH COLUMBIA

BC Duplicate Prescription

Rx – DRUG NAME AND STRENGTH **Morphine IR 2.5mg**	
NUMERIC **100 doses**	ALPHA **One hundred doses**
DIRECTIONS FOR USE T**ake 2.5mg po q4h regularly, and 2.5mg po q1h prn for breakthrough pain.** **Dispense 50 doses q1 week** **Please blister pack regular morphine with other medications.**	

Tips for Safe Opioid Prescribing in Palliative Care

- Discuss safety measures with patient
  - storage, disposal, single prescriber
- Blister pack medications (including prns)
- Indicate dispensing frequency on prescription
  - ‘dispense 25 tablets q 2 weeks’
- Write the indication on the prescription
  - ‘for palliative dyspnea’ or ‘for cancer pain’

Common Side Effects Opioids

- **Constipation - always prescribe a laxative with opioids (sennosides, lactulose, PEG 3350)**
- Sedation - usually self-limited with dose change
- Dizziness - consider opioid rotation
- Nausea - consider a prn anti-emetic
  - Usually self limited
  - If persistent, consider opioid rotation

Mr. O

- morphine IR 2.5mg po q4h regular
- morphine IR 2.5mg po q1h prn for breakthrough pain

- sennosides 12-24mg po qhs prn for if no BM for 2 days
- metoclopramide 10mg po q6h prn for nausea

Mr. O

Over the course of a month you increase Mr. O's short acting morphine by increments of 2.5mg, and he is now feeling much more comfortable on morphine 10mg po q4h

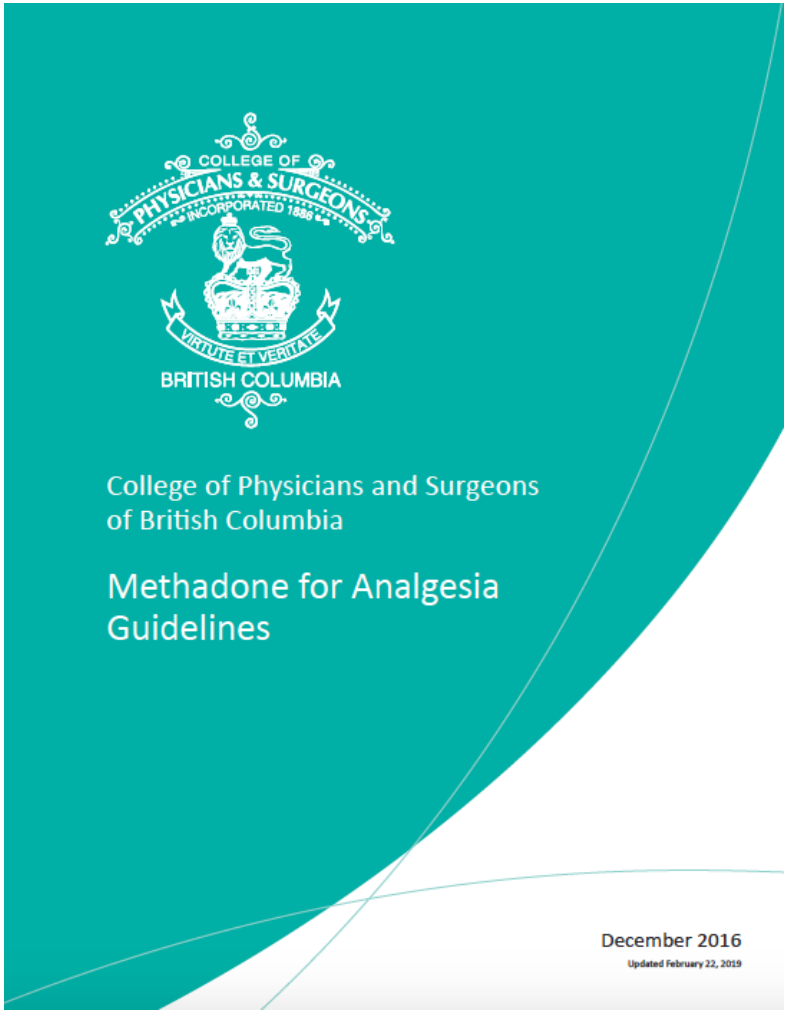
Rotate to morphine long acting 30mg po q12h with morphine IR 5-10mg po q1h prn

*prn dose usually 10-20% of the total 24 hour dose

Mr. O

- A few months later…
- Admitted to hospital for pain, where he was seen by the palliative care physician and rotated to methadone for his malignant pain
- Currently on methadone 4mg po q8h
- Comes to see you (his family physician) for a check in, and for refills, including methadone

Methadone for Analgesia



All physicians with a opioid prescribing privileges can prescribe methadone for
analgesia.

Need to be familiar with properties of methadone.

Consult a palliative care specialist for support or with questions.

PALLIATIVE CARE RESOURCES

Palliative Care Resources - Guidelines

- Canadian Virtual Hospice
  - https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home.aspx
- BC Centre for Palliative Care
  - https://bc-cpc.ca/
- BC Guidelines - Palliative Care
  - https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/palliative-care

Palliative Care Resources

Interior Health
- https://www.interiorhealth.ca/YourCare/PalliativeCare/Pages/default.aspx

Northern Health
- https://www.northernhealth.ca/services/end-life-care-palliative-care

Vancouver Coastal Health
- http://www.vch.ca/your-care/home-community-care/care-options/hospice-palliative-care

Fraser Health
- https://www.fraserhealth.ca/Service-Directory/Services/end-of-life#.X4YZgNlKiM8

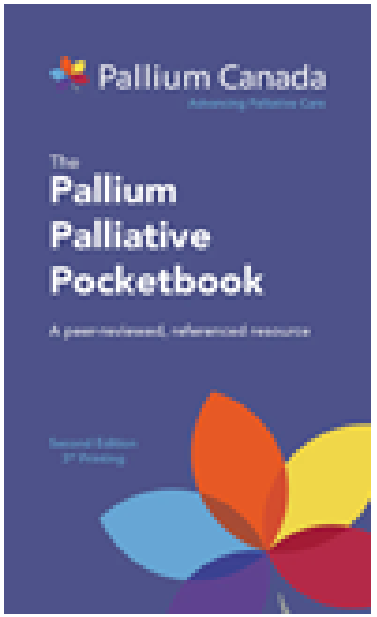
Island Health
- https://www.islandhealth.ca/our-services/end-of-life-hospice-palliative-services

Palliative Care Resources

Pallium Canada:

a national, non-profit organization focused on building professional and community capacity to help improve the quality and accessibility of palliative care in Canada.

https://www.pallium.ca/courses/



Palliative Care Resources - Other

Methadone in palliative care

- http://www.methadone4pain.ca/

Pallium Canada - online modules

- https://www.pallium.ca/

Division of Palliative Care, UBC

- https://palliativecare.med.ubc.ca/

Medical Assistance in Dying

NOT the same as palliative care, but both part of end-of-life care, and work collaboratively together.

Government of BC Site:

https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying

Thank you!