CP 4.11: Palliative Care

Updated:
Reviewed:

Purpose

The Community Paramedic (CP) will work together with the health care team in supporting goals of palliative and end-of-life care which include:

- Supporting the local palliative/home care team members by being the eyes and ears on the ground.
- Supporting patients and their care givers (family/friends) on understanding around progression of the disease and how to support the patient's wishes for care - includes discussions around ACP (advanced care plans) and goals of care, including MOST (medical orders for scope of treatment).
- Identifying patients who could benefit from palliative care approach (using the iPall-advanced disease tool) and report to primary care.
- Completing assessments, including reporting back to palliative/home care team:
  - Edmonton Symptom Assessment System Revised ('ESAS-r' tool)
  - Palliative Symptom Assessment ('OPQRSTUV' tool)
  - Palliative Performance Scale ('PPSv2' tool)
  - Pain Assessment in Advanced Dementia (PAINAD)
  - Confusion Assessment Method ('CAM' with 'PRISME' tool)
  - Supportive and Palliative Care Indicators Tool (SPCIT)
- Providing support with pain and symptom management:
  - Provide comfort care measures (e.g., repositioning, use of fans for air circulation, etc.)
  - Medication self-management (or as managed by family care givers)
  - Provide patient/caregiver teaching on supportive measures
- Supporting navigation of access to other community supports for the patient and family/friend care givers.

Policy Statements

In response to a referral from, a health authority, or a primary health care provider, the (CP) will visit a palliative patient to assess and support symptom management and discussions around advanced care plans and the patient's goals of care.

It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history, including MOST form and previous palliative documentation if available, prior to appointment.
2. **REFER** to Request for Service and care plan for direction with respect to assessment, patient specific care parameters/interventions, and patient and/or caregiver education/support as required.
3. **ASSESS** patient's current level of pain, hydration, comfort, nutrition, and functional status (Patient Palliative Scale) as guided by the referring professional.
4. **PERFORM** physical exam, as required, including:
   - Vital signs (T, P, RR, BP)
   - Pulse oximetry
   - Chest auscultation
   - Level of consciousness
5. **PERFORM** assessments, as required, using:
   - Symptom assessments: ESAS-r, OPQRSTUV
   - Pain Assessment in Advanced Dementia: PAINAD

- Confusion Assessment Method: CAM with PRISME
- Palliative Performance Scale: PPSv2 tool

6. **SUPPORT** navigation of health system by accessing other support and resources as identified by family/caregivers and engage in conversations, as required, around:
   - Advanced care planning
   - MOST forms
   - Palliative care
7. **PROVIDE** comfort measures as determined by the patient, family, or caregivers such as (but not limited to):
   - Repositioning
   - Use of fans for air circulation
8. **SUPPORT** medication self-management, or as managed by family or caregivers.
9. As determined by assessments completed, continue with interventions outlined in the patient's care plan.
10. **COMMUNICATE** with health care provider or health care team for changes in patient status and if any other concerns arise.

Documentation

DOCUMENT details of the visit on the palliative assessment forms (where appropriate) and CP Progress Notes, and notify primary health care provider or health care team of findings and any concerns.

Patient Education Resources

1. British Columbia. Advanced Care Planning Resources. [Link]
2. British Columbia. My Voice Guide. [Link]
3. BC Aboriginal Health. (Link to download PDF under 'Brochures' section of Advanced Care Planning website.) [Link]

References

1. Government of British Columbia. My Voice Advance Care Planning Guide Quick Tips (Link to download PDF at bottom of 'Step 1: Download the Advance Care Planning Guide'.) [Link]
2. Government of British Columbia. After Hours Palliative Tele-nursing Support. [Link]
3. Pallium Canada. LEAP Course Learning Materials. [Link]
4. University of Edinburgh. *Supportive and Palliative Care Indicators Tool (SPCIT).* [Link]