NY–RAH

New York–Reducing Avoidable Hospitalizations

# Palliative Care Policy

**Purpose**
This policy defines principles and objectives for providing palliative care to nursing facility residents

**Responsibility:**
Palliative care team, which should include a physician, NP or PA, social worker, nurse, pastoral care representative, and all interested facility staff.

**Scope**
Palliative care is appropriate for all residents with serious illness. Palliative care helps seriously ill residents and their families understand the conditions afflicting them, assists them in choosing care compatible with their wishes and beliefs, and prevents and treats symptoms such as pain, shortness of breath, nausea, and constipation. Palliative care may include referral to hospice, at the discretion of the attending physician. Palliative care may be provided to residents electing aggressive care, full code status, and re-hospitalization. While palliative care includes comfort oriented measures, it is not the same as comfort care and need not be limited to residents at the end of life

Palliative care is an ongoing process. Goals of care and advance directives may be revisited, if necessary, at monthly care planning meetings. Likewise, those residents and families resistant to palliative care counseling may be offered this intervention on an ongoing basis, as appropriate.

Palliative care is an ongoing, dynamic team effort, and should include members of nursing, medicine, social work, and all interested facility staff.

Conditions Appropriate For Palliative Care Referral:

- Moderate to late stage dementia,
- Advanced neurologic disease such as stroke, Parkinson's disease, and ALS,
- Any illness causing abnormal, progressive weight loss,
- Late stage pressure ulcers,
- Late stage heart failure (EF < 25%), or advanced coronary artery disease with symptoms at rest,
- Late stage lung disease with shortness of breath at rest or oxygen dependency,
- Advanced cancer, whether or not on anti-neoplastic therapy,
- ESRD whether or not on dialysis,
- Late stage liver disease; e.g., cirrhosis with ascites,
- Advanced vascular disease with amputations and/or open wounds,
- Any condition expected to cause death within 6 months.

**Policy:**

*Overall departmental responsibility for directing palliative care counseling and implementing palliative care recommendations is at the discretion of each facility.*

1. Residents appropriate for palliative care intervention will be identified at initial care planning meetings and throughout their stay as appropriate. *Facility should indicate who is primarily responsible for this activity.*

2. Residents and/or their loved ones will be invited within one month of admission to participate in palliative care counseling, which may be part of overall care planning meetings.

3. Advance directives, such as MOLST, including discussion of DNR/DNI/DNH and PEG placement, and the Health Care Proxy, will be a priority during palliative care counseling.

4. Symptom management (e.g., pain, nausea, and shortness of breath) is a palliative care priority. It is the responsibility of the primary MD or NP to assure that unpleasant symptoms are aggressively managed.

5. Spiritual support is a palliative care priority and should be offered to residents and families as appropriate and depending on availability.

6. Palliative care consultation is provided by medical staff trained and experienced in this specialty. It should be reserved for those residents who remain problematic after implementation of the facility protocol (and may not be available at all facilities).

**Procedure**

1. Ensure effective pain management,

2. Minimize other unpleasant symptoms such as dyspnea, nausea, vomiting, constipation, anxiety, and delirium,

3. Optimize quality of life for resident and family,

4. Educate resident and family about underlying disease processes and available treatment options, from the most aggressive care to comfort oriented measures only,

5. Educate resident and family about interventions available to them during serious illness or at the end of life, such as resources from the INTERACT curriculum,

6. Provide an environment conducive to comfort and healing

References: Resources for palliative care are readily available to all facility staff through the NY-RAH RNCC and include off the shelf interventions such as the INTERACT curriculum