**SAMPLE**

**Palliative Care Policy and Procedure**

It is the policy of this facility to ensure compliance with Section 2997-c of the Public Health Law, also known as the Palliative Care Information Act (PCIA) and Section 2997-d the Palliative Care Access Act(PCAA).

**The Palliative Care Information Act (PCIA**) requires that a terminally ill resident’s attending health care practitioner offers the resident with verbal or written information and counseling regarding palliative care and end-of life options. Under the law, information and counseling concerning palliative care and end-of-life options must be offered only to patients with an illness or condition that is reasonably expected to cause death within six months. This information should include the range of options available to the resident, the prognosis of the illness, the risks and benefits of the corresponding options, and the legal rights to end-of life comprehensive pain and symptom management. If the resident lacks the capacity to make informed medical decisions, then this information and counseling should be provided to a person with authority to make health care decisions for the resident.

**The Palliative Care Access Act (PCAA**) applies to residents with “advanced life-limiting conditions or illnesses who might benefit from palliative care” and not just those who are terminally-ill. The PCAA requires not only an offer to provide information and counseling, but also that the health care provider/residence (includes nursing homes) facilitated access to appropriate palliative care consultation and services, including associated pain management consultation and services

Both the PCIA and the PCAA were enacted to ensure that Residents will be fully informed of the options available to them when they are faced with a serious illness or condition or are terminally ill, so that they will be empowered to make choices consistent with their goals for care, wishes and beliefs, and to optimize their quality of life.

Definitions:

Terminally ill resident- one whose illness or condition can reasonably be expected to cause death within 6 months, regardless of whether treatment is provided

Advanced life-limiting conditions or illnesses – a medical condition causing significant functional and quality of life impairments, that is not likely to be reversible by curative therapies and that is likely to progress over time and ultimately contribute to the physiological and functional decline and shorten survival

Attending health care practitioner- the physician or nurse practitioner who has primary responsibility for the care and treatment of the resident

Palliative care- health care treatment, including interdisciplinary end-of life care, and consultation with residents and family members, to prevent or relieve pain and suffering and to enhance the resident’s quality of life, including hospice care

Procedure:

1. Resident referrals for Palliative Care will be determined based on diagnosis, symptoms and physical conditions that may have a prognosis which could be considered to be terminally ill or with advanced life-limiting conditions/illnesses.
2. Each member of the IDT will contribute to an initial comprehensive assessment. This assessment includes:
   1. Patient and family understanding of the serious illness, goals of care, treatment preferences, and a review of signed advance directives, if available
   2. A determination of decision-making capacity or identification of the person with legal decision-making authority
   3. A physical examination including identification of current symptoms and functional status
   4. A thorough review of medical records and relevant laboratory and diagnostic test results
   5. A review of the medical history, therapies, recommended treatments, and prognosis
   6. The identification of comorbid medical, cognitive, and psychiatric disorders
   7. A medication reconciliation, including over-the-counter medications
   8. Social determinants of health, including financial vulnerability, housing, nutrition, and safety
   9. Social and cultural factors and caregiving support, including caregiver willingness and capacity to meet patient needs
   10. Patient and family emotional and spiritual concerns, including previous exposure to trauma
   11. The ability of the patient, family, and care providers to communicate with one another effectively, including considerations of language, literacy, hearing, and cultural norms
   12. Patient and family needs related to anticipatory grief, loss and bereavement.
3. The IDT will establish policies for how to effectively facilitate communication, care coordination, and transitions of care; this includes the share of documentation with everyone involved in the plan of care and safeguarding resident and family privacy.

**\**The following steps represent a sample procedure. Please be sure to amend this document to reflect a procedure that is consistent with your facility policy\****

* 1. The RNS/RN Unit Manager will be responsible for communicating the team’s recommendation for review of the resident by the Primary Care Physician for palliative care and for documenting this discussion in the medical record.
  2. The Resident will be followed in the morning meeting until a decision has been made by the PCP with regard to offering palliative care as an option to the resident. The PCP will document the decision in the medical record.
  3. The Primary MD (PMD) in conjunction with the IDT team will be responsible for offering to provide the resident determined to have a terminal illness/advanced life-limiting condition or illness verbally or in writing information and counseling regarding palliative care and end of life options.
  4. The PMD in conjunction with the IDT team will be responsible for facilitating access to appropriate palliative care consultation and services (either Generalist Level or Specialist Level of Palliative care Services, as indicated) including pain management consultation and services.
  5. The PMD will be responsible for providing this information and counseling for residents that lack medical decision- making capacity to the person who has the authority to make health care decisions for the resident.
  6. All offers of information and counseling, as well as any declination by the resident or an authorized decision-maker must be documented in the medical record by the MD. \*
  7. If the PMD is unwilling to offer and coordinate access to the information and counseling, the Medical Director will be notified. The Medical Director will be responsible for assigning the resident to another physician.

1. The IDT will be responsible for the development of and on-going evaluation of a Palliative Care CCP, as indicated. The Palliative Care plan will address the resident’s physical, psychological, social and spiritual needs, in addition to the resident/family’s preferences, needs, values, expectations, concerns, and goals.
2. All members of the IDT will understand their role and responsibility with regards to the care of residents receiving Palliative Care. The goal of the palliative care team should be to provide all patients a peaceful and suffering free death while at the same time maximizing the patient’s functional and mental status so they can maintain their highest possible level of well-being.
   1. Physicians will focus on advanced care planning discussions with resident/resident representative(s), prognosis, and treatment plan. The PMD will complete a MOLST (Medical Order for Life Sustaining Treatment) form as needed for individual resident
   2. Nursing staff will provide direct care and serve as a resident advocate and educator.
   3. Social Workers will work with residents and resident representatives, facilitate access to resources, support coping mechanisms and mediate conflicts.
   4. Pharmacists/Pharmacy Consultants in collaboration with the primary physician and nursing staff will optimize medication management through a thorough review of the resident’s medications to ensure comfort, resolve or prevent drug-related adverse effects, and reduce the amount of medications prescribed when appropriate.
3. The plan of care will be individualized and consider resident preferences and goals for care including areas below:

* Restorative Therapies
* Routine weight monitoring
* Showering
* Medications
* Routine Blood Work
* Vital Sign Monitoring

1. The IDT will perform subsequent assessments at regular intervals, and whenever the resident’s status significantly changes, or if the resident experiences a transition in health care setting or provider.
2. The facility will establish an Ethics committee to guide policy development and provide staff education in areas, such as:
   1. Medically non-beneficial care
   2. A patient’s right to decline treatments of any kind
   3. Cessation of medically provided nutrition and hydration
   4. Foregoing or discontinuing technology (e.g., ventilators, dialysis)
   5. Use of high-dose medications
3. The resident may be referred to Hospice as requested by resident/resident representative or upon physician order with IDT review. All residents placed on Hospice services will have a significant change MDS 3.0 completed as well as a care plan meeting with the IDT team
   1. Hospice is a specific type of palliative care provided to individuals with a life expectancy measured in months, not years. To be eligible to receive hospice under the Medicare or Medicaid hospice benefit, adult patients must have a defined, time-limited prognosis (certified by two physicians as six months or less if the disease follows its usual course) and desire care focused on comfort, foregoing insurance coverage for further terminal disease-directed curative treatment efforts.

The RAND Evidence-Based Practice Center systematically reviewed the literature to formally grade the evidence and identify gaps for future research. Findings suggest that more well-designed trials of commonly used interventions in palliative care across populations are needed to bolster the evidence base in key areas. These areas include: early/integrated palliative care; complementary and alternative therapies (e.g. acupuncture, massage and medication) for symptom management; life review/dignity therapy and other spiritual interventions; and advance care planning interventions

Source:

https://www.rand.org/topics/palliative-care.html