Palliative Supports, Trail

COMMUNITY SERVICES

- Home Care Nurses/Home Support
- OT/PT or Respiratory Therapy
- Community Paramedic
- Transport (Handidart)
- Long-Term Care
- Respite or End of Life Bed
- Red Cross Equipment Loan

Contact: Trail Home Health, 250-364-6224

SPIRITUAL CARE

- Grief & Loss
- End of Life Care
- Religious and Spiritual Support
- Aboriginal Navigator

Contact: Palliative Social Worker
250-364-5163

Aboriginal Patient Navigator
250-304-5621

SOCIAL WORK SERVICES

- Emotional Support
- Family & Caregiver support
- Connection to resources (i.e. financial, spiritual, legal, cultural, etc.)
- Advance Care Planning
- Person-centered planning
- Advocacy

Contact: Palliative Social Worker
250-364-5163

HOSPICE SERVICES

"Caring You Through"

- Ongoing Caring & Support
- Family Support
- Education regarding End of Life Issues
- Assistance with Advance Care Planning
- Grief and Bereavement Support

Contact: Trail Hospice, 250-364-6204

MEDICATION & SYMPTOM MANAGEMENT

- Medication regime/titration
- Dietition
- Nursing Care
- Home Visits
- Wound Care
  Community Respiratory Therapist
- Radiation Therapy and advanced pain interventions
- MAiD – Medical Assistance in Dying

Contact: Home Health, 250-364-6224, Family Doctor, NP, or Community Pharmacist

HOSPITAL CARE

- Access to Specialists
- Active Disease Management
- Acute Care
- Crisis Management
- ICU

Contact the Family Doctor/NP

Kootenay Boundary Division of Family Practice
A GPSC initiative

Interior Health
Every person matters

SharedCare
Partners for Patients

Palliative Supports

Facilitating Conversations about Life-Limiting Conditions

- Utilize the *Serious Illness Conversation Guide* © (bit.ly/pallcareguide) to set up the conversation, assess illness understanding, share the prognosis, and explore key topics (goals, fears, support).

Preparing the Patient to Live with a Life-limiting Condition

- Offer the patient the opportunity to connect with the Palliative Social Worker or Hospice Navigator (Hospice volunteer trained in upstream palliative care) for psychosocial support
- Encourage the patient to accurately report symptom changes and side-effects for best symptom control
- Emphasize that the patient should bring a support person with them to subsequent visits to hear the conversations and plans
- At each visit ask the patient what is most important to them right now

Resources:

BC Medical Guidelines: *Palliative Care for the Patient with Incurable Cancer or Advanced Disease* (bit.ly/pallcareapproach)

BC Inter-professional Palliative Symptom Management Guidelines (bit.ly/psmguide)

Palliative Social Worker: A registered SW can assist with emotional, financial, legal, practical & family needs. Phone: 250-364-5163

Hospice Volunteer Navigator: A volunteer with advanced training who journeys with clients who have a life-limiting illness but are early in their palliative process. They help the patient and their family navigate the emotional, psychosocial and spiritual challenges they are beginning to encounter as their disease changes. Phone: Greater Trail Hospice Society 250-364-6204.

Canadian Virtual Hospice (bit.ly/vhospice) Patient Guide for Palliative Care Services in Trail (bit.ly/pallcaretrail)

Upstream/Early Stage Checklist:

- ☐ Review General Indicators of Poor or Deteriorating Health on SPICT Tool (bit.ly/spicttool) PPS generally >50%
- ☐ Discuss patient goals of care using the *Serious Illness Conversation Guide* (bit.ly/pallcareguide)
- ☐ Provide the patient with the "Resources for You" Brochure and review relevant information (bit.ly/pallcaretrail)
- ☐ Review chart on opposite page – Would this patient benefit from other team referrals at this time?
- ☐ Discuss need for *Advance Care Plan* , & Representation Agreement (Trail Hospice can help with ACP forms)
- ☐ Discuss and determine how much the patient wishes to know about their disease and how much they want to participate in decision-making
- ☐ Review current treatment plan
- ☐ Use the ESAS-r to assess changing symptom burden
- ☐ Establish plan for potential acute exacerbation of symptoms
- ☐ Assess patient's current support system
- ☐ Discuss & complete MOST form

Advancing Disease/Late-Stage Checklist:

- ☐ Review Clinical Indicators of Life Limiting Illness on SPICT Tool (bit.ly/spicttool) PPS generally <50%
- ☐ Determine if patient is eligible for Palliative Benefits Program and make referral if appropriate (bit.ly/pallbenefits)
- ☐ Discuss changing prognosis with patient/family
- ☐ Review MOST form
- ☐ Let patient know you are submitting a referral to the Home & Community Care Program
- ☐ Ensure an *Advance Care Plan* is on file; discuss any potential changes
- ☐ Discuss where patient wants care to take place in the future (Home? Facility?)
- ☐ Complete an "*Expected Death at Home*" Form if appropriate (and renew every 3 months)
- ☐ Regularly use the ESAS-r to assess current symptom burden
- ☐ Assess any changes in patient's support system or support needs
- ☐ Review chart on opposite page: Would this patient benefit from other team referrals at this time?