Leamington Mennonite Home
Long Term Care

POLICY AND PROCEDURE

CATEGORY: **Resident Care**	**SUBJECT:** **Palliative Care**	**SECTION:** **P** **POLICY:** **4**
DATE: **February 1999** **REVISION DATES:** **December 2004**	**Administrator:** _____ **Director of Care:** _____	

PALLIATIVE CARE

POLICY:

Palliative care is a program of active, compassionate care primarily directed at improving the quality of life for those who are coming to the end stages of their life. The goal of LMH is to provide these residents with dignity and comfort in their last stages of life.

PROCEDURE:

Palliative Care is provided by an interdisciplinary team comprised of:

- The Physician
- The Registered Staff
- The HCA's
- The Dietitian
- The Chaplain
- The Administrator

Together, they will provide sensitive, skilled care to meet the physical, psychological and spiritual needs of both the resident and their family members.

When a resident's condition changes and the decision has been made to provide palliative care it gives the Physician and Registered Staff a clearer understanding of the wishes expressed by the resident and family. When a resident's health status becomes palliative, the family will be asked if they wish to move the resident to the Palliative Care Room.

All members of the interdisciplinary team have input into providing individualized quality care. It is important that family become actively involved as well. The involvement is either informal, during regular visits, or, formally during care conference meetings, Doctor's visits, etc.

These areas are focused on when palliative care has been determined:

- Pain management and control.
- Skin care assessment and individual plan of care for prevention of skin breakdown.
- Positioning to decrease the possibility of developing contractures and increase comfort.
- Nutritional management and ongoing dietary assessment.
- Spiritual intervention and support.

Palliative care is individualized and constantly changing with the needs of each resident. As their condition enters a new phase, so does the plan of care, till death occurs.

Good communication between all members of the interdisciplinary team and family members is the key.

Care of the Resident in their last hours:

- The resident's care is focused on dignity and comfort.
- Turning and repositioning is required at least Q2 hrs, following the turning schedule.
- Mouth care is to be done Q 1 – 2 hrs or more often due to mouthbreathing and dehydration. Use water on a sponge and clean the tongue and teeth. If the tongue is coated, ½ tsp of baking soda in ginger ale can also be used.
- Lubricate lips with vaseline. Use KY jelly if the resident is using oxygen.
- Eye drops are instilled Q 1 – 2 hrs PRN as ordered for palliative comfort.
- On going communication with the resident as to the care being provided is very important.
- Ensure the environment is calm: soft music, clean and clutter free.
- Keep the family comfortable.
- Offer fluids and food to family.
- Provide support and reassurance to both the resident and family members.
- HCA's will communicate to Registered Staff if discomfort is noted while care is given.
- Registered Staff will monitor pain control closely and administer pain medication as ordered. Registered Staff will advocate to the Physician when, or if, pain medications are not adequate. See Policy & Procedure for Pain Management.
- Residents who have a decreased gag reflex are no to be fed or given fluids unless the risk of aspiration is not present.