The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” Palliative care cuts across sectors, being delivered in hospitals, outpatient centres, hospice, residential care facilities and at home.
BC NURSES’ UNION BELIEVES THAT:


British Columbians need and deserve excellent care at all stages of life, up to and including death and bereavement, and that nurses are central to quality palliative and end-of-life care. BCNU believes that British Columbians should have the right to choose from a full range of quality, publicly funded palliative and end-of-life services in the care setting of their choice.

WHAT IS PALLIATIVE CARE?
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BACKGROUND
Fewer people die suddenly, and more people are living with chronic diseases than ever before. The Canadian health care system is adapting to increasing numbers of Canadians living with life-limiting illness, who wish to receive care at home or in their communities as much as possible. Canadians also have a relatively new option to consider in the context of death and dying; in 2016, new legislation on Medical Assistance in Dying (MAID) came into effect across the country, presenting new choices and new challenges for patients, families and health care professionals. This legislation continues to evolve, with significant changes made in 2021 to broaden the scope of individuals able to access MAID in Canada. Further study continues at the national level to inform decisions on eligibility for other populations as well. In making decisions on expanding eligibility criteria for MAID, particular attention must be paid to ensuring that Canadians have timely, equitable access to all forms of treatment and support, such that decisions about MAID are made without the overwhelming stress of financial hardship.

All British Columbians should have the opportunity to benefit from equitable access to appropriate services as they cope with serious illness and eventual end of life. However, a recent CIHI review showed that just 25% of Canadians who died in acute care and 15% of those receiving home care services received palliative care services, and most of those who did receive such care were only able to access it in their last month or last days of life.

WHAT’S GETTING IN THE WAY?

Diagnosis
Palliative care was developed mainly with advanced cancer in mind. Referral to many palliative services requires a prognosis of less than six months to live. Physicians have often been reluctant to make that determination in patients with non-cancer diagnoses, as their disease trajectory tends to be less predictable. What this means in practice is that cancer patients make up over 90% of palliative care referrals, despite accounting for just 30% of deaths in Canada.

Age
Traditional palliative services are designed for older adults and their families. The needs of youth, children and infants facing life-limiting illnesses are different, and require specialized services. Although pediatric palliative care programs are on the rise in Canada, they are only available in urban centres, most often connected to children’s hospitals.

Place of Residence
There are only around two hundred palliative care specialists in Canada, and the vast majority work in urban centres. This means that Canadians living in rural and remote communities are least likely to access palliative care services, and end up spending more time in hospital at the end of their lives, far from their homes and their families. Nurses living and working in rural areas struggle to provide quality palliative care, as they are more likely to work alone, having to make do with very few supports.

British Columbians who live in residential care facilities also have greater difficulty...


REDEFINING PALLIATIVE CARE

We often think of palliative care as beginning when all else fails – comfort care immediately preceding death. iPANEL researchers and other experts, however, are seeking to expand this definition by including palliative care alongside other interventions for serious conditions such as heart disease, kidney disease, lung disease, dementia and frailty, among others.

A palliative care approach includes some basic palliative principles: team-based care; maximizing quality of life; relief from pain and other symptoms; addressing psychological and spiritual needs; support for families and other caregivers; and supporting dying as a normal process. Patients who receive palliative care alongside other services report better quality of life, symptom management and satisfaction of care than those who receive treatment as usual. Providing an integrated palliative approach to care has also been shown to decrease hospitalization and emergency room visits, while facilitating more appropriate referrals and better use of community-based services.

SUPPORTING THE ROLE OF NURSES

The increasing demand for palliative care services will require further reliance on nurses and nurse practitioners. The need to educate nurses to meet these needs is strong; research shows that many health care professionals, including nurses, are not comfortable with palliative care.

According to research conducted by the iPANEL team, nurses in BC report needing education in particular around spiritual and social needs and ethical and legal issues.

Nurses who work with patients at the end of life also need support for their own mental, emotional and spiritual health to protect against their increased risk for compassion fatigue, burnout and vicarious traumatization. This support should include adequate time and encouragement for debriefing and grieving after the loss of a patient, inclusion of palliative care nurses and spiritual health practitioners where appropriate, education on death and dying for care team members, patients and families; decreasing job stress as much as possible, and working to ensure that nurses...


THE ROLE OF NURSES IN MAID

Research shows that patients often approach nurses first with questions about MAID30. Though the assessment to determine if a person is eligible for MAID must be completed by the physician or nurse practitioner who will carry it out, nurses can assist outside of the formal assessment process by supporting patients and their loved ones with information and emotional support. LPNs, RNs and RPNs are permitted to aid in the provision of MAID, but there is no requirement for a nurse to participate if they object31, 32. Nurses in BC are allowed to insert an IV, but are not allowed to administer the medication that will end the patient’s life. The BC College of Nurses & Midwives recommends that nurses refrain from handling MAID medications in any way. Nurses are also not allowed to encourage, recommend, counsel or advise a person to consider MAID, pronounce death related to MAID, document any aspect of the procedure, or aid in the provision of MAID for a member of their family. The BCCNM requires registered nurses aiding in the provision of MAID to have additional education33. Resources created through the provincial MAID working group include a series of three learning modules and a decision support tool. Available through the Health Authorities Research shows that nurses who receive this education are more open to discussing these difficult topics with patients and their families34.

As advocates for patients and families, nurses can work to ensure that the necessary resources are in place to provide the full range of options to British Columbians at the end of life. These resources must include:

> timely, equitable access to palliative care services for patients and their families at no cost;
> appropriate staffing levels to ensure that nurses have the time they need to provide palliative care;
> comprehensive palliative care education for nurses;
> appropriate tracking of patient MAID requests, approvals, denials and referrals to ensure that safeguards are being maintained without preventing access to MAID;
> evidence-based resources and supports for nurses engaged in MAID; and
> research on the effects of MAID on patients, families, caregivers and health care professionals in Canada.