Ontario

Palliative Care
Inspection Guide

This Inspection Guide provides ***guidance*** to the inspector during the initial planning of an inspection. Not all sections will be applicable in every situation and the inspector may need to adjust the inspection based on information collected.

PROFILE FOR RESIDENT

- Name, room number, home area
- Date of birth, date of admission, date of discharge (if applicable)
- Diagnoses
- Other resident information, as applicable: Most Responsible Person (MRP), Physician, SDM, Advance Directives, Activities of Daily Living, and RAI-MDS Outcome Scores, e.g., CPS, CHESS (0-5, higher score = more complex)

CLINICAL RECORD REVIEW (ELECTRONIC AND HARD COPY)

ASSESSMENTS

- RAI-MDS - Section B (Cognition), Section G (ADL Decline), Section J (Pain, Health Conditions)
- PPS (Palliative Performance Scale)
- Pain assessments (software generated, PAINAD)
- Nutritional/RD assessments; Palliative consultations, as applicable (Therapies, Specialty surfaces, Skin and Wound)
- Documentation of care (flow sheets, tasks - intake, transferring, turning and repositioning, ADLs, hygiene and grooming, mouth care, continence care, skin integrity)

PLAN OF CARE

- Plan of care based on assessments - Palliative care focus – reflect physical/emotional/psychological/social/spiritual/cultural needs; preferences of resident/SDM; Early palliative care needs (if applicable); End-of-Life Care (EOL) needs (if applicable); Includes interventions implemented – comfort measures.
- Evidence of revisions when condition changed/interventions ineffective.

MEDICATION ADMINISTRATION RECORDS (MAR)

- Palliative orders – implemented – review administration record, given as prescribed

TREATMENT ADMINISTRATION RECORDS (TAR)

- Palliative orders – implemented – review administration record, given as prescribed

PROGRESS NOTES

- Progress of decline/change in condition. Monitoring and follow up completed.
- SDM informed and involved in decisions.
- Physician involvement; implemented palliative orders in timely manner.
- If transferred to hospital – notes prior to being transferred/returned.
- Evidence of pain management – if not, what action taken.
- Family or friends able to visit 24 hours per day for any resident who is dying or who is very ill.

OBSERVATIONS

If Resident Not Deceased

- Provided care respecting choice and dignity; provided privacy for palliative needs – when doing care, when family in, and provided as per plan of care.

INTERVIEWS

RESIDENT/SDM

- Discuss the care they received, able to provide decisions with needs and preferences, and were they followed. Any concerns with visiting.
- Discuss if they were given reasonable opportunity to practice their religious and spiritual beliefs.

DIRECT CARE STAFF

Care Aides, PSW, RPN, RN, activation as applicable

- Discuss how staff are made aware of a resident's care needs, preferences, and how made aware of changes, e.g., plan of care, shift reports etc.
- Discuss what education and training (including additional training on EOL care) provided for palliative care measures, e.g., policies, evidence-based

assessments utilized, approaches utilized, additional supports available-local palliative network, palliative committee.

- Confirm familiarity of resident and their care.
- Confirm the staff members awareness of the resident's change in condition, assessments completed, and the measures implemented.
- Explore if there are approaches and tools used in the monitoring of the resident's condition and care provided – where is this documented.
- Explore if there were any identified concerns with the palliative care and/or EOL care received

REGISTERED STAFF AND MEDICAL PERSONNEL

- Discuss the process of implementing palliative measures/orders – who involved in plan of care.

MANAGEMENT

Director of Care, Administrator/Delegate

- Discuss the Palliative program-who involved and process of palliation.
- Discuss the area of NC, if identified.

OTHER RECORD REVIEW

- CI report, internal investigation notes, if applicable
- Consultation with Palliative specialist – recommendations (implemented); advance care planning; recent hospital transfers/admissions (hospital summaries)
- MD or Coroner reports, if applicable
- Relevant policies – Palliative Care (including EOL), Plan of Care, Medications
- Complaint log – was a complaint submitted and addressed
- Video or audio recordings

FOR FURTHER GUIDANCE

Please refer to policies, guidance documents, and job aids available in the eInspectors' Handbook.