CHCA Project ECHO
Home-Based Palliative Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home-Based Palliative Care

Compassionate Care in Last Days and Hours

Anticipating End of Life:
Competencies for Compassionate, Person-Centred Care

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Palliative Care Physician
Fraser Health Authority, British Columbia

Host: Jennifer Campagnolo, Canadian Home Care Association
September 24, 2025

Land Acknowledgement

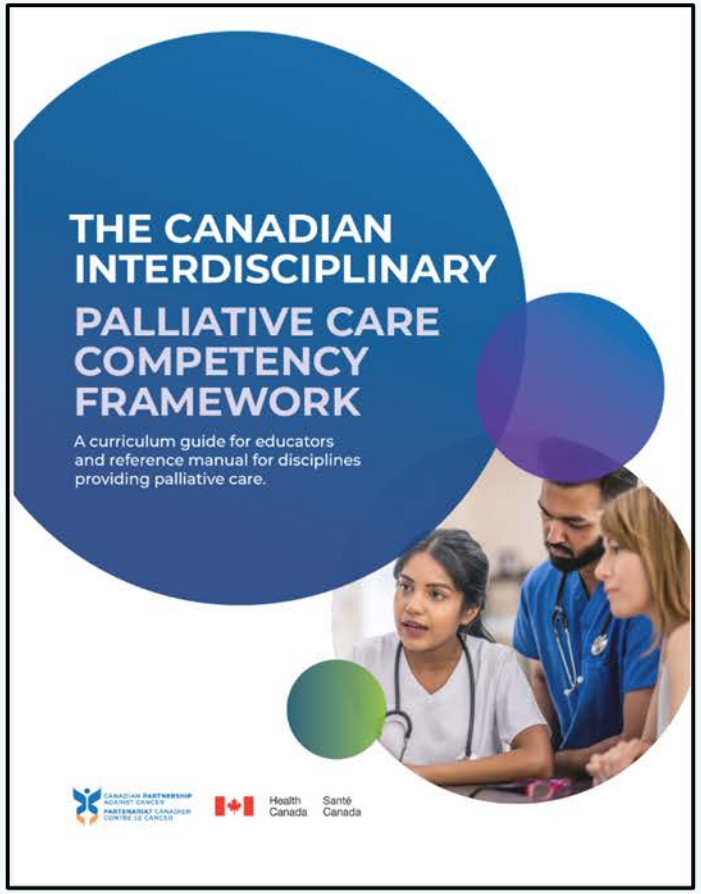
Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Reminders

- Say “Hello!” and introduce yourself via the chat! Remember to select “Everyone”.
- Use the chat function if you have any comments or are having technical difficulties.
- Multilingual captioning is available and can be activated through your Zoom options.
- Microphones are muted. **Please use the Q&A function to ask the panelists questions.** We will be taking time to answer any questions at the end of the presentation.
- This session is being recorded and will be available at **https://cdnhomecare.ca/chca-project-echo-home-based-palliative-care**
- Remember not to disclose any Personal Health Information (PHI) during the session.

THE CANADIAN INTERDISCIPLINARY PALLIATIVE CARE COMPETENCY FRAMEWORK



Compassionate Care in Last Days and Hours

Domain 6: Last Days and Hours

For members of the Interdisciplinary Team (nurses, SW, PSWs, generalist physicians and volunteers) competency is a combination of the SKILLS, KNOWLEDGE and ATTITUDES needed to:

- **Recognize** the dying phase and identify signs of approaching death.
- **Educate and prepare** the person and their family/caregivers about expected physical, emotional, and psychological changes.
- **Provide comfort and support** through appropriate symptom management, medications, and interventions.
- **Support families and caregivers** emotionally and practically during the last days and hours.

[1] Canadian Partnership Against Cancer & Health Canada. *The Canadian Interdisciplinary Palliative Care Competency Framework.* Toronto, ON: 2021.

Introductions

Dr. Doris Barwich, MD, CCFP (PC)
Palliative Care Physician
Fraser Health Authority, British Columbia

Recognizing End-of-Life in Home- based Palliative Care

Dr Doris Barwich MD, CCFP(PC)

Clinical Associate Professor UBC

BC Centre For Palliative Care (Founder)

Palliative Care Physician (Fraser Health, BC)

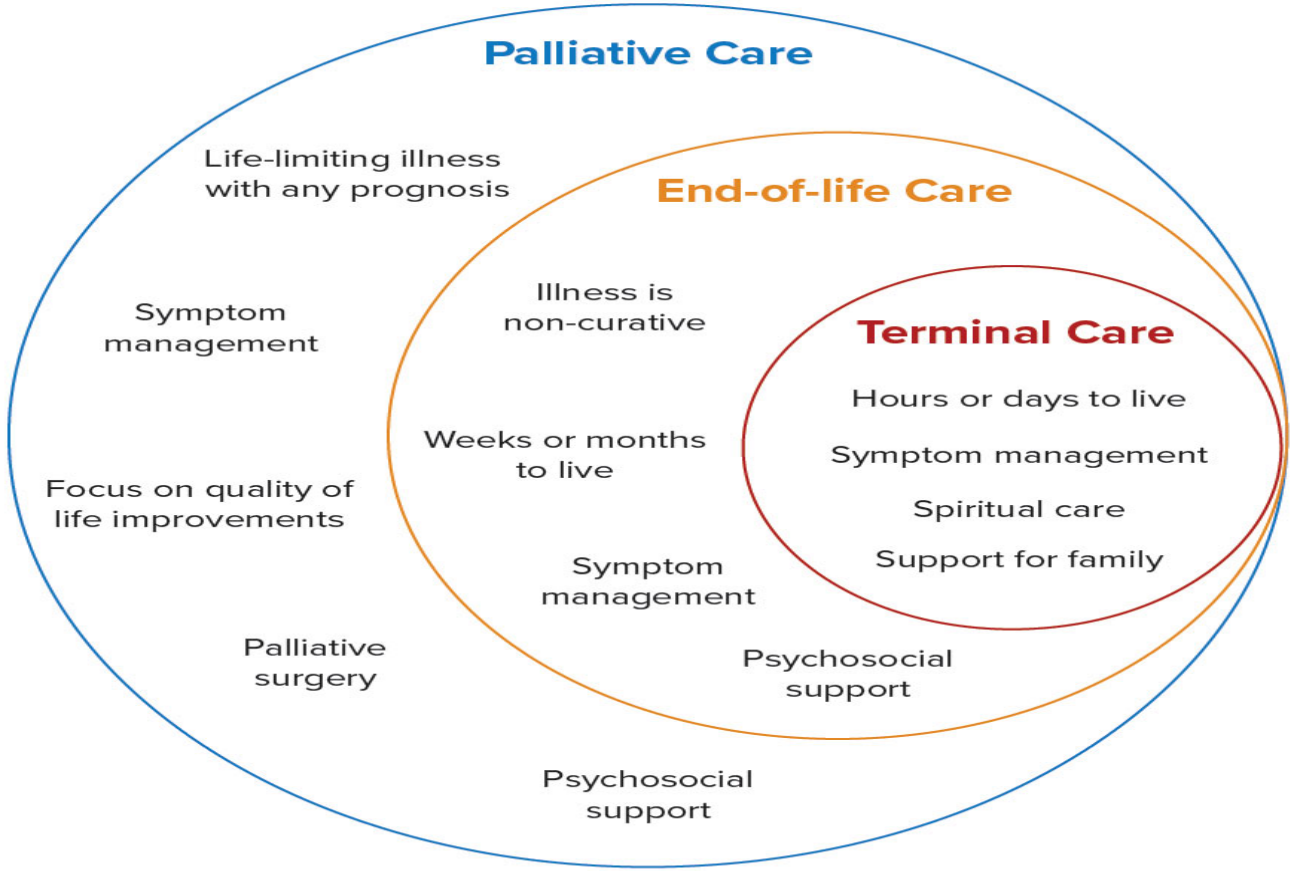
Objectives

1. Review:
   - The continuum of Palliative care
   - Common issues as patients approach end of life
2. Recognition & management
3. Discuss practical applications (Case study)
4. Questions and comments

Palliative Care: Definition

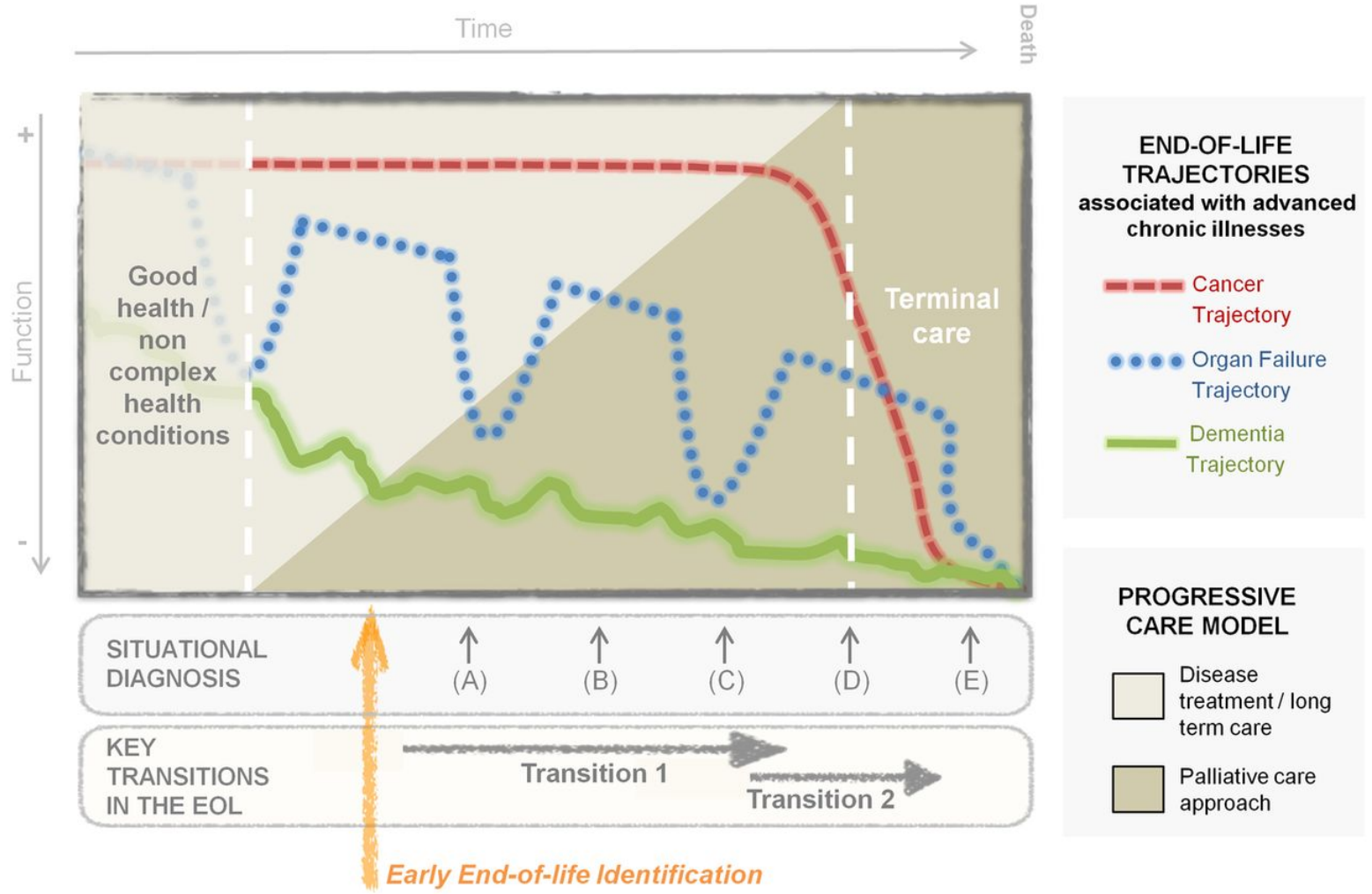
An approach to care that addresses physical, practical, psychosocial & spiritual needs of patients & families in the context of life limiting or serious illness

- Person/Family centred care: Unique goals & values
- Focus on quality of life & relieving suffering
- Includes early identification, correct assessment, pain & symptom management, good communication & coordination of care
- Team approach to ensure wholistic care
- Provides a roadmap…


Palliative Care
Life-limiting illness with any prognosis
Symptom management
Focus on quality of life improvements
Palliative surgery
Psychosocial support
End-of-life Care
Illness is non-curative
Weeks or months to live
Symptom management
Psychosocial support
Terminal Care
Hours or days to live
Symptom management
Spiritual care
Support for family


Terminal Care
End-of-life Care
Palliative Care
Diagnosis
Death

Trajectories at end of life



Assessment

- **Functional status:** Palliative Performance Scale (PPS),
  - "Typical day": Needing assist, energy/LOC, pain
  - Current issues: Dyspnea? Constipation? Confusion?
- **Nutritional issues:** Especially when not able to take PO
- **Is pt able to make informed decisions?**
  - If not, is there a substitute decision maker: Someone they have talked to about their wishes?
  - Any previous planning or discussions?
  - Code or MOST status

Palliative Performance Scale (PPSv2) version 2[2]

	PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
Stable	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
	80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
Transitional	70%	Reduced	Unable to do normal job/work Significant disease	Full	Normal or reduced	Full
	60%	Reduced	Unable to do hobby/housework Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion
	50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
	40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
End-of-Life	30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
	20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- confusion
	10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Drowsy or coma +/- confusion
	0%	Death	-	-	-	-

Physical Assessment:

1. **PPS:10-30%**
2. **Symptom issues**:
   - Pain: Increased in 1/3; Same: 1/3; 1/3: Decreased
   - New symptoms: ?bleed, rupture, pulmonary embolus
   - Physical exam: ?Pneumonia, ?ascites, constipation
3. **Common symptoms at EOL**:
   - Respiratory congestion, breathing changes
   - Confusion/agitation- Terminal restlessness/ Delirium
   - Decreased level of consciousness/awareness
   - Circulatory changes: Cold extremities, mottling
   - Incontinence

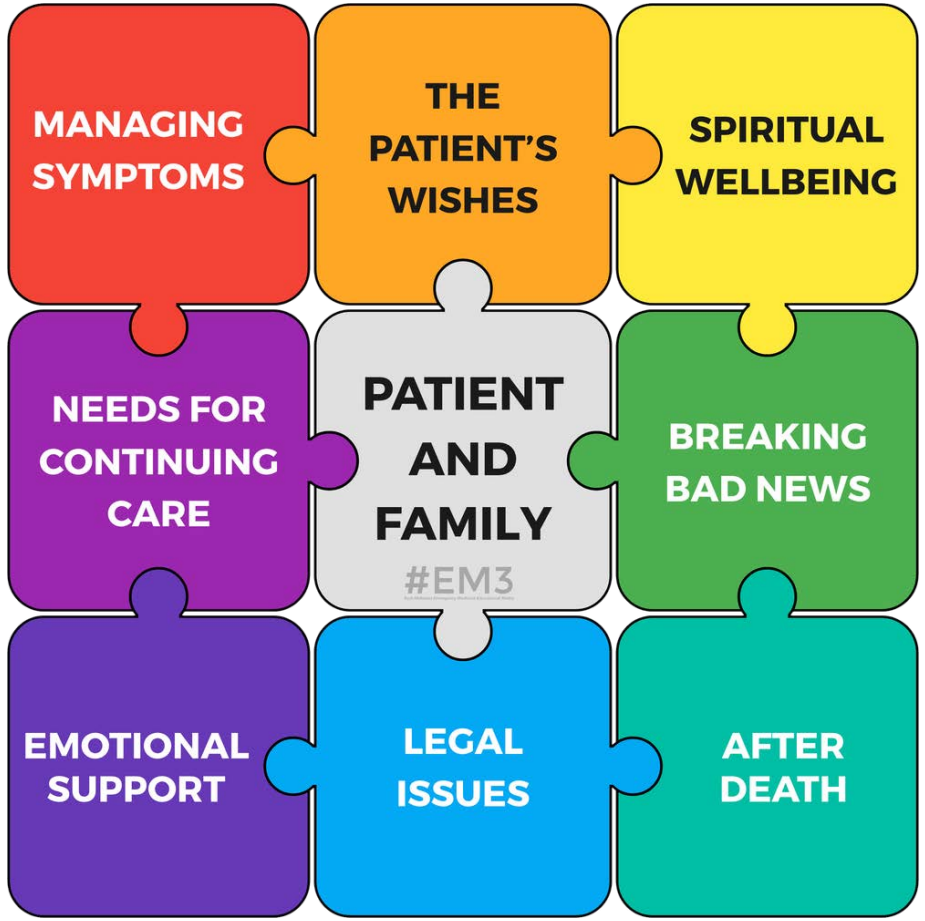
Assessment

4. **Spiritual issues**:
   - Unfinished business
   - Choices, values, concerns, rituals: Different cultures, ethnicities but also very individual
5. **Psychosocial:**
   - Depression or anxiety
   - Caregiver: Support needs. ?Stress or burnout
   - Family conflict
   - Family: Need for information & education: What to expect, roles (SDM vs POA vs Executor), what to do
6. **Practical issues -> Care Planning**

Managing transitions

- Key to good Palliative Care is anticipatory care planning & ongoing communication: ASK/TELL/ASK..
  - *“ I’m seeing some changes that suggest we may be approaching ….”*
  - *Has anyone talked to you about what to expect?*
  - *Fears? What are the most important goals of care?*
  - *Have you had that discussion as a family?*
  - *What supports do you have?*
  - *Caregiver issues:*

Patient & family centred care: Checklist
Care at Home binder



Care Planning: Decline q2-3 days

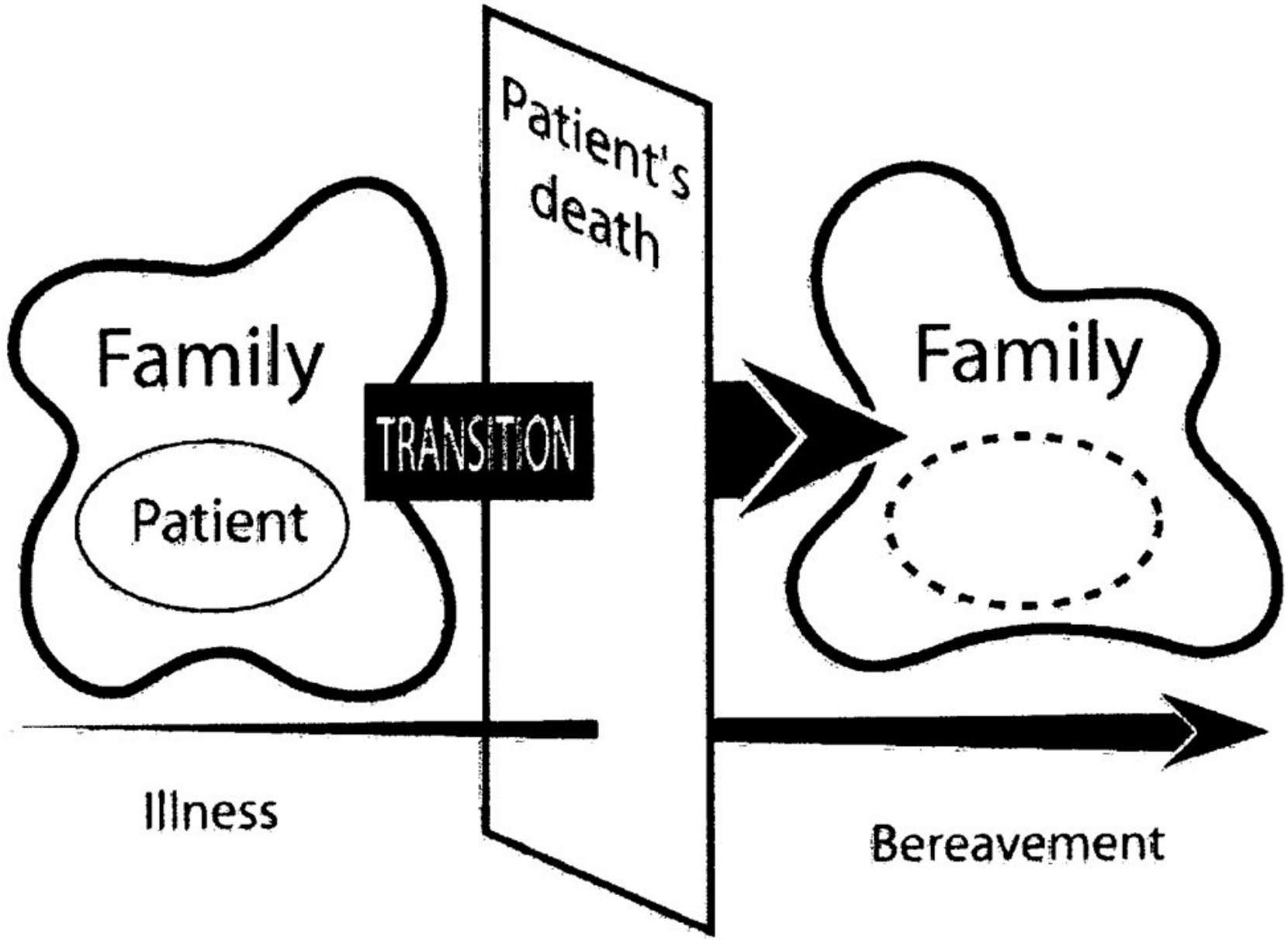
- Confirmation of
  - Level/goals of care: DNR, MOST form
  - Place of care
- Is EOL planning done? Will? POA? Other priorities
- Important conversations:
  - https://irabyock.org/books/the-four-things-that-matter-most/: "Please forgive me," "I forgive you," "Thank you," &"I love you"
- Education and increasing support

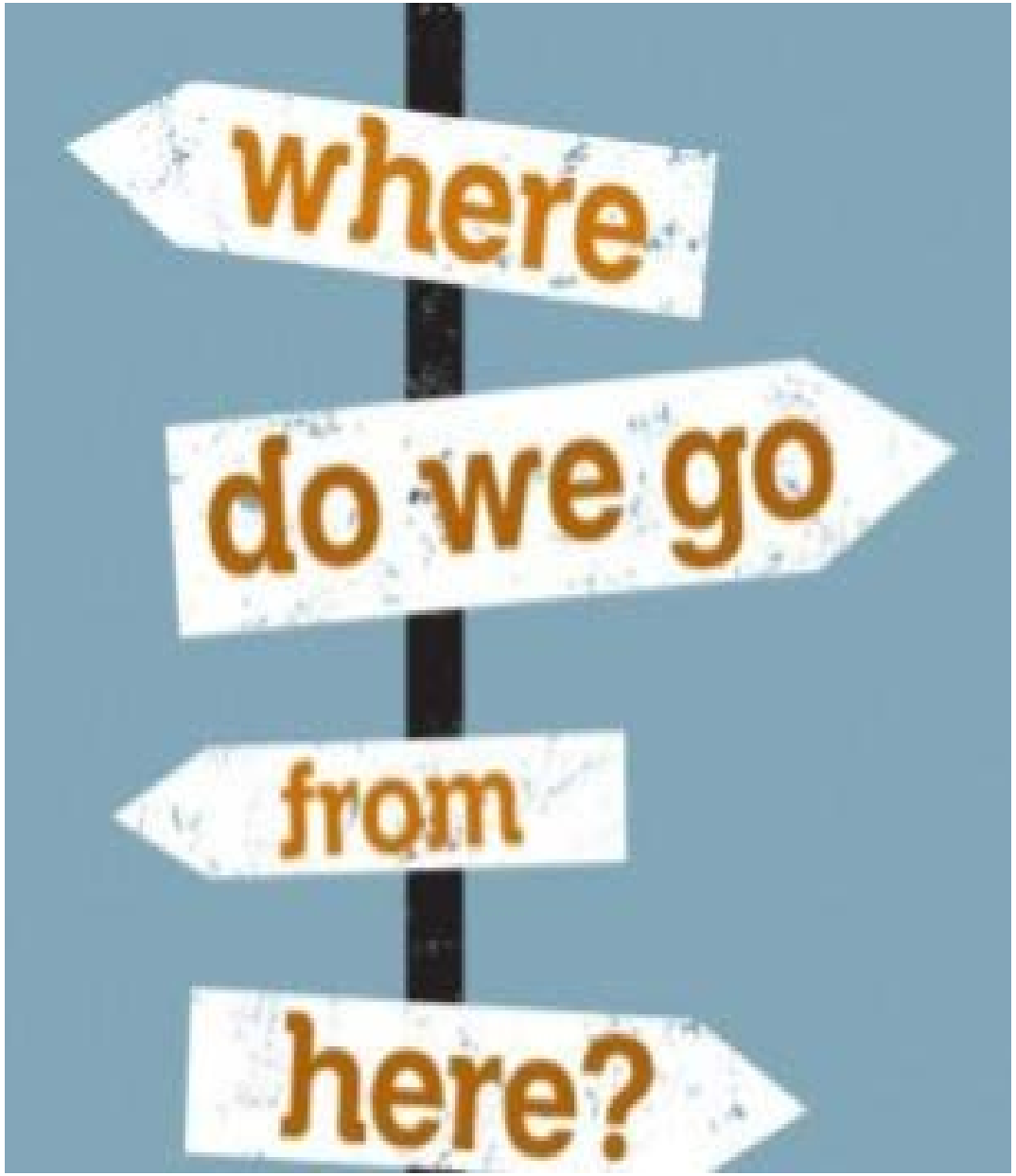
Ongoing Care Planning & Education

- Expected physical changes & what to do:
  - Decreased PO intake: Focus on mouth care, not IV
  - ?Pressure sores: Frequent turning; Pillows
  - ?Incontinence or retention: ?Foley, Bowel care
  - Agitation or confusion: “Terminal restlessness”
    - ?Hallucinations, ?Unresolved business,
  - Breathing changes: Meds, Oxygen, fans/air flow
- Medications/supplies: SQ meds, ?Bed, Oxygen, ?
- Information re what to expect

Preparation for death:

- Managing changes/crisis: Ensuring comfort
  - What to do/Who to call: Home support, Home care nurse, Family Physician, EHS/Paramedics
  - Crisis meds: Medication kit
  - EDITH form: Expected Death in The Home: MB, BC
  - If no DNR in place: Clear discussion about process
- At time of death:
  - Presence of family
  - Certification/Pronouncement of death
  - Calling the Funeral home


Patient's death
Family
Patient
TRANSITION
Family
Illness
Bereavement



- Bereavement
- supports

Thank you!

Questions? Comments?

Case Study: B.T.

Meet B.T.:

- Age: 43
- Gender: Non-binary (they/them)
- Diagnosis: Metastatic pancreatic cancer with liver and peritoneal metastases
- Lives in rural home in central Manitoba; nearest hospital emergency department is in Thompson, MB
- Living situation: Resides with spouse, supported by a large extended family; B.T does not have children of their own
- Care plan: B.T. wishes to remain and die at home; advanced care plan documented in electronic health record
- Care team: – Local home care nurse and health care aides (HCAs/PSWs) through the regional health service – Primary care provider (family physician) – Virtual specialist palliative care team for consultation and symptom management (through WRHA)

Case Study B.T.

Present Situation:

- Over the past 48 hours the family and home care team have noticed a significant change ; B.T. is now resting or sleeping nearly continuously and his times of alertness are becoming less and less; while alert, B.T. mumbles words and phrases that are incomprehensible or do not make sense; B.T. continues to have periods of extreme agitation and is no longer interested in any food or fluids
- Family is showing and expressing increased levels of anxiety and worry, distress from what they are witnessing and experiencing
- As family caregivers they have read some materials to prepare them for end of life, but feel overwhelmed by all they are experiencing and have read

Case Study B.T.

Care Challenges:

- The home care nurse has limited experience in palliative care and has never cared for someone as young or agitated as B.T.
- The home care nurse recognizes the emotional distress the family is currently experiencing and this contributes to the nurse's own anxieties and their desire to support the family and B.T.
- The home care nurse recognizes their own emotions and anxieties, as well as those of the family members are contributing factors
- The nurse is aware that B.T.'s condition has changed but is unsure whether these changes indicate the final hours to days of life and if the next steps are valid:
    - Initiating anticipatory guidance with the spouse and extended family
    - Deciding when to escalate to the virtual palliative team for medication adjustments
    - Shifting the focus entirely to comfort and end of life care.

Discussion / Q&A

Dr. Doris Barwich, MD, CCFP (PC)
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Fraser Health Authority, British Columbia

Upcoming TeleECHO Sessions

Honouring Lives: Building Competency in Equity, Cultural Humility and Inclusion at End of Life

October 15, 2025 12 – 1pm ET

Presenter:

Dr. Sarina Isenberg MA PhD (she/her), Bruyère Chair in Mixed Methods Palliative Care Research | Bruyère Research Institute | Assistant Professor University of Ottawa

Strengthening Team Communication Through Role Clarity

October 1, 2025 12 – 1pm ET

Presenter:

Madeline Meehan, Project Manager, Kingston Health Sciences Centre, Ontario

Panelists: Judy Steward, Karen Bell

1 Mainpro+® Certified Activity credits

Register: cdnhomecare.ca/chca-project-echo