A Palliative Approach

Creating a culture shift in medical practice

An integrated palliative approach can start anywhere – and everywhere. Everyone has a role to play, including you.

In today's health care settings the role of the expert palliative care team may vary in each jurisdiction. With a palliative approach in place, the same practitioners providing the person's care in any community setting can initiate and support integrated palliative care.

ALLER DE L'AVANT THE WAY FORWARD

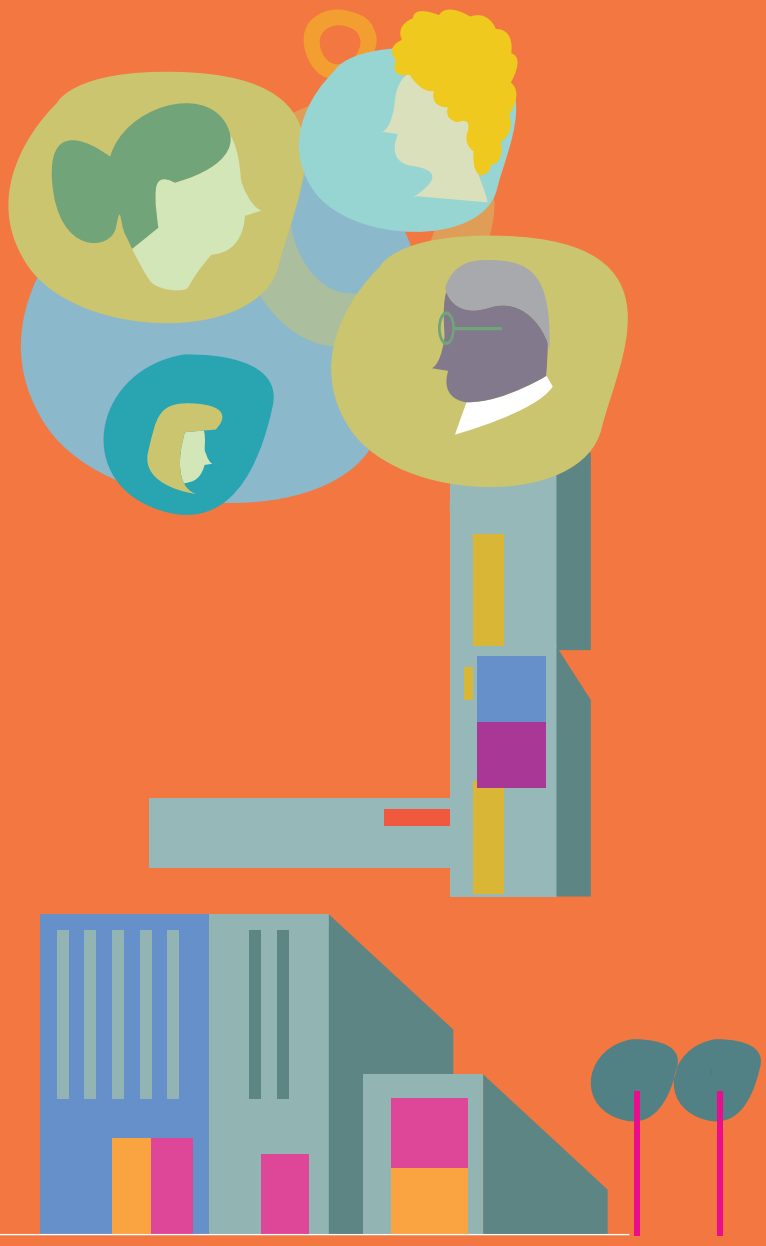
The Canadian Hospice Palliative Care Association and its 37 partners in the Quality End-of-Life Care Coalition of Canada have a collective goal to share The Way Forward, an integrated palliative approach to care that focuses on an individual's quality of life throughout their illness trajectory – not just at the end of life.

02

Shared-Care Shift

As a community develops an integrated palliative approach and more primary care providers in different settings have the confidence and skills to integrate palliative services into their patients' care, the expert team will shift to more of a shared-care role, which can include:

- → Educating providers
- → Assessing individuals and referring them to the setting that best meets their needs and preferences
- → Being available to consult and provide advice to primary and community care professionals
- → Providing on-call, after-hours or weekend services to reduce the burden on primary care professionals
- → Sharing the care for people and families who face challenging physical, psychosocial or spiritual symptoms, conflicts over goals of care or decision making, or family distress
- → In some cases, taking over a person's care if he or she has complex medical needs or is transferred to a residential hospice or palliative care unit. When this transition does occur, the expert palliative care team ensures the primary providers are kept informed about the person's care and progress and are able to resume responsibility for the person's care if his or her condition stabilizes and the person can be discharged back home or into long-term care



Creating a Compassionate Vocabulary

For many people – including many health care providers – the word "palliative" is associated with the last days or weeks of life, and an integrated palliative approach to care is new and not well understood. We need to develop a common language and clearly defined terms that embody dignity, compassion and empathy, as well as respect for different cultural attitudes towards dying.

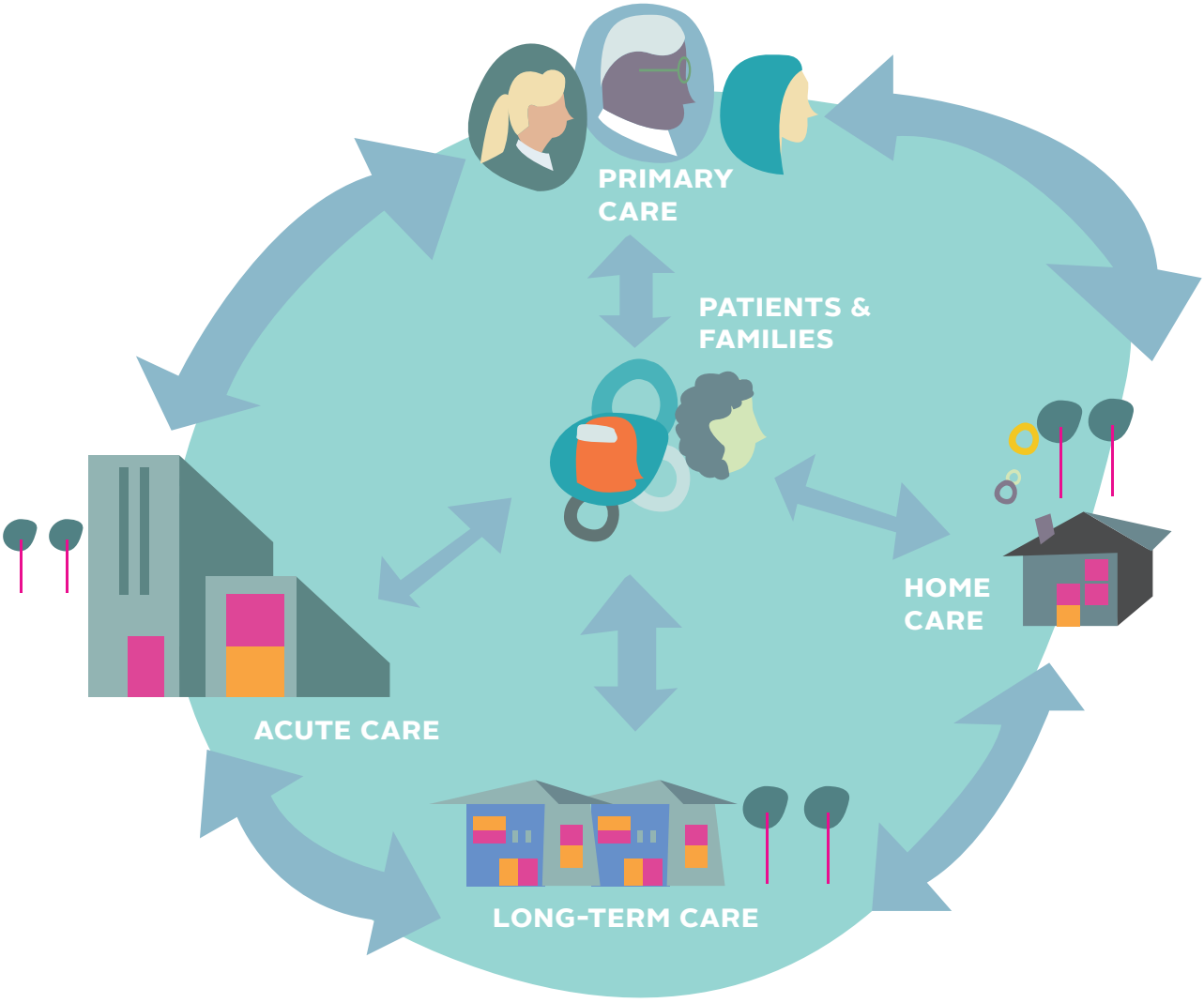
An integrated palliative approach looks at the whole person, providing holistic care that respects each person's values and preferences and optimizes health care resources to support better care across all care settings.

Continuous Quality Improvement

As sites across Canada begin to implement an integrated palliative approach to care, we will learn more about how to do it well. The framework's action steps can be continually updated to reflect best practices, lessons learned, and feedback from the many people and organizations involved in providing or receiving palliative services integrated into their care and in the setting of their choosing.

04

Patient & Health Care Setting Map



Home Care

Home care programs provide hospice palliative care services that reduce the pressure on acute care, allow individuals to remain in their homes, and lessen cost to the health care system.

Home care teams are often not assigned until a person is deemed palliative, with no more than six months to live. Those clients who could die suddenly due to frailty or life-limiting chronic illness do not have access to a palliative approach. We can change that by promoting a culture shift:

Culture Shift Actions

- → Reassess eligibility criteria for palliative services to include life-limiting chronic illnesses
- → Ensure a palliative approach is available to clients whose health could deteriorate quickly
- → Create strategies for flexible services allowing: more service hours, broader access to health care teams, better serve clients and families
- → Ensure all members of home care service providers are trained in a palliative approach
- → Develop assessment tools to identify patients who would be better served by having access to hospice palliative care programs and services, and planning earlier in diagnosis and management
- → Change front-line services to ensure all clients have advance care plans, engage client in discussions about prognosis, treatment options and benefits/risks
- → Home care coordinators facilitate advance care planning discussions and develop home care plans
- → Educate on culturally-safe palliative services for Aboriginal peoples, and/or diverse cultures
- → Develop tools for advance care planning, communication cues, descriptions of benefits and risks for different treatments and life-limiting conditions, triggers and reminder systems to revisit care plan and care goals
- → Develop strong links and communication between home care programs and primary care and chronic care teams
- → Measure and assess impact of a palliative approach on client outcomes, provider satisfaction, use of health care resources such as client satisfaction, management of pain and symptoms, and use of emergency services

06

Long-Term Care

Most residents in long-term care are highly vulnerable, and are often frail, or have life-limiting illnesses including Alzheimer's or dementia. Long-term care staff members have good relationships with residents and would prefer to provide care at the end of life themselves rather than have specialists "parachuted in." A palliative approach can help. Get started:

Culture Shift Actions

- → Build strong links with specialized hospice palliative care programs and community agencies
- → Modify strategies for a resident nearing end of life
- → Ensure tools and guidelines are practical, accessible and easy to use
- → Integrate palliative care education into mandated education programs
- → Educate staff on how to provide culturally-safe and appropriate integrated palliative care for people of different cultures in their facility and/or community
- → Collect data, enhance coding capacity, and monitor impact
- → Track indicators such as:
  - The number of residents who have up-to-date advance care plans
  - Resident satisfaction with care and location of care
  - Use of emergency services
  - Hospitalizations
  - Use of staff resources
  - Proportion of residents who die in the home rather than being hospitalized at time of death
- → Share best practices with colleagues in the long-term care sector
- → Talk to families about hospice palliative care options and services at the residence to prevent hospitalization

Primary Care

Primary care providers offer comprehensive care including managing and treating chronic diseases and also being actively involved in their patients' care throughout illness and at end of life. A palliative approach can increase skills and knowledge and enable primary care providers to effectively use resources for advance care planning and end-of-life care. Here's how we can get started:

Culture Shift Actions

- → Identify primary care team members who will be palliative approach champions; create team expert or specialist
- → Provide education and training: advance care planning, plans of care, communication with individuals and families, pain and symptom management, and community services
- → Provide culturally-safe education and training for diverse cultures and Aboriginal peoples
- → Develop assessment tool for early identification of patients with health conditions, frailty, or chronic illness that put them at risk of hospitalization or sudden death
- → Identify patients for whom a palliative approach is a priority
- → Develop tools for: advance care planning, communication cues, descriptions of benefits and risks of treatments for life-limiting conditions, criteria and reminder systems triggering revisit of patient care plans and care goals
- → Collaborate and connect with specialized palliative care teams, hospices and community services
- → Measure:
  - The number of patients with up-to-date care plans
  - The number of patients who are frail or have chronic life-limiting illness that are well managed at home or long-term care
  - The uptake of care pathways
  - Patient satisfaction
  - Avoidance of emergency room visits
  - The number of deaths in patient's preferred setting or where the majority of care was provided

08

Acute Care

There are a large number of patients moving through chronic disease management teams in acute care. Acute care teams are challenged to improve care, optimize care across departments and within the acute care system, and ensure cost efficient care. Acute care staff need protocols and skills to help them talk to patients and family members when hospitalized with an illness. By adopting a palliative approach, acute care teams and other health care professionals can help a patient and their family make informed decisions and plans earlier in the course of an illness, aid transitions when intensive measures are no longer appropriate.

Culture Shift Actions

- → Set policies and expectations to implement a palliative approach
- → Acute teams who work with frail or life limiting conditions can work with specialized hospice palliative care programs in community to develop skills and protocols
- → Identify champions on team who demonstrate skills in integrating a palliative approach to care
- → Educate acute staff on services available; visit other care settings; find effective ways to collaborate to improve patient care throughout illness and at the end of life
- → Track and measure: collect data on Key Performance Indicators of integrated palliative approach such as the number of patients who have updated care plans; proportion of patients dying in ICU; proportion discharged to die in preferred setting; satisfaction of family members of people who die in hospital; cost of care; care costs avoided

Please visit these sites to learn more:

The Way Forward and a palliative approach:
www.hpcintegration.ca

Advance Care Planning:
www.advancecareplanning.ca
(including workbooks and tools by province)

Palliative care education and resources:
www.pallium.ca

Hospice palliative care:
www.chpca.net

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Quality End-of-Life Care Coalition of Canada
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Canadian Hospice Palliative Care Association
Association canadienne de soins palliatifs

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