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# **Building Operational Excellence in Home-Based Palliative Care:**

## ***Access to Advice & Advance Care Planning: An Edmonton Perspective***

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**2018 Home Care Summit**  
**October 2<sup>nd</sup>, 2018**

## PRESENTATION OVERVIEW:

- **Overview of Edmonton Zone Palliative Care Program**
  - **Enhancing Care in the Community**
  - **Access to Advice**
  - **Access to Advance Care Planning**
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# OVERVIEW OF THE EDMONTON ZONE PALLIATIVE CARE PROGRAM

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# The Edmonton Zone Palliative Care Program





# ENHANCING CARE IN THE COMMUNITY

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## Enhancing Care in the Community (ECC)

*“We are further investing in enhancing community care and **shifting from a focus on providing care in hospitals to more community-based care**, closer to home for all Albertans, ensuring the quality of care received is consistent and focuses on the needs and wishes of Albertans first.”*

Source: <https://insite.albertahealthservices.ca/sh/Page16634.aspx>



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Alberta

Mar 20, 2017 [Media inquiries](#)

### **\$200 million invested in community health care**

Budget 2017 is boosting home and community care by \$200 million, allowing more Albertans to receive care in their homes and remain independent.

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# Enhancing Care in the Community (ECC)

## What Is Community-based Care?

*“...brings together programs such as primary care, home care and mental and public health care as we know them today with other community and social supports like increased home care services, day programs, respite services, palliative services, community urgent response teams, hospital day programs and **innovative approaches to assessments and system-wide case management.**”*



Source: <https://insite.albertahealthservices.ca/sh/Page16634.aspx>

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## Palliative Home Care

# The Edmonton Zone Palliative Care Program



## Urban Palliative Home Care

- Provides Palliative/End of Life Care services in the community setting for Urban Edmonton
  - Services are delivered by an interdisciplinary team comprised of Case Managers, Nurses, Rehabilitation Therapists, and Social Workers, along with volunteers and support service providers – all with a palliative focus
  - Twenty-four hour on-call nursing support is available
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## Urban Palliative Home Care *(cont'd)*

**Enhancing Care in the Community (ECC) has resulted in additional team positions to support the shift of care from acute to the community:**

- **Therapy Assistant (TA):** enables rehabilitation staff to work to full scope of practice and have a TA augmentation to support the care that community clients receive
  - **Respiratory Therapist:** allows for dedicated respiratory services for palliative clients in the community – can assess and support caregivers and other team members on care decisions
  - **Nurse Practitioner:** a new palliative specific role was created to enhance home-based access to advice for end-of-life clients
  - **Systems Case Manager:** working to bring clients home from Acute Care who choose to pass away at home and require Palliative Home Care services
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  - **Clinical Nurse Educator:** raising educational opportunities for staff and other stakeholders to support the needs of clients receiving palliative care in the home setting
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## Suburban/Rural Palliative Home Care

- The suburban/rural service delivery model differs slightly from urban palliative home care
- Palliative Case Managers have been introduced to the rural home care offices to better support palliative home care clients
- The Palliative Case Managers are integrated into the geographic home care networks.

# ACCESS TO ADVICE

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## EZ Palliative Community Consult Team

- A specialized team of Physicians, Nurse Practitioners and Nurse Consultants who provide palliative care consultation for client in any Edmonton Zone community setting
  - A **Physician/Nurse Practitioner led triage system** in both urban and rural areas to expedite referrals & access to 85 hospice beds in the Edmonton Zone (including the homeless population)
  - The Edmonton Zone Community Palliative Care Program **palliative physicians are available 24/7 to provide support** via a provincial palliative on-call roster
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## EZ Palliative Community Consult Team *(cont'd)*

Assist in providing holistic care to the client and family with a life-limiting disease.

Assist physicians and other health care professional to control symptoms that the client may experience

Work closely with the Family Practitioners, Nurse Practitioners, Nurse Practitioners, Home Care Nurses and Hospital teams

Address symptoms and concerns of the client and family in the home setting, review Goals of Care Designations and may recommend transfer to the Tertiary Palliative Care Unit or to a hospice unit.

### **FAST FACTS:**

- Average of 2012 palliative community consults are completed annually
  - 68% of referrals for consult services are community-based
  - 766 admissions to hospice annually (38% of total annual referrals)
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# Care of the Imminently Dying Pathway

*Advice for staff in the acute, long term care or home setting...*

- An evidence based tool to enhance quality of end of life care by:
  - Improving outcomes
  - Promoting safety
  - Increasing satisfaction with care
  - Optimizing the use of resources
- Guidance for any member of the health care team
- Utilized within any care setting, **including the home**

The Care of the Imminently Pathway includes:

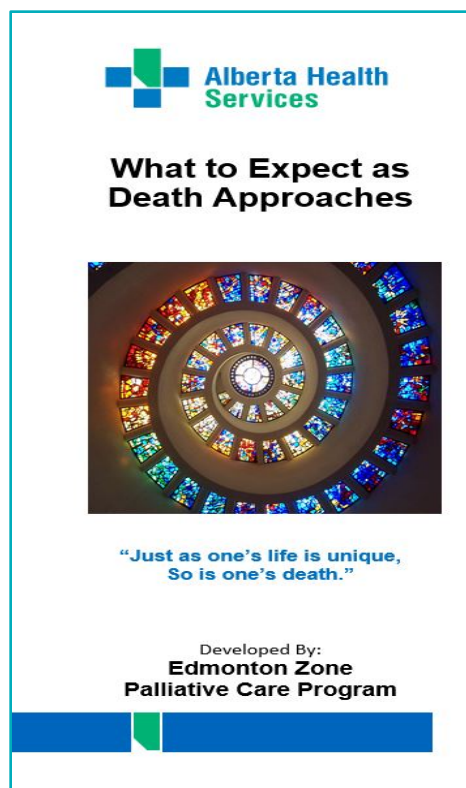
1. Instructions
  2. Initial Care Needs Assessment
  3. C2 Medication and Care Orders
  4. Nursing Symptom and Care Assessment and Documentation
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## Access to Advice: Resources

### White Rose Program



Please stop at the nursing station prior to entering



[www.palliative.org](http://www.palliative.org)

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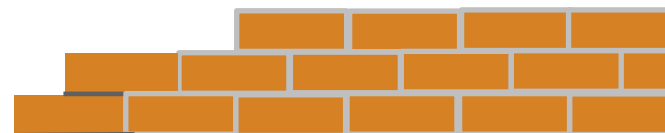
\*Resources available for order from Data Group\*

# Access to Advance Care Planning

# Policy, Procedure, Website, Workbooks, Advance Care Planning...



**STRONG  
FOUNDATION 4 ACP**



## Advance Care Planning in Alberta

### Advance Care Planning (ACP)

1. **Think** about wishes and values
2. **Learn** about own health
3. **Choose** someone to make decisions and speak on your behalf
4. **Communicate** wishes and values about health care
5. **Document** in a Personal Directive

### Goals of Care Designation (GCD)

Medical order

Focus of care & location for appropriate medical care

Align values and beliefs with expert clinical advice

ONLY medical treatment

Ongoing discussion and wishes

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## Access to Advance Care Planning

### ACP Conversation and Documentation: Role of all Professionals

#### Tracking Record

- All professionals can use it
- Document element of discussion / conversation
- Kept in the Green Sleeve
  - Also holds GCD and PD
  - Property of resident
  - Taken to medical appointments

**Alberta Health Services**  
Advance Care Planning/Goals Care Designation Tracking Record

**Purpose:** to document the content of Advance Care Planning (ACP)/Goals of Care Designation (GCD) conversations and/or decisions.

**Benefits:**

- Assists healthcare providers in being aware of previous conversations and to understand the reasons underlying the current GCD order.
- Gives clues about where to pick up the conversation if decisions need to be reviewed or confirmed.
- The ACP GCD Tracking Record is a continuous record that goes in the Green Sleeve. Documenting on both Tracking Record and progress note may be necessary to ensure transfer of critical information.
- The original form is kept in the patient's Green Sleeve. When the patient moves to a new care setting, including home, a copy remains with the sending facility.

Date (yyyy-MM-dd)	Site/Attendees	Conversation Summary Notes	Required Documentation
			<b>Any member of the healthcare team can record conversations on this form.</b> <b>Include who was involved in today's discussions (i.e. patient, family, healthcare provider - include name and relationship/discipline)</b> <b>Summarize conversation and/or key decisions from today's discussion</b> <b>It helps to document responses to the following speaking prompts.</b> <ul style="list-style-type: none"><li>■ Have you completed a Personal Directive?</li><li>■ Have you selected an alternative decision maker? If so do they know your wishes?</li><li>■ What is your understanding now of where you are with your illness?</li><li>■ If your health situation worsens what are your important goals?</li><li>■ Do you know if you have a Green Sleeve?</li><li>■ Do you know if you have a Goals of Care Designation (GCD) order?</li></ul>

103162(Rev0219-03) Learn more - [www.conversationsmatter.ca](http://www.conversationsmatter.ca) Page 1 of 1 (Side A)



# Access to Advance Care Planning



## Goals of Care Designations: RMC



- **Resuscitative Care** - Focus on prolonging or preserving life using medical or surgical interventions, including resuscitation and intensive care if needed



- **Medical Care** - Focus on medical tests and interventions to cure or manage a person's illness, but does not use resuscitative or life support measures



- **Comfort Care** - Focus on providing comfort for people with life-limiting illness when medical treatment is no longer an option

# Access to Advance Care Planning

## “Green Sleeve” Information for Clients



- ✓ Keep it on / near the fridge. Paramedics know to look there in a medical emergency
- ✓ Take it with you to medical appointments or if going to the Emergency Department.
- ✓ Share your wishes with your family.

# Access to Advance Care Planning: Serious Illness Conversations Guide

*Bringing advice to clients and caregivers...*

**Earlier conversations about patient goals and priorities for living are associated with outcomes including:**

- ✓ Enhanced goal-concordant care Mack JCO 2010
- ✓ Improved quality of life
- ✓ Reduced suffering
- ✓ Better client and family coping
- ✓ Higher patient satisfaction Detering BMJ 2010
- ✓ Less non-beneficial care and costs Wright 2008, Zhang 2009



## Serious Illness Conversations Guide *(cont'd)*

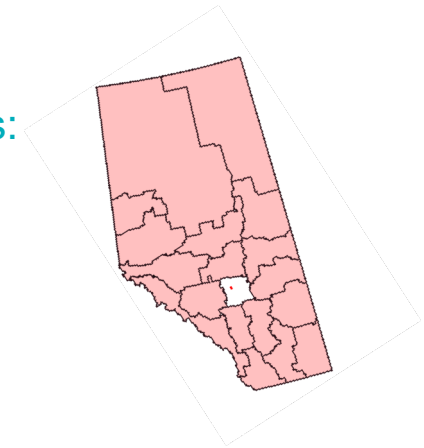
- Too often patients with serious medical illnesses do not discuss EOL preferences, or first discuss them only in the last days to month of life  
Wright 2008, Dow 2010, Halpern 2011
- “Who” has the conversation “When”? It depends!
- Patients with serious illness have priorities besides living longer.



## Serious Illness Conversations Guide *(cont'd)*

**Recent Chart audits and interviews show that most clients had a GCD (87-95%), however:**

- Calgary: LTC and SL residents:
  - Less than half (47 %) had documentation regarding participating in a conversation
- Edmonton: Acute Care: for seriously ill patients over 55 years:
  - 53 % had match between preferences and GCD
  - 16 % report being asked what is important

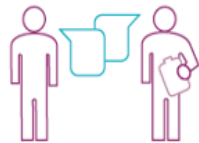


# Serious Illness Conversations Guide *(cont'd)*

## The quality of conversations support decision making



### Conversation training & coaching



Gaining and honing communications skills

### Patient ID



Finding the right patients

### Reminder to clinician



Knowing when to talk

### Clinician/Patient conversation



Learning what's most important to patients

### Documenting conversation



Making sure the information is easily accessible

### Patient and family support



Providing patients and families tools to continue the conversation

# Serious Illness Conversation Guide: Resources

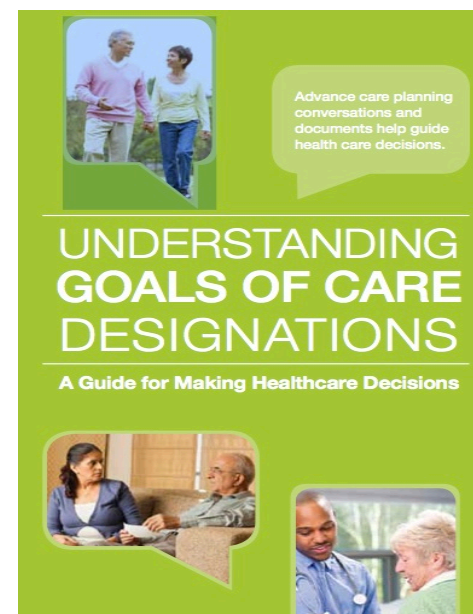
## Guidebook (7 languages)



## GCD Poster



## GCD Brochure





October 10, 2018