Canadian Home Care Association
canadienne de soins et services à domicile
Advancing Excellence in Home Care

KNOWLEDGE NETWORK
Building Capacity... Improving Performance

VIRTUAL LEARNING SERIES

About the Canadian Home Care Association's Virtual Learning Series

The aim of the virtual learning series is to improve the capabilities of individuals and organizations across the home and community care sector.

The webinar may be heard through your computer or a dial-in audio connection.

Close other programs on your computer for best results

Use the “Questions and Comments” chat pod to the left of the presentation and indicate who your question is directed to

The link for the recording and slides will be available on the Home Care Knowledge Network site later this week.

INTEGRATING A PALLIATIVE APPROACH TO CARE BY HAVING CONVERSATIONS EARLY (IPACE) :

Empowering frontline staff to incorporate early conversations with patients about their goals for care.

JEANNE BANK,
Project Specialist
Canadian Home Care Association

Project Overview

Purpose:

To explore opportunities for operational process improvement in home-based palliative care, specifically in:

1. inclusion of advance care plans into delivery
2. assessment and care planning
3. effective communication strategies and tactics
4. management of equipment, supplies and medications

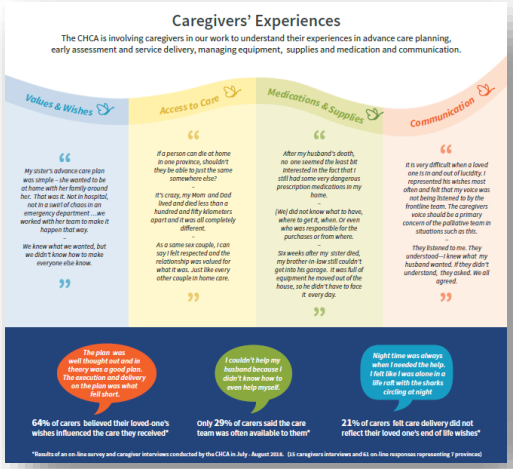
Project Activities

Multi-phased engagement process to understand palliative care experiences

- One-on-one interviews with caregivers and patients
- Discussions with key informants
- Interviews with cultural group representatives
- Four invitational expert consultations (BC, AB, PEI, ON)
- Online survey of caregivers, patients, providers
- Validation of priority areas for improvement (e-Delphi)

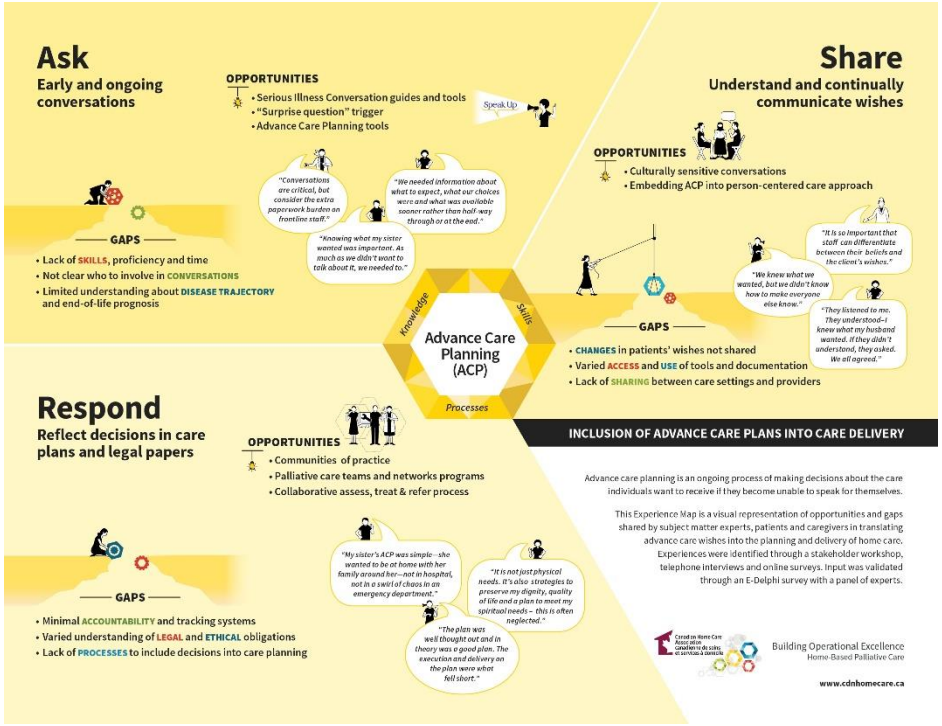
Project Outcomes – Caregivers Experiences

- “We knew what we wanted, but we didn’t know how to make everyone else know.”
- “Night time was always when I needed the help. I felt like I was alone in a life raft with the sharks circling at night.”
- “After my husband’s death, no one seemed the least bit interested in the fact that I still had some very dangerous prescription medications in my home.”
- 15 caregivers shared their personal experiences - 61 on-line responses



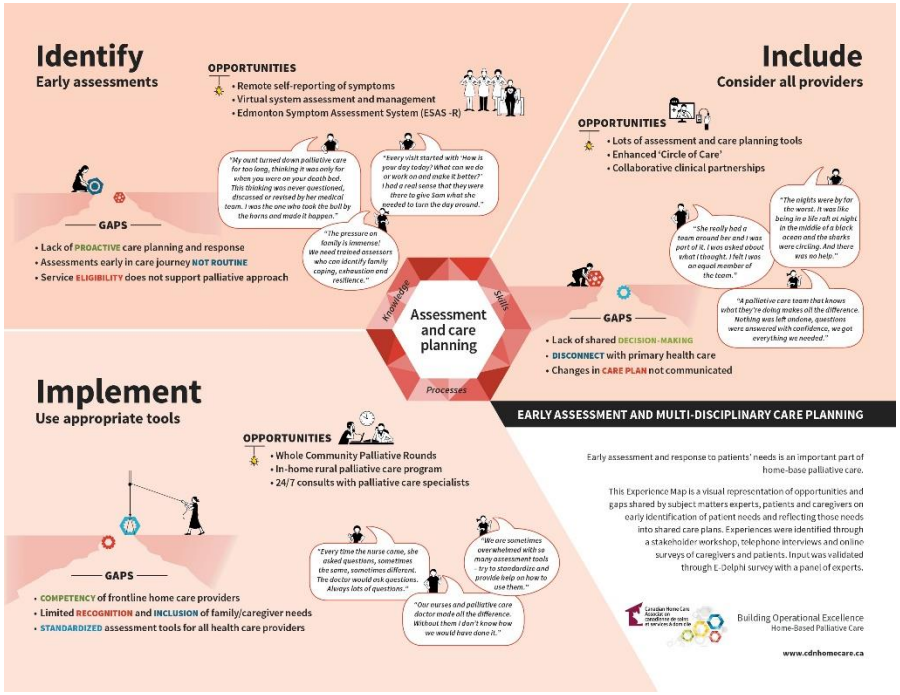
Advance Care Planning

- Early and ongoing conversations about end of life wishes and values
- Understand and consistently communicate end of life wishes
- Documentation (care plan and legal requirements) should reflect wishes and values



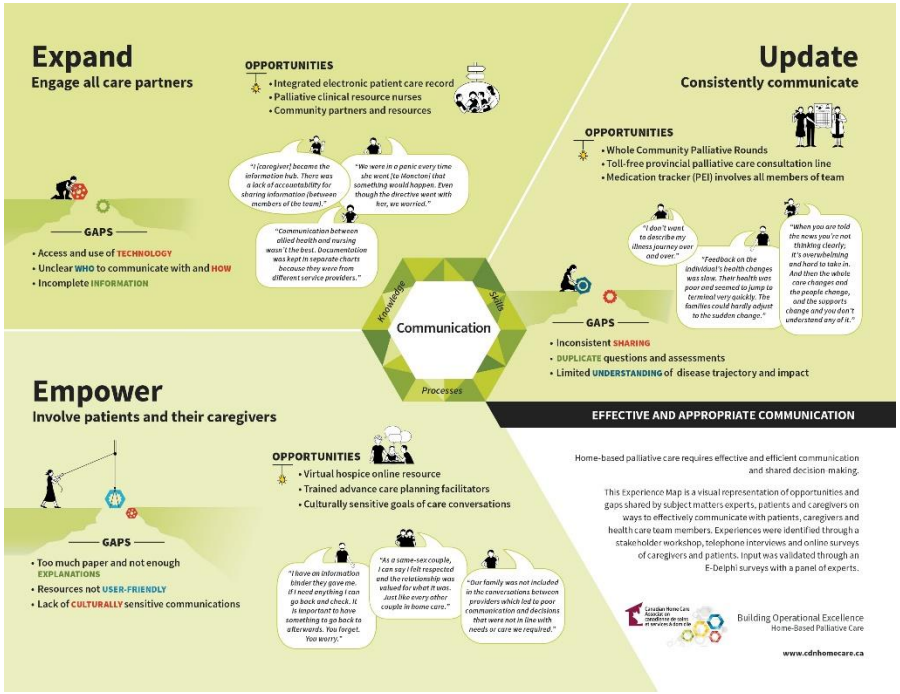
Assessment and Care Planning

- Palliative approach to care in identifying and responding to patient needs
- Involve patients, caregivers and providers in developing and updating care plans
- Understand and use assessment tools early in the process



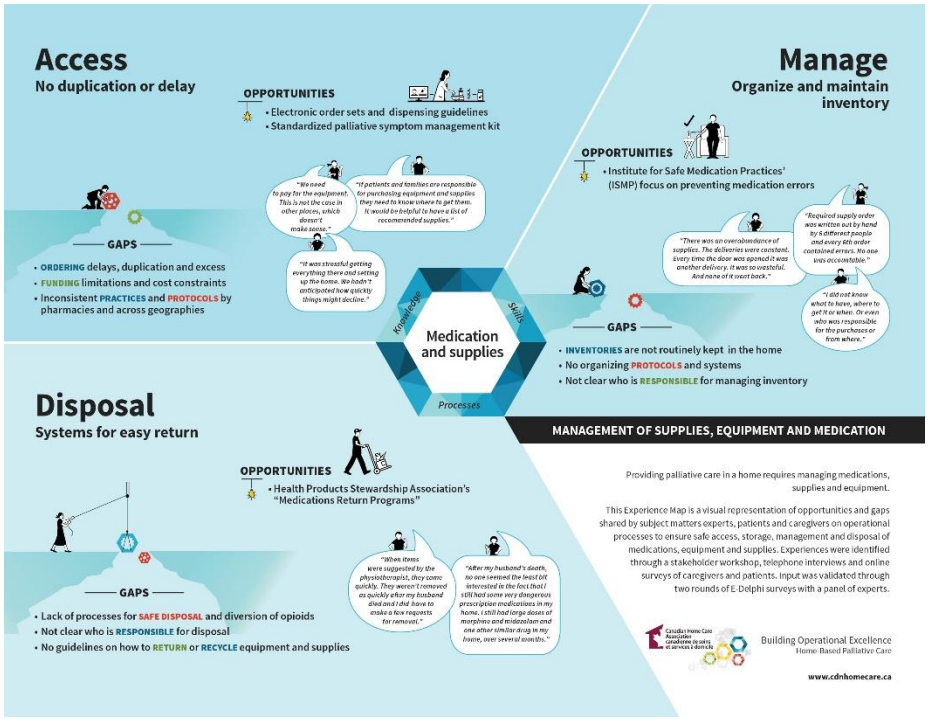
Communication

- Know and communicate with all team members
- Consistently communicate changes in the patient's condition and needs
- Communicate with patients, family and caregivers in a manner that is appropriate, timely and practical



Management of Supplies, Equipment & Medications

- Know and communicate with all team members
- Consistently communicate changes in the patient's condition and needs
- Communicate with patients, family and caregivers in a manner that is appropriate, timely and practical



SPRINT

Implementation Collaborative for

Whole Community Palliative Rounds

Spreading and Scaling Innovation

Project Status

- Palliative Care Experience Maps developed to share the stories and show opportunities for innovation
- 5 projects have been identified to showcase as High Impact Practices (HIPs) and being published and made available on our website. These 5 were identified at 2018 Home Care Summit and selected by panel of home care leaders
- SPRINT Implementation Collaborative – Capstone Event December 2019
  - 7-month Implementation Collaborative to support teams in testing, adapting and implementing one of the profiled innovations, ***Whole Community Palliative Rounds***
- Development of Implementation Framework and User Guide to help organizations put HIPs into practice

Presenters:

Ingrid See
Clinical Lead for the Nancy Chan Palliative Care Ambulatory Clinic (NCPCAC)

Sarah Lau
Clinical Educator for IPACE in Vancouver Community with Vancouver Coastal Health.

High Impact Practice IPACE: Integrating a Palliative Approach to Care by Having Conversations Early

Identification and Conversations about Serious Illness

Developed By: Ingrid See, Clinical Practice Leader

Sarah Lau, Educator

Regional Palliative Approach to Care Education Team

October, 2019

Objectives

- Gain an overview of the components of the IPACE (Serious Illness Care Program) and its importance
- Apply tools to help with identifying clients who can benefit from a palliative approach to care
- Have an understanding of why early conversations are important
- Identify challenges and strategies when implementing the Serious Illness Conversation Guide (SICG)
- Bring ideas to take back to areas of practice to see if implementing a similar program may be feasible

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IPACE

- *Made possible by the generous donation of Robert and Greta Ho*

"We wanted to give a gift that would enable those taking care of patients nearing the end of their lives," Robert explains.
"This money will empower those great nurses and health care staff to provide better care their patients."

(VGH Foundation, 2017)

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Which Areas Have We Trained?

Vancouver, Richmond, Coastal, Sea to Sky, Sunshine Coast, Powell River, Bella Coola, Bella Bella

- Acute care hospitals
- Community programs (including home health, mental health, primary care, assisted living)
- Small rural communities
- Long term care (Embedding a Palliative Approach in Residential Care - EPAIRS training)

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Components of IPACE

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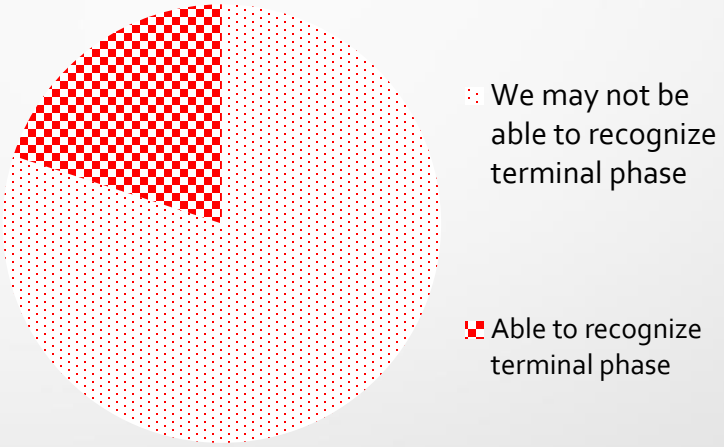
Why is IPACE important?

- "By 2025, only 20% of Canadians will die with an illness that has a recognizable terminal phase. 2/3 of Canadians will die with 2 or more chronic diseases and will live in a more frail and vulnerable state
- People's trajectories will be less predictable, therefore, many will not be identified needing "palliative care" before they die
- Because of this many Canadians will not receive benefits associated with palliative care services

Canadian Hospice Palliative Care Association Fact Sheet 2012

Canadians at the end of life



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Traditionally……

- Palliative care is usually associated with the last weeks/months of life
- Palliative care clinicians are the 'default' clinicians to initiate goals of care discussions
- The concept of palliative care is viewed as cure versus palliation rather than working alongside each other
- Palliative care is only for people with cancer

A New Approach……

- Introducing palliative care alongside conventional treatment for anyone with a serious illness
- Empower all disciplines to learn to have conversations about wishes, values, and goals
- Empowering clients and families to have time to think about what is important to them and allow health care providers to plan care based on their wishes and not those imposed by the health care system

What Are Some Challenges We Face in Home Health?

- Staff do not routinely identify who can benefit from palliative approach
- Staff have varied skills in having conversations about goals of care/client's wishes
- Workload
- Many competing priorities
- Constant staff & leadership turnover
- New grads in the community

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Strategies for Overcoming Challenges at Management/Leadership Level

- Engaging all levels of leaderships right from the get go
- Goal was to prioritize which areas go first
- Ensuring that frontline leadership received extra training so that they can advocate/support the work

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Strategies for Overcoming Challenges at Staff Level

- Work with frontline leadership teams in determining when to hold education and format
- Circle back (many times!) to catch staff
- Embed strategies for supporting staff to think about identification ie weekly huddles, What Matters Most brochure, case reviews with frontline leaders

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Prioritizing Workload – Helping Staff Identify Who Can Benefit from the Serious Illness Conversation

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Identification Worksheet

Integrating a Palliative Approach to care by having Conversations Early

Identification Worksheet

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Identification Tools

	Surprise question?	Frailty Scale	Supportive and Palliative Care Indicator Tool (SPICT) General Indicators						Supportive and Palliative Care Indicator Tool (SPICT) Clinical Indicators	Priority for needing goals of care clarified (Low, Medium, High)
Patient/ Resident Name	Yes/ No/ Uncertain	Low Moderate High Risk	Has there been any unplanned hospitalization?	Is the patient/ resident in bed/ chair more than ½ day?	↑ Dependence on others for physical/ mental health needs?	↑ Weight loss over last 3-6 mos, low BMI?	Are there persistent symptoms?	Is the patient/ resident/ family asking for treatment withdrawal?	List patient/ resident's medical conditions or serious illness below	< 3 Low Risk 4-6 Medium Risk > 6 High Risk
	Yes/ No/ Uncertain		☐	☐	☐	☐	☐	☐	☐ ____ ☐ ____ ☐ ____ ☐ ____	
	Yes/ No/ Uncertain		☐	☐	☐	☐	☐	☐	☐ ____ ☐ ____ ☐ ____ ☐ ____	
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Identification

- Pick one client from your pre-workshop materials that is complex or have heard staff talk about quite a bit

Initial Screening: The Surprise Question

Would I be **surprised** if this client died in the next 6-12 months?

The Gold Standards Framework Centre CIC , 2011

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Answer "Yes" or "No"

- Yes – doesn't mean that the client may not fit the criteria for screening
- Important to go on to the other indicators

- No – means that this client may be at high risk for hospitalization or dying in the next year
- Important to go on to the other indicators and determine priority

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Low Risk

Moderate Risk

High Risk

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

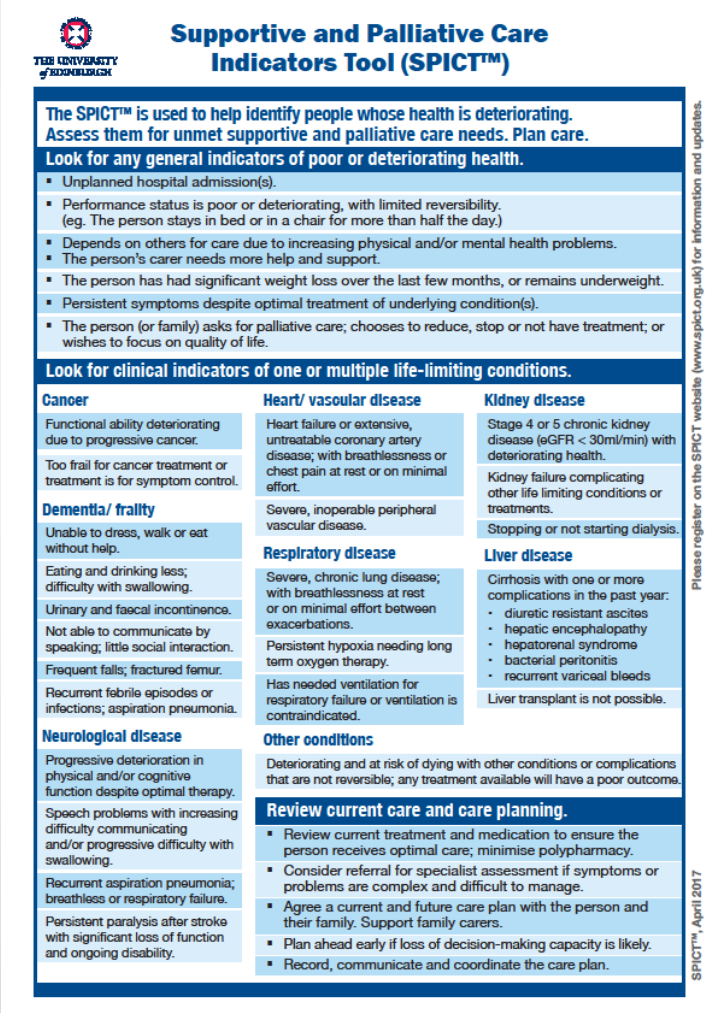
In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

SPICT TOOL



THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

- Functional ability deteriorating due to progressive cancer.
- Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

- Unable to dress, walk or eat without help.
- Eating and drinking less; difficulty with swallowing.
- Urinary and faecal incontinence.
- Not able to communicate by speaking; little social interaction.
- Frequent falls; fractured femur.
- Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.
- Recurrent aspiration pneumonia; breathless or respiratory failure.
- Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vasoular disease

- Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.
- Severe, inoperable peripheral vascular disease.

Respiratory disease

- Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.
- Persistent hypoxia needing long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation is contraindicated.

Other conditions

- Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Kidney disease

- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
- Kidney failure complicating other life limiting conditions or treatments.
- Stopping or not starting dialysis.

Liver disease

- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant is not possible.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2017

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You can download this from the side bar

General "Clues"

- Unplanned hospitalizations
- Change in functional status
  - Spending more time in chair/bed
  - May be needing more supports at home
- Significant weight loss over the past 3-6 months or a low body mass index
- Persistent symptoms despite optimizing treatment
- Client/ family want to focus on quality of life

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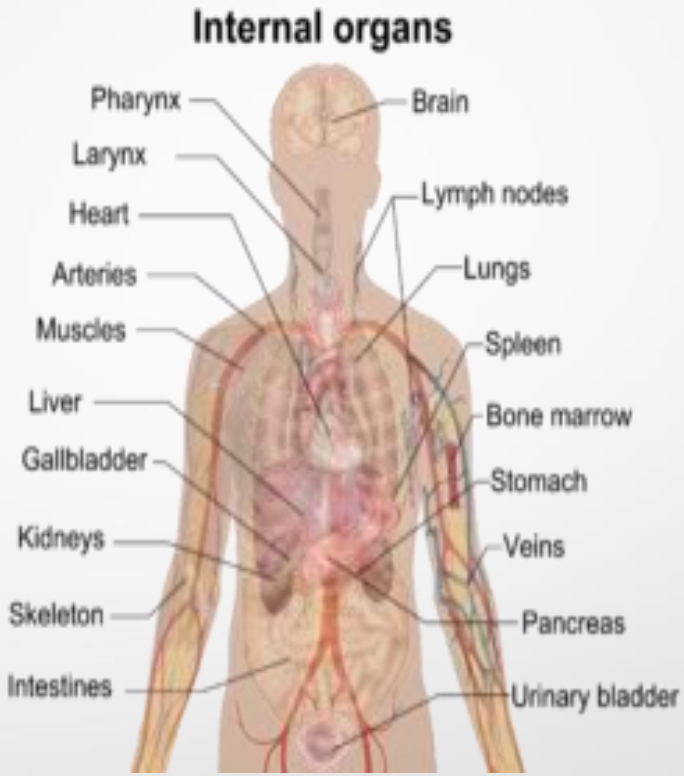
Clinical Indicators

- Cancer
- Dementia/Frailty
- Neurological Diseases
- Heart/Vascular Diseases
- Respiratory Diseases
- Kidney Diseases
- Liver Diseases



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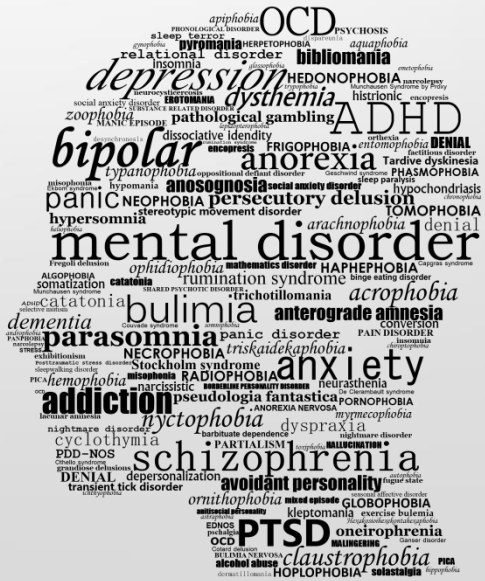
General Category

- Deteriorating and at risk of dying with any other condition or complication that is not reversible
- Consider social determinants in life which may put clients at risk ie. substance use, suicide ideations, severe mental health conditions, homelessness



Risk Assessment & Priority Setting

- 0-3 Low
- 4-6 Moderate
- >6 High

Start with First Step: Identification

- Help staff learn to identify clients in their caseloads who can benefit from a palliative approach to care
- Find common grounds for documentation for identification

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Introducing the Serious Illness Conversation Guide (SICG)

Based on the work by Ariadne Labs' Serious Illness Care Program

***Follow the first link to see a demonstration of the SICG and second link for resources from Ariadne Labs. ***

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Dr. Atul Gawande

- "The battle of being mortal is the battle to maintain the integrity of one's life—to avoid becoming so diminished or dissipated or subjugated that who you are becomes disconnected from who you were or who you want to be."

Being Mortal: Medicine and What Matters in the End

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Why Do Earlier Conversations Help?

Client and family

- Care aligns with client goals
- Gives client and family time to make decisions; affects ability to manage
- Clients can be connected to resources earlier rather than during a crisis
- Improves quality of life, higher client satisfaction, & bereavement outcomes

Health care system

- Fewer unnecessary hospitalizations
- Less unnecessary medical interventions
- Earlier referral to palliative care resources
- Increase client satisfaction

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Ariadne Labs, 2016

Purpose of the SICG

- Focuses on finding out what is important to a person
- The questions in the Guide do not focus on death or dying
- The priority is learning about the clients' goals, values and wishes as they live with a serious illness

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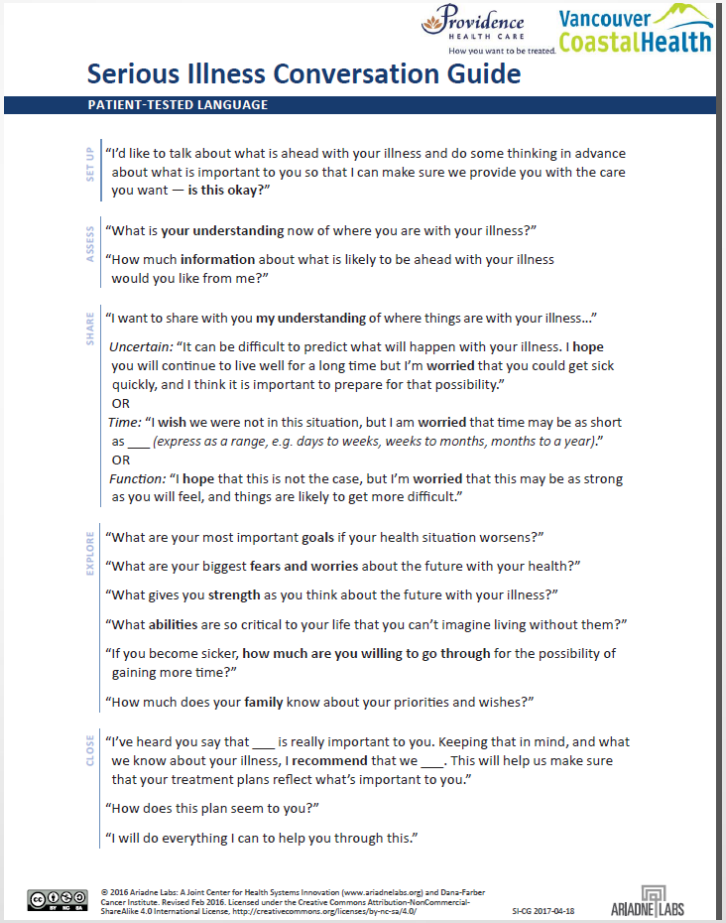
Framework of the SICG

- Setup
- Assess understanding and preference
- Share Prognosis
- Explore 6 key topics
- Close with summary and recommendations



Providence HEALTH CARE
How you want to be treated.
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Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"

ASSESS

"What is **your understanding** now of where you are with your illness?"

"How much **information** about what is likely to be ahead with your illness would you like from me?"

SHARE

"I want to share with you **my understanding** of where things are with your illness..."

Uncertain: "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."
OR
Time: "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*."
OR
Function: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."

EXPLORE

"What are your most important **goals** if your health situation worsens?"

"What are your biggest **fears and worries** about the future with your health?"

"What gives you **strength** as you think about the future with your illness?"

"What **abilities** are so critical to your life that you can't imagine living without them?"

"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"

"How much does your **family** know about your priorities and wishes?"

CLOSE

"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you."

"How does this plan seem to you?"

"I will do everything I can to help you through this."

SI-CG 2017-04-18

ARIADNE LABS

You can also download our VCH version if you'd like to follow along

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Challenges We Encountered When Teaching the SICG

#1 Resistance to learning something new

- Goals of care conversations are usually had by nurses and physicians in my area of practice
- I have lots of experience in palliative care and have goals of care conversations regularly

Strategies

- Helps increase the awareness and competency of those who are new to embedding a palliative approach to care in their practice or have been working in a more generalist area
- The guide can be used by all disciplines
- For those who are more familiar with goals of care conversations or are palliative care specialists, the guide is to help complement the clinician's existing skills

Challenges Cont…..

#2 Staff often get stuck during "prognosis" sharing

- It is not within my scope of practice
- It is the doctor's job
- I do not know the right words
- I am not the correct person to delivery prognosis

Strategies

- Is not meant to give a specific time frame but intended to let clients know that things may change
- It is important for the health care team to be aware about a client's wishes, values, and goals in order to plan ahead

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Challenges, Cont….

#3 Staff report that they do not have time to finish the full conversation

- Clients may get tired from such a long discussion e.g. pain crisis, exacerbation
- There are many other assessments that need to be completed during a home visit

Strategies

- Conversation does not have to be finished all at once
- Ask 1-2 questions over several visits
- Provide a copy of the SICG worksheet for client to think ahead of time [provide pdf document " What Matters Most to Me"

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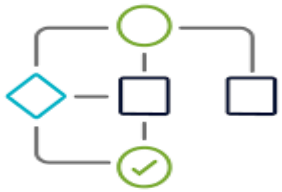
Challenges, Cont…….

#4 Their workflow does not support them to have these conversations

- Some staff have less frequent visits with clients that can range over months to years e.g. case managers
- Other staff provide intense support with frequent visits and end involvement within a month if goals attained e.g. allied health



Strategy

- Prepare the client ahead of time that another team member may start or follow up with the SICG
- Introduce the SICG by providing a copy of the SICG worksheet for client to think ahead of time
- Encourage interdisciplinary collaboration and team based care
- Support the rest of the team with identifying high priority clients to have early conversation

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Challenges, Cont.

#5 Staff have difficulty provide recommendations right after the conversation

- Too busy learning the questions of the SICG and unable to provide recommendations
- Certain roles and disciplines may not have the right solutions to help support client's wishes

Strategies

- Not necessary to provide a recommendation immediately after the conversation
- Suggest a follow up visit with client to consider next steps
- Review outcomes of conversation as a team and care plan together
- Most recommendations will come out of the client's answers to the 6 key topics

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Would the Serious Illness Care Program Work in My Practice Area?

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Training Commitment

Management Buy-in

- Director support
- Manager support
- Unit specific leadership support (educators, operation leaders)
- 1 hour class identification
- 2.5 hr class SICG training
- Support champion training

Front line Buy-in

- Support with extra time when doing first few SICs
- Using "What Matters Most Flyer" to help initiate conversation
- Desire to sustain best practices
- Desire to be champions
- Visual metrics
- Community of Practice

.....AND.....

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ACKNOWLEDGEMENT!

- Champion Recognition Letters
- Highlighting initiatives lead by Educators
- Connecting with staff about their experiences
- Sharing patient/ client stories

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Site, Service or Facility

2222 Any Avenue
Vancouver, BC V2V 2V2

Thank You {firstname}!

On behalf of the iPACE (Integrating a Palliative Approach by Having Conversations Early) team, the Home Health program and Vancouver Coastal Health, we would like to extend our appreciation for the amazing work done by you on the iPACE project.

Your willingness to step up as a champion shows leadership, initiative and a dedication to making positive changes to improve patient care and support your fellow colleagues as they integrate new approaches to care into their daily work. Change can be hard, but seeing your diligence and self-motivation as you lead by example and encourage and support your team as they work to implement iPACE and have early conversations with clients lightens the load for all of us. We hope your positivity and leadership flows into all your work and projects in the future.

Thank you again for your amazing contribution and know that it is appreciated and recognized. A copy of this letter will be placed in your employee file.

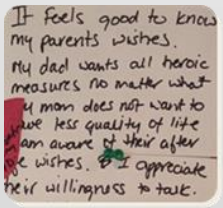
Best Regards,

Nadya Repin
iPACE Project Manager

Manager
Unit/Health Centre

Director

Sender's Name, CREDENTIAL
Title
Program
Tel: 604-123-4567
Fax: 604-123-4567
name@vch.ca
www.vch.ca



Incentives

- Pins
- Lanyard cards
- Webinar Lunches
- Empower Champions with Learning Opportunities

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Working with Clients Who Speak Little or No English

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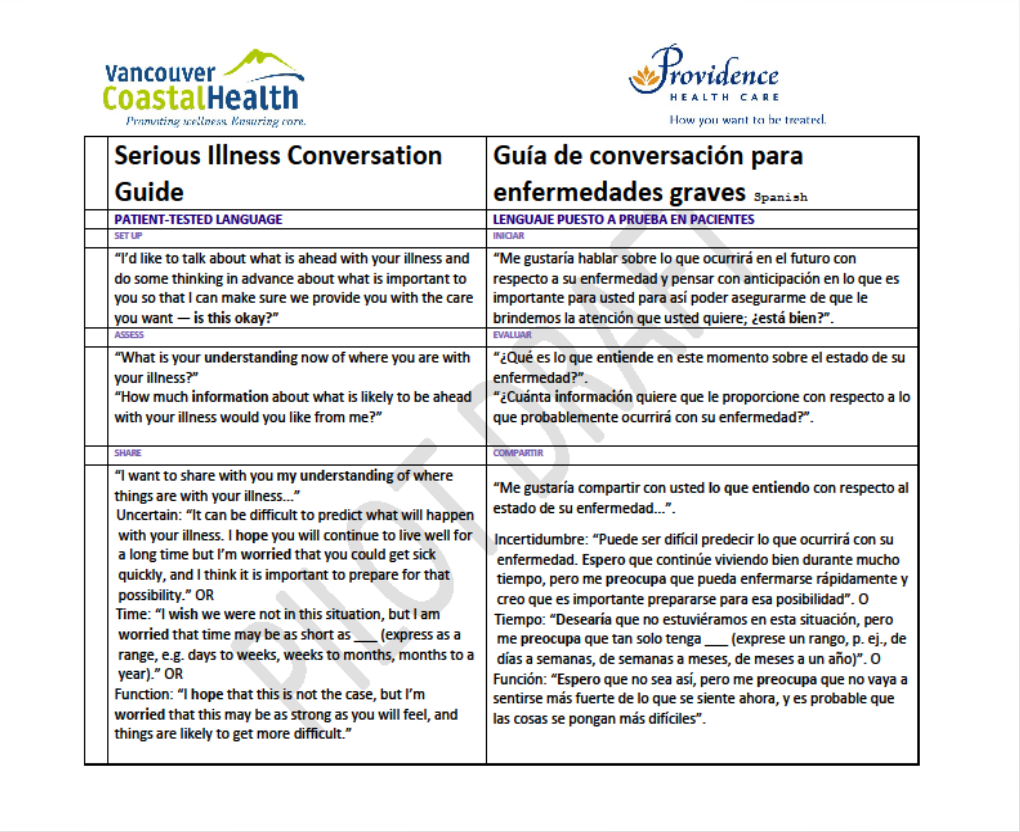
Translations of SICG Available in 11 Languages for Clinician Testing

- Translations of the SICG have gone through a rigorous translation/back translation process using both interpreters and translators
- Currently in clinician testing phase to determine if any of the wording needs to be adapted
- Posted on Ariadne Labs and BC Centre for Palliative Care websites



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Providence HEALTH CARE
How you want to be treated.

	Serious Illness Conversation Guide	Guía de conversación para enfermedades graves Spanish
	PATIENT-TESTED LANGUAGE	LENGUAJE PUESTO A PRUEBA EN PACIENTES
	SET UP	INICIAR
	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — is this okay?"	"Me gustaría hablar sobre lo que ocurrirá en el futuro con respecto a su enfermedad y pensar con anticipación en lo que es importante para usted para así poder asegurarme de que le brindemos la atención que usted quiere; ¿está bien?".
	ASSESS	EVALUAR
	"What is your understanding now of where you are with your illness?" "How much information about what is likely to be ahead with your illness would you like from me?"	"¿Qué es lo que entiende en este momento sobre el estado de su enfermedad?". "¿Cuánta información quiere que le proporcione con respecto a lo que probablemente ocurrirá con su enfermedad?".
	SHARE	COMPARTIR
	"I want to share with you my understanding of where things are with your illness..." Uncertain: "It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I'm worried that you could get sick quickly, and I think it is important to prepare for that possibility." OR Time: "I wish we were not in this situation, but I am worried that time may be as short as ___ (express as a range, e.g. days to weeks, weeks to months, months to a year)." OR Function: "I hope that this is not the case, but I'm worried that this may be as strong as you will feel, and things are likely to get more difficult."	"Me gustaría compartir con usted lo que entiendo con respecto al estado de su enfermedad...". Incertidumbre: "Puede ser difícil predecir lo que ocurrirá con su enfermedad. Espero que continúe viviendo bien durante mucho tiempo, pero me preocupa que pueda enfermarse rápidamente y creo que es importante prepararse para esa posibilidad". O Tiempo: "Desearía que no estuviéramos en esta situación, pero me preocupa que tan solo tenga ___ (exprese un rango, p. ej., de días a semanas, de semanas a meses, de meses a un año)". O Función: "Espero que no sea así, pero me preocupa que no vaya a sentirse más fuerte de lo que se siente ahora, y es probable que las cosas se pongan más difíciles".

Working With Interpreters

- Consider working with interpreter agencies
- Important to understand the meaning and intention of each question
- Support interpreters through education of the SICG (PLS online course)
- When using interpreters, it is important to print a copy of the translated SIC for the interpreter and read the English verbatim

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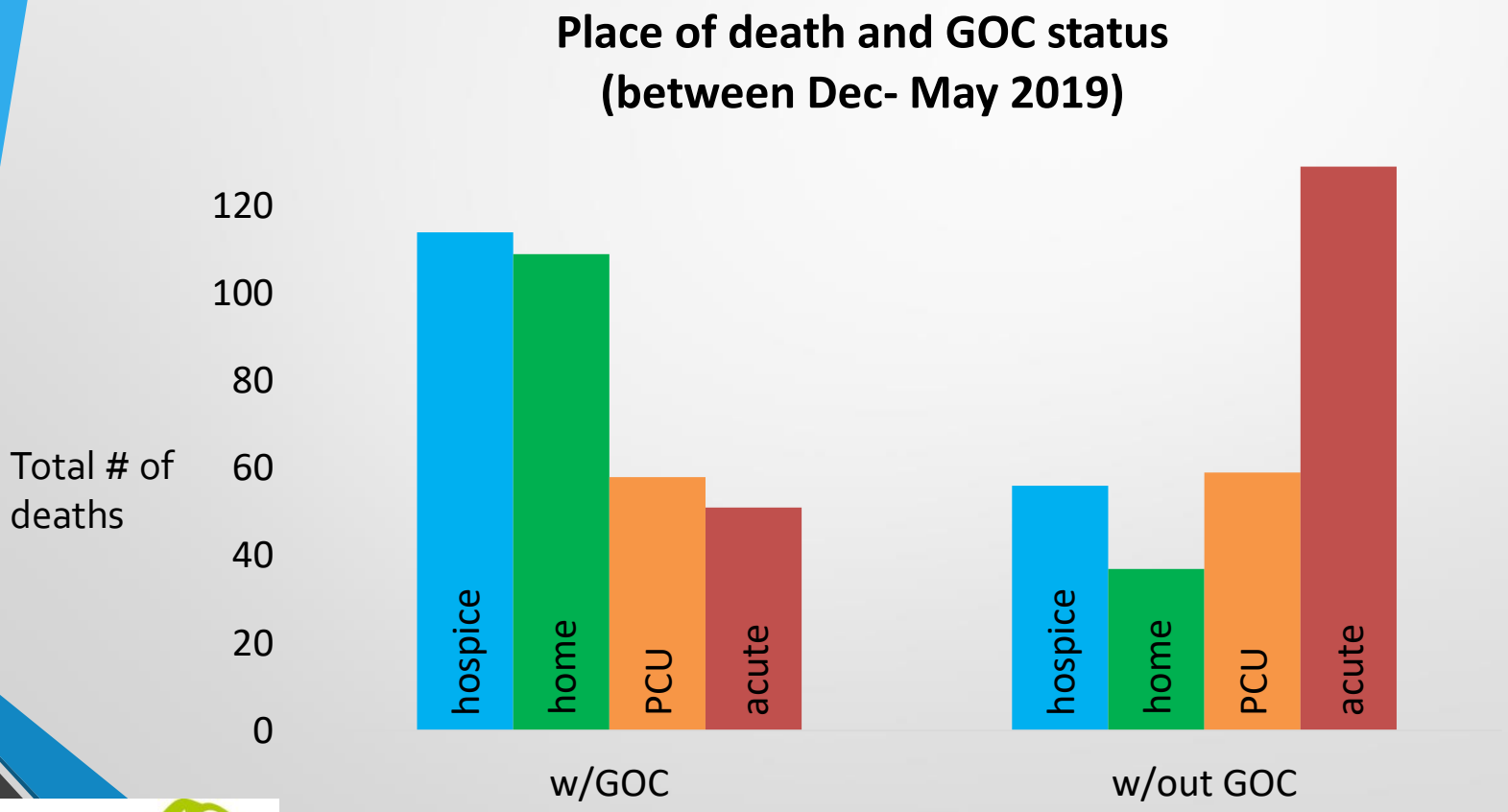
Are These Conversations Making a Difference (Vancouver)?



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Number of Staff Trained

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Patient & Client Impact

"This [conversation] was different. It was very helpful. I wish I'd had the talk earlier. I'd never been asked those questions before."

"Team-based end-of-life planning around my wishes is not something I have experienced before… I'm not afraid of dying now."

"I…have been expecting to have this conversation for quite some time, but ***until now nobody has brought it up. This conversation has decreased my anxiety."***

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Clinician Impact

"Having a guideline is really awesome. **It's all about the client**. You can … **become better, supportive caregivers**"

"Using the guideline, we were able …**to turn a negative into a positive, rebuild clients' trust and allow them die peacefully in accordance with their wishes**"

"**Preparation is very great to have.** Having the [translated] language is very helpful … it's better than how I would have worded it."

"The education is very valuable. It **makes you less anxious about starting the conversation** …."

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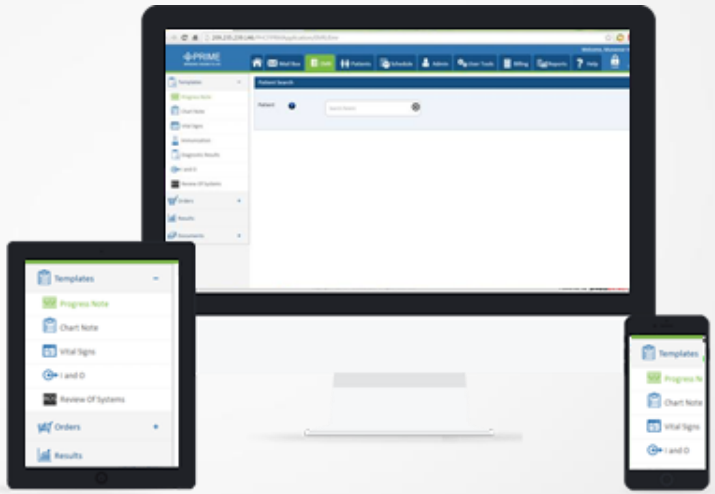
Documentation

CHALLENGES

- Different electronic/paper systems in home health, acute care, residential
- Electronic systems don't often talk to one another
- Paper trail gets "lost" in the shuffle



STRATEGIES

- Work with electronic charting teams to create a common place to chart
- Identify ways to "port" clients' wishes regardless of setting
- Ask client to bring "What Matters Most" flyer to GP, ER, specialists

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Sustainment

- Continued support from directors, manager, leadership teams
- Champions for IPACE
- Support from Ariadne Labs

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Community of Practice (CoP)

- With director/manager support, able to bring all the community program champions together to develop a vision for the CoP
- Pick out one strategy to work on in their areas using a 6 month timeline
- Come to consensus about what platform to use as a way of communication
- Many challenges for sustaining the CoP

Online Courses

- Developed to look at reducing onsite training due to workload and time constraints
- Goal is to keep the practice sessions for SIC so that staff have an opportunity to practice the conversation
- Course has different streams for different areas (home health, mental, assisted living)

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Regional Palliative Approach to Care Education Team (RPACE)

- From this pilot project, the benefits were acknowledged by directors
- Vancouver Coastal received some federal funding and chose to put some of the monies towards permanent positions
- Team vision: We are shifting the culture across VCH to support the practice of an early palliative approach to care. We strive to achieve the benefits of communicating and respecting a client's goals, values and beliefs in all care decisions so that early conversations lead from foundational to exceptional care.

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Tips for Moving Forward

Environmental scan

- Do staff have the skills to identify who can benefit from early conversations?
- Are staff having conversations about client's wishes, values, and goals? Is there a common tool being used for the conversations?
- Where are the conversations being documented – is there a consistent place?
- How does this get relayed to other care settings?

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Summary

- Consider if this is a High Impact Practice that you would like to implement in your home health areas
- Consider next steps – leadership support, pilot site
- Consider resources available:

  https://www.ariadnelabs.org/areas-of-work/serious-illness-care/

  https://www.bc-cpc.ca/cpc/

  https://www.youtube.com/watch?v=-SzA-kWB8-s

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"Developing a skill is painful, though. It is difficult. And that's part of the satisfaction. You will only find meaning in what you struggle with. What you struggle to get good at next may not seem the exact right thing for you at first. With time and effort, however, you will discover new possibilities in yourself-an ability to solve problems, for instance, or to communicate, or to create beauty…"

Dr. Atul Gawande

Q & A Session

Webinar participants – please post questions for our speakers in the ‘ Questions and Comments’ chat pod to the left of the presentation.

Please tell us who your question should be directed to.

Ingrid See
Clinical Lead for the Nancy Chan Palliative Care Ambulatory Clinic (NCPCAC)

Sarah Lau
Clinical Educator for IPACE in Vancouver Community with Vancouver Coastal Health.

Thank you for joining us.

Please take a moment to complete the 60 second survey immediately following the webinar.

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