Canadian Home Care Association
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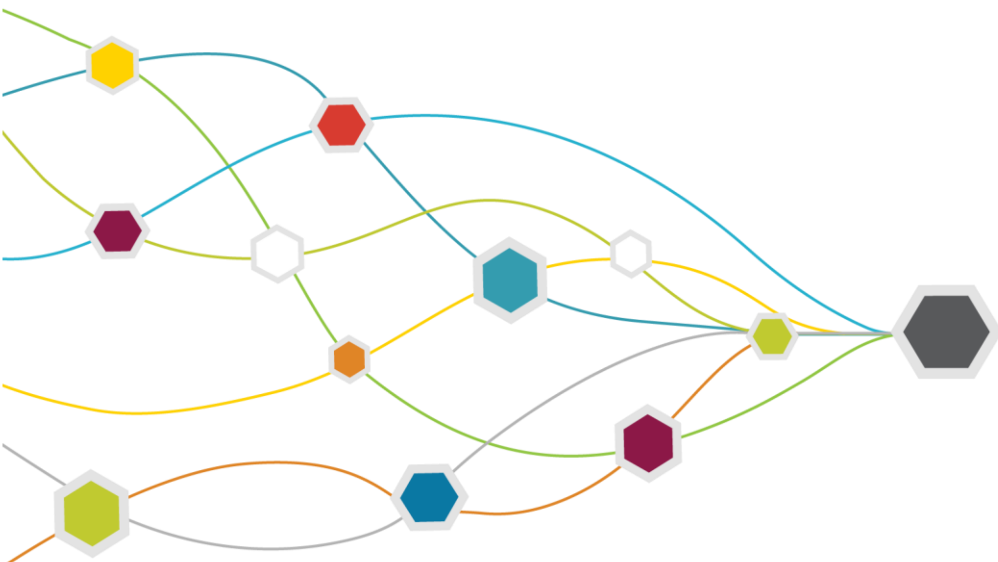
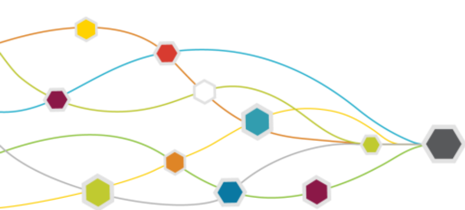


SPRINT Implementation Collaboratives™

Whole Community Palliative Rounds

VIRTUAL LEARNING SESSION
July 19



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Agenda

12:00 -12:10 Welcome

- National WCPR Implementation Collaborative – Advancing pan-Canadian priorities

12:10 – 12:55 Team Reports (4 minutes/team)

- AIM Statement, high level measurements, 1st PDSA (action step)

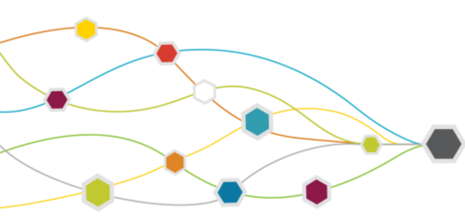
12:55- 13:20 WCPR Practice Changes – Tools & Tactics

Practice Changes	Tools & Tactics	
Enhancing the Circle of Care	Circle of Care memo	Attachment 1 *(Circle of Care Memo May 9 2018 Final)* Attachment 2 *(Circle of Care Information Sharing Memo)*
Referrals to WCPR	SBAR form	Attachment 3 *(SBAR for Communication in WCPR)* Attachment 4 *(SBAR in One Note Sample 1)* Attachment 5 *(SBAR in One Note-Sample 2)*
Actions from the WCPR	WCPR records	Attachment 6 *(WCPR Record)*
	Physician/nurse practitioner communication form	Attachment 7 *(WCPR Physician Nurse Communication Record)*

13:20 – 13:20 Action Period (Team Activities, July – August)

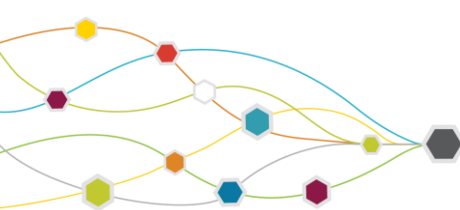
- Complete project charter
- Advance local determined PDSA
- Enhance the circle of care (Defining community partners)
- Communication test

OFF to a FAST START….



Advancing Pan-Canadian Priorities

Nadine Henningsen



SPRINT - WCPR Implementation Collaborative™

- Alignment with the 2018 **Framework on Palliative Care in Canada** - "collective action of parties at all levels, as well as the flexibility to evolve and respond to new ideas."
    1. Palliative care education and training for health care providers and caregivers
    2. Measures to support palliative care providers and caregivers
    3. Measures to facilitate equitable access to palliative across Canada

- Awareness campaign of **SPRINT - WCPR Implementation Collaborative™**
    - Press release – announcing teams and goals
    - F/P/T Governments – profiling WCPR HIP and SPRINT application
    - Messaging to key stakeholders and partners
    - Broad awareness (social media, website profiles)
    - CHPCA Conference (Sept) / Capstone Event (Dec)

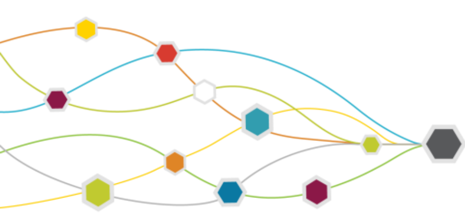
Building Operational Excellence
Home-Based Palliative Care

HIGH IMPACT PRACTICES

Whole Community Palliative Rounds

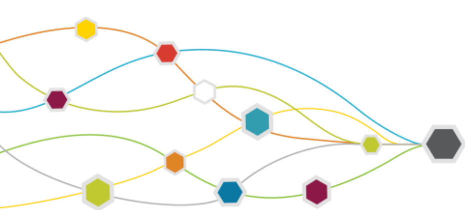
An innovative approach to inter-professional care planning and delivery in Interior Health

BACKGROUND



TEAM REPORTS

Collaborative Teams



AIM STATEMENT:
We will complete 5 Whole Community Palliative Rounds by November 22, 2019 with a focus on improving communication and shared decision making between providers as well as the continuity and quality of care for individuals receiving a palliative approach to care.

MEASURES:
Pre and post implementation surveys to providers within the WCPR catchment area (on a scale of 1-10):

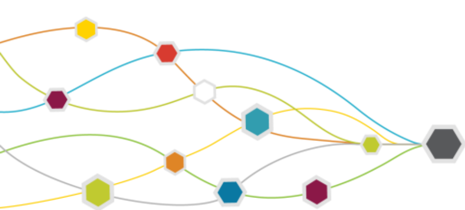
- Physicians and Nurse Practitioners
- Home Care Case Coordinators
- Palliative Care Team

A caregiver survey has also been developed where we can draw data pre and post implementation measuring their sense of inter professional communication and how well supported they felt while providing palliative care

Additional measures include: How many referrals received for WCPR, were recommendations from WCPR well received, are referrals to WCPR increasing, the number of referrals that are resolved without going to WCPR, if the people that are on WCPR on a regular basis are able to contribute to the discussions

CHANGE IDEA:
The first WCPR that we hold will go through the PDSA cycle.

Southern Health Santé Sud



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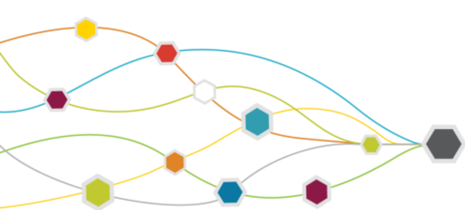
AIM STATEMENT:
To optimize and expand existing Palliative Care Rounds in Prince County to include MIH Coordinator attendance, greater involvement from acute care, establishment of Hub and Spoke Model with West Prince and Lennox Island, and formalized documentation processes to increase effectiveness of rounds, prevent gaps in support and improve follow-up and communication with clients' primary care providers by December 2019.

MEASURES:
-Conduct pre and post survey of round attendees on subjective effectiveness of rounds.
-New member at Rounds are involved and attending. New spoke sites are involved and attending.
-Succession planning in place to ensure clients and staff in East and West Prince are supported through transitions.
-Tracking forms and SBARs are completed following each Rounds meeting.

CHANGE IDEA:

-MIH Coordinator attending Rounds (Started July 2/2019)
-Use tracking sheets that we already had available to document discussions regarding specific clients at Rounds.
-Coding Client Discussions (1-Action Required, 2-Information Sharing, 3- Updates)
-At meeting highlight who Home Care PC is when Oncology presents
- Utilize SBAR to Primary Care Physician's when client present at meeting and Action Required

Health PEI
One Island Health System



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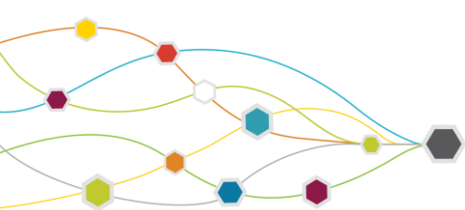
AIM STATEMENT:
Connect with existing collaborative tables in NB, NL, PS to implement palliative rounds for complex case load and short stay oncology patients. Start with the LHIN, nursing and physician team members and include ad hoc members based on patient and family needs. We will have trialed the rounding process in each area at least once in the 7 month period.

MEASURES:
- At least 2 community patients from each area will be rounded on at Palliative Rounds
- Round Members will be provided a survey to measure qualitative metrics and receive feedback from group on process ie. Time, location, referral process, etc..

CHANGE IDEA:
- Initiate monthly group meetings with Meagan, Joanne, Melissa, Natalie and Royanne to discuss initiative and next steps.
- Establish next collaborative table meeting dates to discuss project and bring forward as an agenda item.

CarePartners



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AIM STATEMENT:
Improve support and symptom management for palliative patients and their families / caregivers within the Prince Albert Area. We will do this by formalizing the referral process to rounds, having focused discussions and provide timely and written feedback to MRP. We will have this process set up by December 2019 in the Prince Albert Area to see 75% of referrals reviewed at the next scheduled Palliative Rounds.

MEASURES:

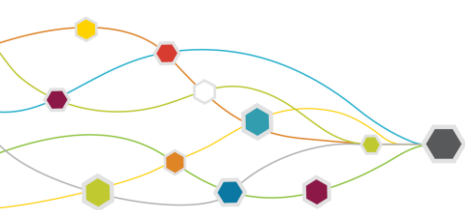
- # of referrals and when they are discussed – Goal of 75% of referrals within the next scheduled rounds
- Communication back to MRP – did it happen, timeliness. Tracking form developed to track communication back to MRP. Goal is 100% of communication is sent to MRP by end of business day of rounds.
- Qualitative outcome measures – Patient/family & Provider satisfaction surveys and f/u phone calls. This will allow us to gain feedback about process / forms.

CHANGE IDEA: Development of Forms – referral form utilizing SBAR.

- Palliative Nurse will fill out and use on one client at Rounds on July 24 (as a "mock referral")
- Testing of form with other nurses that do not have background knowledge to gain feedback on ease of use.
- make any edits necessary to allow form and process to be as simple as possible.

Saskatchewan Health Authority

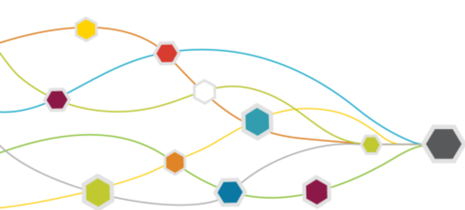
North East – Prince Albert



AIM STATEMENT:
Improve clinical rounding by adapting the principles of Interior Health BC's WCPR to meet the needs of patients of Miramichi Extra Mural and Hospice Miramichi. Make the model expandable and adaptable to meet the needs of other communities within NB. Provide a platform for rapid clinical problem-solving for symptom burden in the palliative population. Hold weekly rounds with an inter-professional care team that have been recruited to meet the specific needs of the patient. Adopt a shared decision making model and collaborative care plan approach. The goal is to improve symptom burden, as demonstrated by improved ESAS scores. Three WCPR to be held by Nov 12, 2019.

MEASURES:
ESAS scores will improve

CHANGE IDEA:
Prepare Miramichi Extra Mural staff for change (other relevant partners such as Hospice, Hospital, Physicians and Ambulance NB will be addressed next)

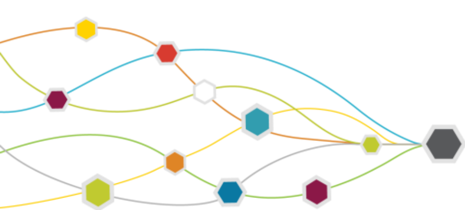


AIM STATEMENT:
Population: Chronic complex palliative with physical and social issues who repeatedly visit hospital.
Reduce distress scores in clients by 20% by April 2020.

MEASURES:
Reduction in self-reported distress score.
Increased client discussions at rounds.
Increase # clients who are connected to primary care.

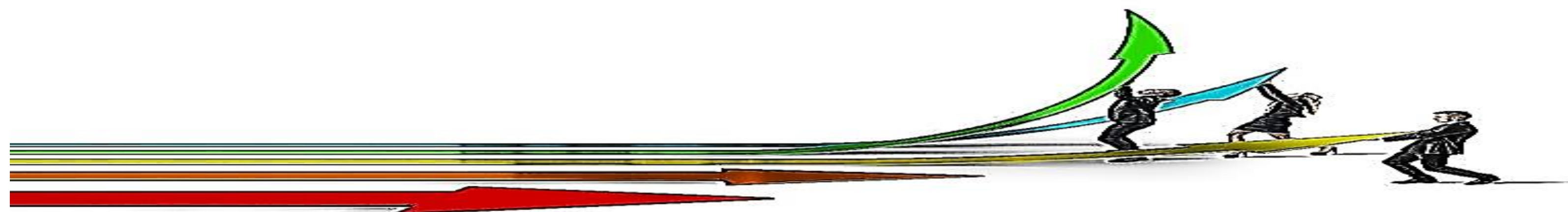
CHANGE IDEA:

Introduce the SBAR tool at rounds so there is more focused/organized discussion.



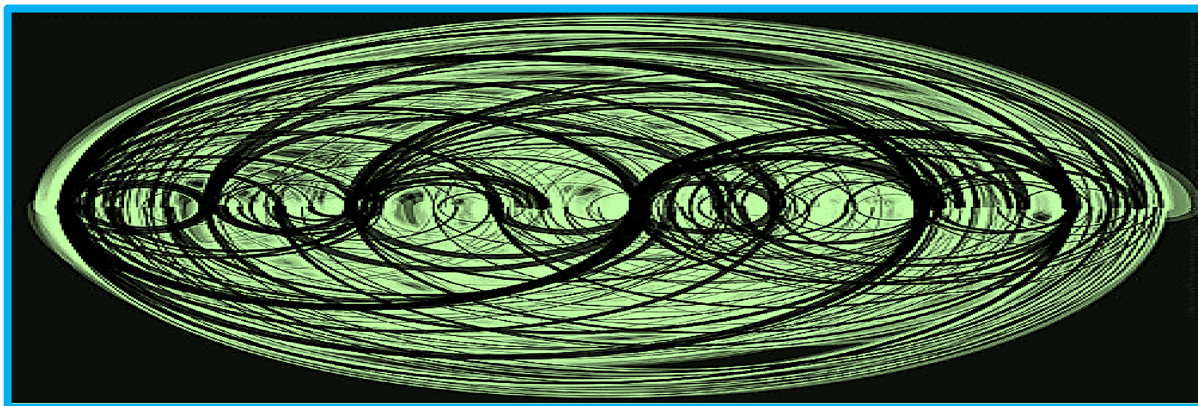
AIM STATEMENT:
By November 30th, 2019 the Alberta Health Services (AHS) Edmonton Zone (EZ) Palliative and End of Life Care (PEOLC) Program and Consultant Team will have launched a weekly platform for Whole Community Palliative Rounds (WCPR) to occur in the urban-palliative network. 90% of completed referrals which meet WCPR criteria will be reviewed and acted upon by the established AHS WCPR Circle of Care within 1 week.

MEASURES:

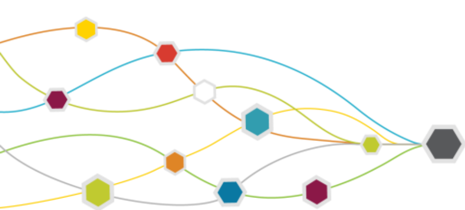


WORK IN PROGRESS

CHANGE IDEA: Our first PDSA cycle involved establishing a common meeting time for core group members to convene and address the work of the SPRINT Collaborative. What appeared to be a simple undertaking became quite complex: PLAN DO STUDY ACT.



Alberta Health Services



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AIM STATEMENT:

Improve the efficiency/quality of the existing Regina Palliative Care Services (RPCS) weekly rounds to include community members in a shared decision making process for patients who might benefit from a palliative approach to care by October 2019. Participants will feel empowered and better prepared to present clients in the new format. We hope to improve access to palliative approach for patients and families; improve the quality of referrals and presentations to rounds; and facilitate high quality transitions between RPCS, the North Primary Health Care (PHC) Network and the Palliative Paramedic Program .

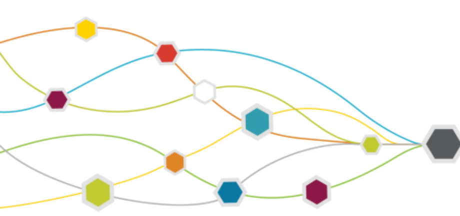
MEASURES:

We plan to use the following measures: Patient/Participant satisfaction measure; increase the number of shared care/ consolations between North PHC Network, Palliative Paramedic Program and RPCS; and improve the quality of information provided at rounds and on referral forms.

CHANGE IDEA:

Our first PDSA was to develop an Elevator Speech and share it at the existing rounds participants, and with many of our other care teams. We tweaked the information based on the feedback provided. We have also built a communication wall, to share updates and provide information regarding our project.

Saskatchewan Health Authority
Regina



AIM STATEMENT:

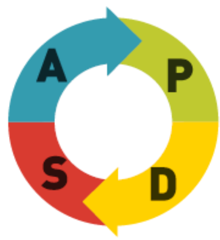
Over the next 7 months, we will establish a weekly WCPR in Clarenville with interdisciplinary representation from acute care, community care, primary care and long term care/personal care homes. A minimum of one medical leader will be identified by September, 2019 to participate in the round and will be provided with additional palliative care training if needed. A minimum of one rounds facilitators will be identified by July, 2019 and provided with coaching to enable effective rounds facilitation. Initial processes will be established for referral, patient presentation and appropriate follow-up that ensures effective team based care planning (end of August, 2019). WCPR testing will begin in September, 2019.

MEASURES:

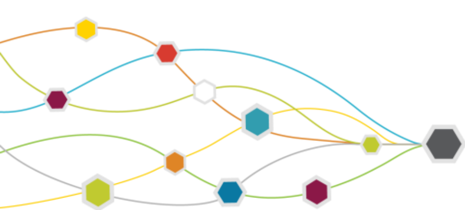
Process Measures: Weekly round held, Interdisciplinary representation from all sectors identified and attend regularly; medical leader(s) identified and attends regularly, minimum of 1 rounds facilitator identified and provided with training, # of referrals received, weekly meeting de-brief to assess meeting effectiveness (what went well, what was tricky, what could/should we do differently the next time), processes established for referral, patient presentation and follow-up, health care providers in the area report awareness of WCPR and how to refer

CHANGE IDEA:

To engage medical leadership for the WCPR, a family practice physician was provided with information about WCPR to determine interest and feasibility of assuming this role.



Eastern Health



AIM STATEMENT:

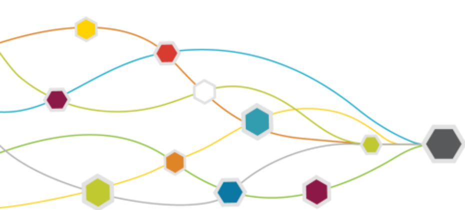
- Identify and connect with existing community palliative round leads and present new and successful innovations of formal WCPR concept and ideas and obtain stakeholder buy-in no later than Sept. 30, 2019. Conduct 3 WCPR by Nov. 30, 2019.

MEASURES:

- Successfully conduct 3 rounds with multiple attendance by Nov. 30, 2019. (measure invited vs attended)
- Wait lists to hospice will be reduced by 50% in six months from time of first round.
- Increased attendance by community caregivers by 50% in 6 months.

CHANGE IDEA: ACT, PLAN, DO, CHECK (QI of processes and products)

PDSA's: Referral form,
Referral process,
Location,
Date / Time,
Length of Rounds,
Invited vs Attended



SPRINT Implementation Collaboratives™

Whole Community Palliative Rounds

Canadian Home Care Association
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AIM STATEMENT:

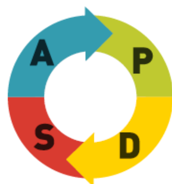
Palliative Care in the NW aims to provide access to an inter-professional care team which will assist primary care providers in supporting their PC population by responding to their needs and preferences, accessing local resources and building community capacity. WCPR will be implemented in Sept. 2019 within the Battleford's (accessible by Acute Care, LTC, HC and BTC). This will provide formalized referral, assessment, planning, implementation of individualized recommendations to meet client needs and having documented communication and follow up with most responsible care providers. At the end of 7 month trial, process to identify and implement "SPOKE" communities to the Battleford's "HUB" will be established.

MEASURES:

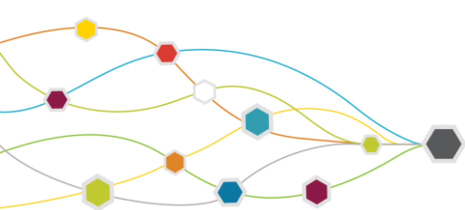
-End of Sept. 2019 weekly rounds will be scheduled and implemented
-patient and provider satisfaction surveys will be implemented to gain feedback on process
-# of referrals will be monitored to help determine program need
-Communication to MRP to be tracked with goal of 100% of round summary communicated by end of business day of rounds

CHANGE IDEA:

-Assessment of referral forms utilizing SBAR- Testing of referral form to be completed with Home Care representative.
-Representative will be orientated to SBAR utilizing Alberta Health Services SBAR Communication Tool Orientation (2010).
-Make edits to same as necessary to allow form and process to be as simple as possible.
-Communicate concerns with NE Palliative group as standardization of all related forms planned for Integrated North.

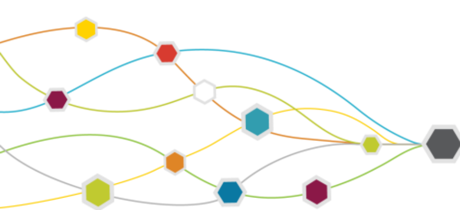


North West – Battleford's



WCPR PRACTICE CHANGES TOOLS & TACTICS

Elisabeth Antifeau & Vicki Kennedy



PRACTICE CHANGE: ENHANCING THE CIRCLE OF CARE
TOOL: CIRCLE OF CARE MEMO

Attachment # 1

Date: May 9, 2018

To: IH Palliative Rounding Teams

From: Karyn Morash and Tony Yip

Re: Circle of Care – Palliative Rounding

The term "circle of care" is commonly used to describe a group of internal and external health care providers supporting a specific person. Interior Health (IH) operates under the Freedom of Information and Protection of Privacy Act (FIPPA) and shares personal information within a circle of care based on an implied consent model that we establish via IH standard notification signage posted at all points of registration and admission in IH facilities.

Rounding practice and the definition of inter-professional care teams are evolving. A person's circle of care may include IH acute, community and allied staff as well as external partners such as: hospice coordinators; Aboriginal care provider partners; community pharmacists; spiritual care providers; P3 residential partners; and others. IH staff can and should share information about the person with members of this circle of care as long as it is for the purpose of contributing to their health care plan and meeting the service needs for them and their family. Remember to share with the external partners only the amount of information necessary and appropriate to enable them to provide their speciality care for the person.

Attachment # 2

July 5, 2018

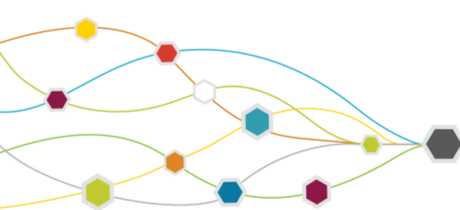
To: IH Clinical Staff
From: Glenn McRae, Chief Nursing Officer and Professional Practice Lead / Interim Corporate Director, Quality, Risk and Accreditation

Re: Circle of Care – Information Sharing

The term "circle of care" is commonly used to describe a group of internal and external health care providers supporting a specific person. Interior Health (IH) operates under the Freedom of Information and Protection of Privacy Act (FIPPA) and shares personal information within a circle of care based on an implied consent model that we establish via IH standard notification signage posted at all points of registration and admission in IH facilities.

Collaborative practice and the definition of inter-professional care teams are evolving. A person's circle of care may include IH acute, community and allied staff as well as external partners such as: hospice coordinators; First Nations Health Authority (FNHA) care providers; First Nation community health staff, Urban Aboriginal care providers; community pharmacists; spiritual care providers; Public, Private Partnership (P3) residential partners; and others. IH staff can and should share information about the person with members of this circle of care as long as it is for the purpose of contributing to their health care plan and meeting the service needs for them and their family. Remember to share with the external partners only the amount of information necessary and appropriate to enable them to provide their specific care for the person.

Some health care professionals may be hesitant to bring external partners into a person's circle of care



SPRINT Implementation Collaboratives™

Whole Community Palliative Rounds

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PRACTICE CHANGE: REFERRALS TO WCPR

TOOL: SBAR FORM

Attachment # 3

Interior Health

Guidelines for Communicating Palliative Needs in Whole Community Palliative Rounds

Purpose: A tool to communicate concerns about an individual who presents with current unstable or transitioning symptom burden (ESASr 4+) that is not well managed, causes distress and requires an inter-professional approach

Population: Any individual and family members living with advancing life limiting illness (malignant or non-malignant) who present with current symptom burden and distress. Individuals may be registered with BC Palliative Care Benefits Program, but may also not yet be eligible but require symptom supports. They may be located in any sector of care.

Most Responsible Prescriber (MRP): Family Physician, Nurse Practitioner or Medical Specialist

Most Responsible Clinician (MRC): Nurse, Social Worker, or any Allied Health member

Instructions:

1. Complete the SBAR with brief bullets, providing enough salient information to correctly communicate the context and palliative needs:

S	**Situation**	• Name, Age, Location (home, LTC, hospital, Community Hospice Bed) • Diagnosis, Current PPS (include rate of decline in known) • Current Problem, presenting symptom(s), including ESAS Scores for each symptom of concern (e.g., Pain 8/10; Dyspnea 6/10; Fatigue 4/10; Anxiety 8/10)
B	**Background**	• Succinct description of medical history (other conditions, current treatments or related factors); • Known Goals of Care, MOST, Chosen location of death (if known); • Known/relevant health team members/services • Current medications, any known allergies
A	**Assessment**	• Further assessment of presenting symptom: • *O –Onset* • *P – Provoking/Precipitating factors* • *Q - Quality* • *R – Region/Radiating* • *S – Severity (ESASr score for each symptom)* • *T – Treatment/timing* • *U – Understanding (what does the person think is happening)* • *V – Values/Goals for symptom management (includes trade-offs)*
R	**Recommendations**	Requests: • "I am asking for… new/revised/different orders to address these XYZ symptoms" • Example: "He has had 6 break-through doses in the past day, can we please evaluate and titrate the regular dosing to give him better pain relieve?" Recommendations: • "I wondered if we could try…." • Example: "Would low-dose Haldol be a possible solution to relieve his nausea?"

Interior Health

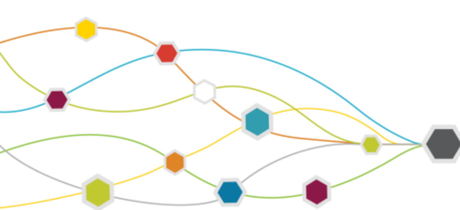
Name
PHN
DOB

SBAR for Communicating Palliative Needs in Whole Community Palliative Rounds

See Guidelines to complete form on reverse side

S	Situation:		
B	Background:		
A	Assessment:		
R	Recommendations:		
	Clinician Signature:	Clinician Name	Date:
	WCPR Outcomes: Actions and Follow-up (Be specific, e.g., who does what by when) Comments:		

DRAFT



PRACTICE CHANGE: REFERRALS TO WCPR

TOOL: SBAR FORM, ONE NOTE

Attachment # 4

Mar. 13, 2019
Thursday, March 07, 2019
3:51 PM

P4
Gibson - no tracker info
Clt not yet seen by P4- Sara
Anticipate rapid decline - ?brain mets

SBAR format to ensure a complete, concise report (2-3 min).	PPW 5	Allison
S – SITUATION current problem	Client Name	Mary [redacted] (last HH Palliative Assessment 10/03/19) (below completed following PC as requested to f/u re: pain)
	MRP MRP will follow Y / N	Dr. [redacted]--Dr. [redacted] is now covering for mat leave. Y
	MAIN CONCERN	Pain
	Age	77
	PHN	[redacted]
	PPS	60 % (24/02/19)
	ESAS	
Pt/Cl/Res B – BACKGROUND	DIAGNOSIS	Small Cell Carcinoma-(Neuroendocrine) July 2017
	Allergies	Morphine/Metoclopramide
	History or Related Factors	stopped chemo Aug 2018 d/t impact of TX -recurrent small cell esophageal with mets to lung T8&T9 Lytic lesions-
	Team involved (OT, PT, SW, Onc clinic, Renal.)	PPW 5 -referral to OT EOL March 12/19-pain-esp mid back-radiates to chest-worse at night and while laying down
	Trending Condition Stable / Declining	Declining
	Current Medications	Hydromorphone SR 4.5(recently increased from 3mg)/Escitalopram 20mg/Restorlax/Ondansetron
	Physical S/S	Continued nausea in AM
	Psychosocial S/S	

Attachment # 5

June 26, 2019
Friday, June 21, 2019
3:25 PM

Please present a succinct report in 2 minutes or less.
- Focus on clt main concern and supporting information relevant to that concern.

SBAR format to ensure a complete, concise report (2-3 min).	PPW 3	Carol
S – SITUATION current problem	Client Name	Loretta [redacted]
	MRP MRP will follow Y / N	Dr [redacted] Dr. [redacted]
	Clt / SDM MAIN CONCERN	Tiredness, itching, increased confusion, caregiver burnout
	Age	65
	PHN	[redacted]
	PPS	50%
	ESAS	Tiredness 6/10
Pt/Cl/Res B – BACKGROUND	DIAGNOSIS	Lung Ca with mets to liver and brain. Diagnosed 2018
	Allergies	NKA
	History or Related Factors	COPD, Sleep apnea, Febrile neutropenia while on chemo, Hypothyroid, hypertension, renal colic 2016, cholecystectomy
	Team involved (OT, PT, SW, Onc clinic, Renal.)	PPW Oncology - next chemo July 2,3,4
	Trending Condition Stable / Declining	stable Recent increase in weakness & start of incontinence since chemo.
	Current Medications	Decreasing doses Dexamethasone, Dexamethasone prior to chemo, Hydromorphone 2 mg at HS PRN, Levothyroxine, Pantoprazole, Pregabalin, Sertraline, Zopiclone, Metoclopramide PRN, Salbutamol PRN, Diphenhydramine PRN
	Physical S/S	Very tired, walks very slowly and has to rest frequently, variable confusion, itchiness. **answers mostly in yes/no and husband often corrects re: symptoms.
	Psychosocial S/S	Large group of supportive family and friends. Husband is main support and is very involved in all aspects of care. Risk of caregiver burnout.
	Wishes to die at ___ Home / CHB	Client not prepared to discuss at this time as focusing on curative measures. To see Dr. [redacted] this Friday - husband will clarify goals of care.
Pt/Cl/Res A - ASSESSMENT *Required for ESAS 4+*	O – onset P – provoking/palliating Q – quality R – region/radiating S – severity	Tired all the time, especially with any exertion. Resting helps. Itchiness (possibly from chemo?) is concern as keeps her awake at night. Started taking Benadryl which has been helpful at first - could benefit from

PRACTICE CHANGE: ACTIONS FROM THE WCPR
TOOL: WCPR RECORDS

Attachment # 6

Interior Health

Palliative Rounds Record
Palliative Care

Date ______________ Location ______________

Admission Date ______________ Diagnosis ______________

Allergies **(see ADR Record)** ______________

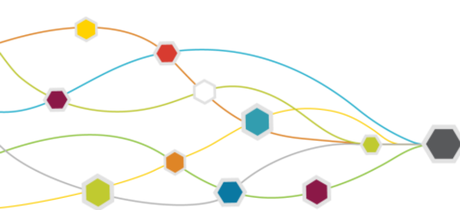
PPS on Admission ______________

Circle all that apply: EOL Respite Symptom Management

Pertinent Background and Goals of Care

Weekly Rounds Progress Note

Date	PPS	Focus / Need / Symptom	Action / Follow-Up *(includes communicating back to family and care team)*	Team Member Responsible / Date Resolved



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Whole Community Palliative Rounds

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PRACTICE CHANGE: ACTIONS FROM THE WCPR

TOOL: PHYSICIAN/NURSE PRACTITIONER COMMUNICATION

Attachment # 7

Interior Health

PHYSICIAN / NURSE PRACTITIONER COMMUNICATION
Palliative Rounds

Date of Rounds ______________________

Date Sent ______________________

Fax ______________________

Dear Physician / Nurse Practitioner ______________________ ,

Your patient, ______________________ , was reviewed in weekly Palliative Rounds today.

Patient Information ______________________

Issue Discussed at Rounds ______________________

Suggestions ______________________

Name ______________________ Signature ______________________

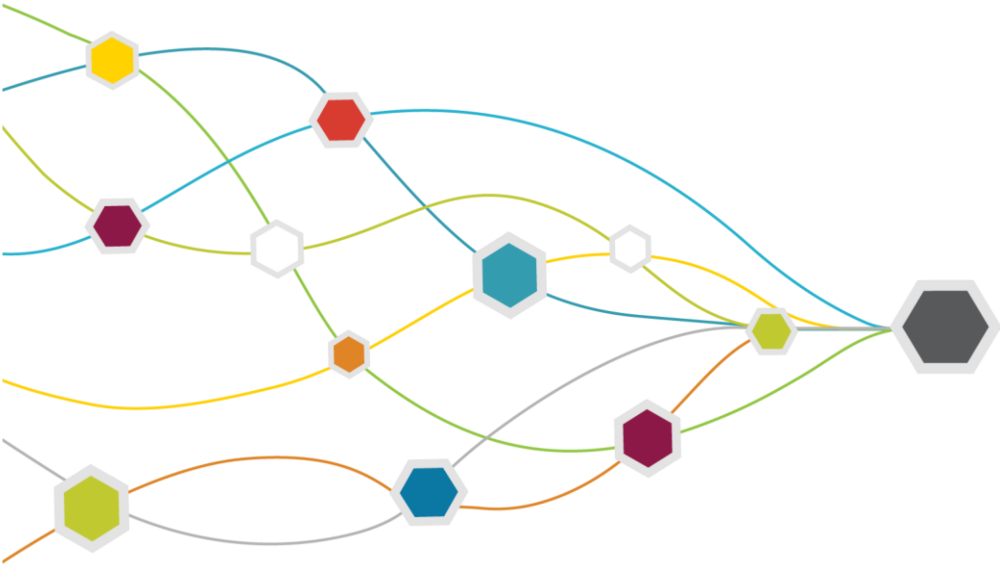
Designation ______________________ Contact Number ______________________

Please write Physician / Nurse Practitioner Orders, if required, on the attached order sheet

Suggestions Noted – New Orders Attached: ☐ Yes ☐ No

Physician / Nurse Practitioner Signature	Printed Name	Date (dd / mm / yyyy)
		/ /

821298 Sept 7-18



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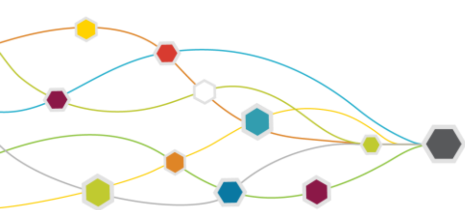
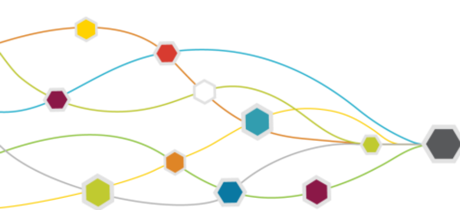
ACTION PERIOD – NEXT STEPS



ACTION PERIOD (July – August)

- Complete project charter – send to csuridjan@cdnhomecare.ca by August 1st
- Advance local determined PDSA
- Enhance the circle of care (defining community partners)



July- August:
Coach support

September 9, (13:00 – 14:30 EST):
Virtual learning webinar
(Enhancing Circle of Care, WCPR Facilitator, Implementation Science)

--Action Period/Coaching support–

October 9 (13:00 – 14:30 EST):
Virtual learning webinar

--Action Period/Coaching support--

November 4 (12:00 – 13:30 EST):
Virtual learning webinar

--Action Period/Coaching support–

December 2 & 3:
Capstone Event (TBC: Banff)

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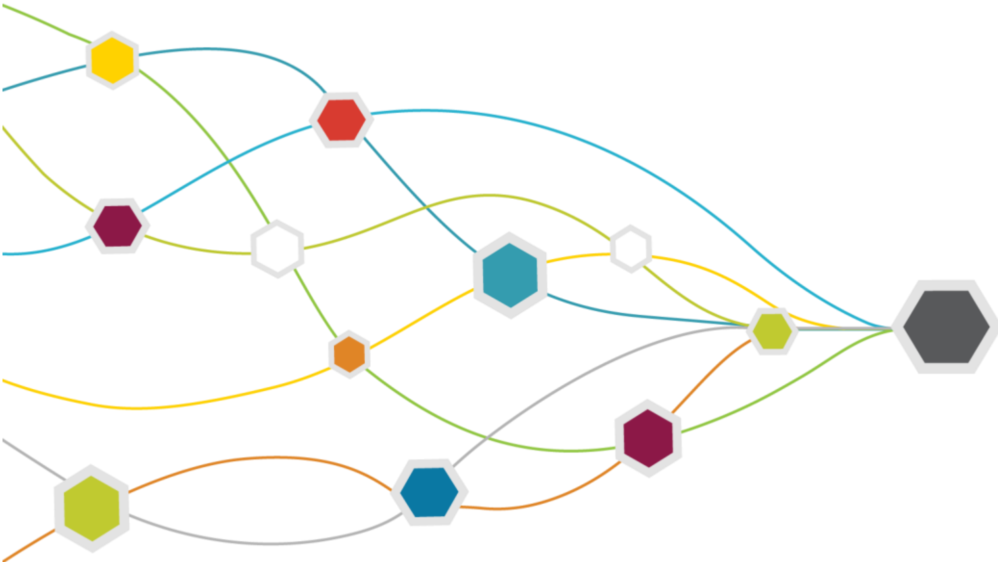

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THANK YOU

csuridjan@cdnhomecare.ca