



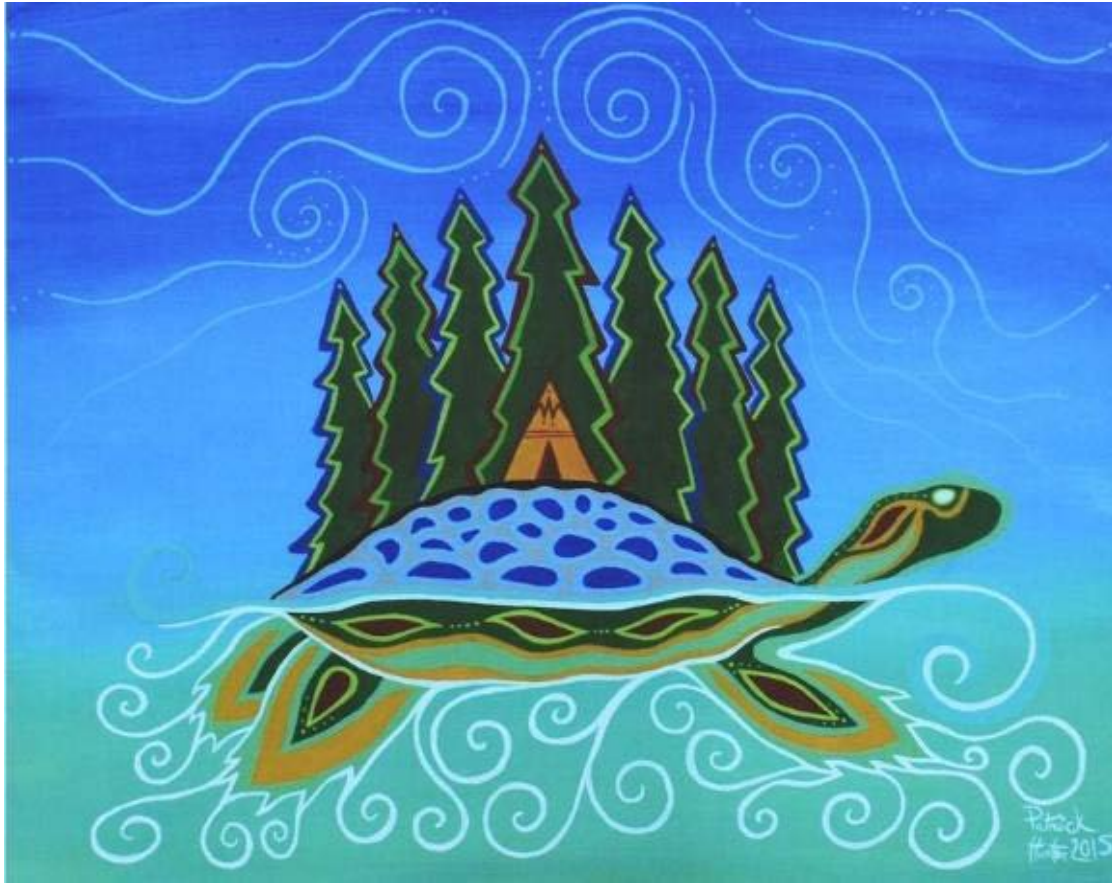
Developing emotionally intuitive
competency-based
palliative care skills

Communication and Shared Decision Making



Canadian Home Care
Association

Production of this material has been made possible through collaboration and financial support from the Canadian Partnership Against Cancer Corporation and Health Canada.



Turtle Island By Patrick Hunter (www.patrickhunter.ca)

Land Acknowledgement

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Métis Peoples.

On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.



Guest Presenter

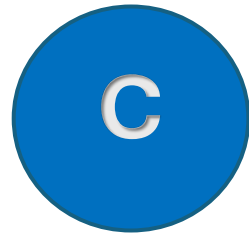


Karine Diedrich

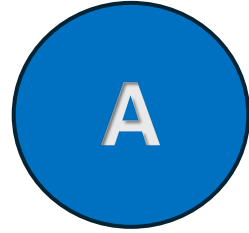
Director, Advance Care Planning
Canadian Hospice Palliative Care
Association (CHPCA)



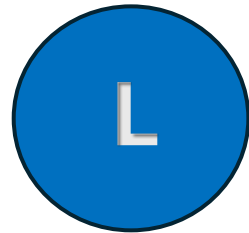
Checking In



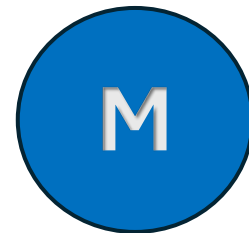
Check-In With Yourself



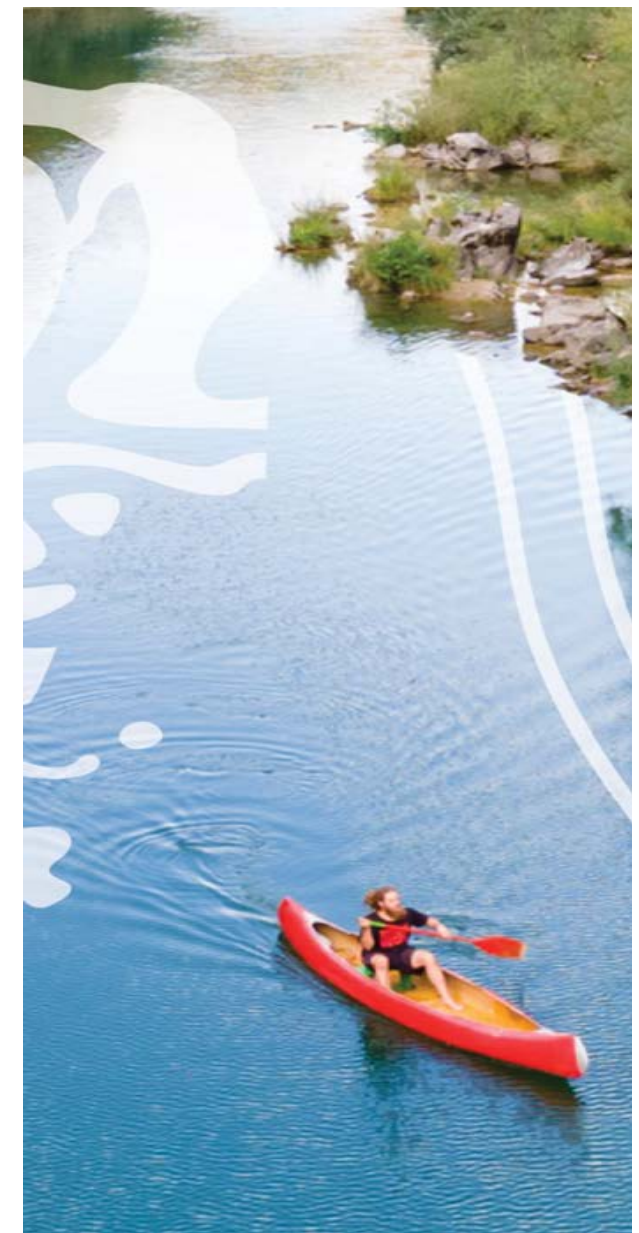
Acknowledge Your Feelings



Listen to What You Need



Make Time





Objectives



1. Understand two types of care planning conversations (Preparing and Deciding).

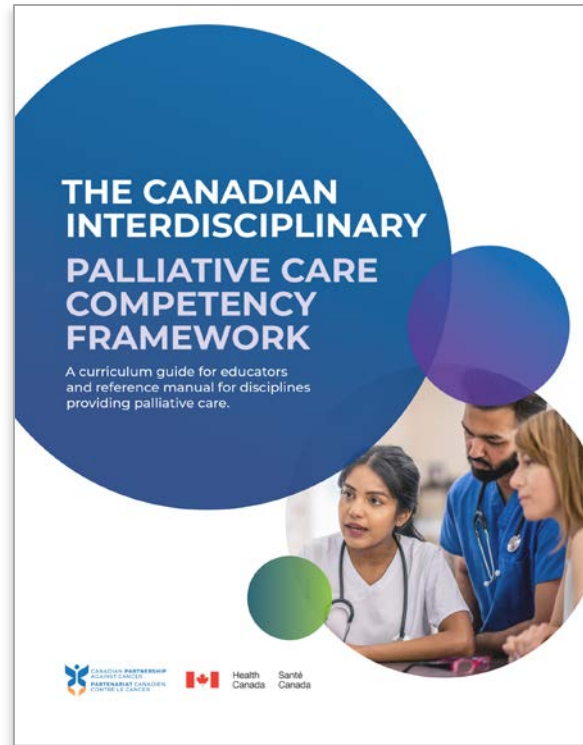


2. Understand how wishes, values, and beliefs can be integrated into care planning through personalized care plans and regular check-ins with patients and families.



3. Recognize your role in collaborative communications to support care planning, such as active listening, empathetic responses, and sharing information with the care team.

Communication Care Planning & Collaborative Practice



Communication is essential in care of those affected by life-limiting illness. The person, their designated family or caregivers, and team may experience uncertainty and strong emotions. Effective communication helps to establish therapeutic relationships, ensures that people, and families and caregivers understand and participate in decision-making, enables interdisciplinary teamwork, and facilitates smooth transitions between care settings.

Good communication contributes to good care planning & collaboration - enabling integrated, coordinated, person-centred care that optimizes comfort and quality of life.

Competencies



3.1 Promoting ongoing collaborative communication

- Recognizing and respecting that each person...has a unique perspective

3.5 Communicate health changes and concerns of the person and their designated family or caregiver(s) with the rest of the health care team.



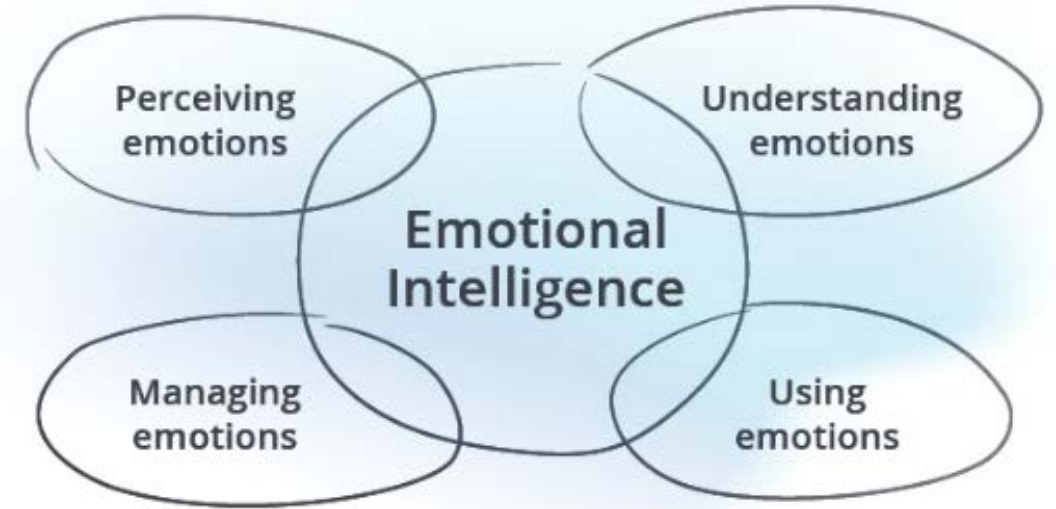
5.3 Promoting Advance Care Planning

- Respect the person's and their designated family or caregivers preferences for care and collaborate to ensure care plans are consistent with goals of care preferences

5.2.1 Evaluate communication (with team, person/family/caregivers) to ensure that their care plan meets the persons' identified needs.

5.3.4 Support the person (and/or their family or caregivers, SDM) in decision-making including withholding or withdrawing an intervention.

Competency Development and EI



Emotional intelligence isn't inherited, it's developed. The brain's neuroplasticity allows us to learn and improve our emotional skills throughout our lifetime.

Dr. Richard Davidson

Neuroscientist and Founder and Chair of the Center for Healthy Minds



Two Kinds of Care Planning Conversations

(Advance Care Planning) (Goals of Care)

What is Advance Care Planning?



ACP is the process of thinking about what matters to you. Your values, goals and preferences, and the care you would like to receive at any age/stage of your adult life.

ACP is also about talking to the people who matter most to you. Those you trust most — as well as your health care professionals — about your wishes.

Five key elements of Advance Care Planning

Think about what is important to you.

Learn about the care you want.

Choose your decision maker.

Share your wishes and preferences.

Record your preferences and decision maker(s).





Advance Care Planning (ACP)

John's Story

John was an active and independent man in his late fifties when he was diagnosed with Parkinson's Disease. One of the first things he learned about his illness was that the medication he would need to manage his physical symptoms could impair his thinking. He realized the day could come where he would have to make a choice. Mobility or mental clarity.

Why is ACP important?



Ensures the people most important to a patient know what they value when it comes to their health and wellbeing.

Reduces anxiety for the patients, those closest to them and the health care team.

Empowers people to reflect on what matters to them, and support decisions that reflect what is best for them.

2024 National ACP Poll – Highlights

- **80 per cent** of Canadians say they believe it is important to have conversations about future health-care decisions.
- **82 per cent** of Canadians agree that documenting their preferences would help relieve the burden on loved ones.
- **77 per cent** agree having an advance care plan gives them a sense of relief that their wishes are understood.
- **80 per cent** agree there is a need for more acceptance around sickness, death, dying and expressing health or personal care needs in our society.
- However, only **17 per cent** have documented their wishes in an advance care plan.



Advance Care Planning (ACP)

Jan's Story

I never thought my faith would be tested in such a stark, cold room. The sterile smell of the hospital clung to the air, mixing with the quiet hum of monitors. My heart pounded harder than it should, a reminder of why I was here. At 64, facing a sudden heart condition wasn't part of my plan, but life rarely consults us on such things.

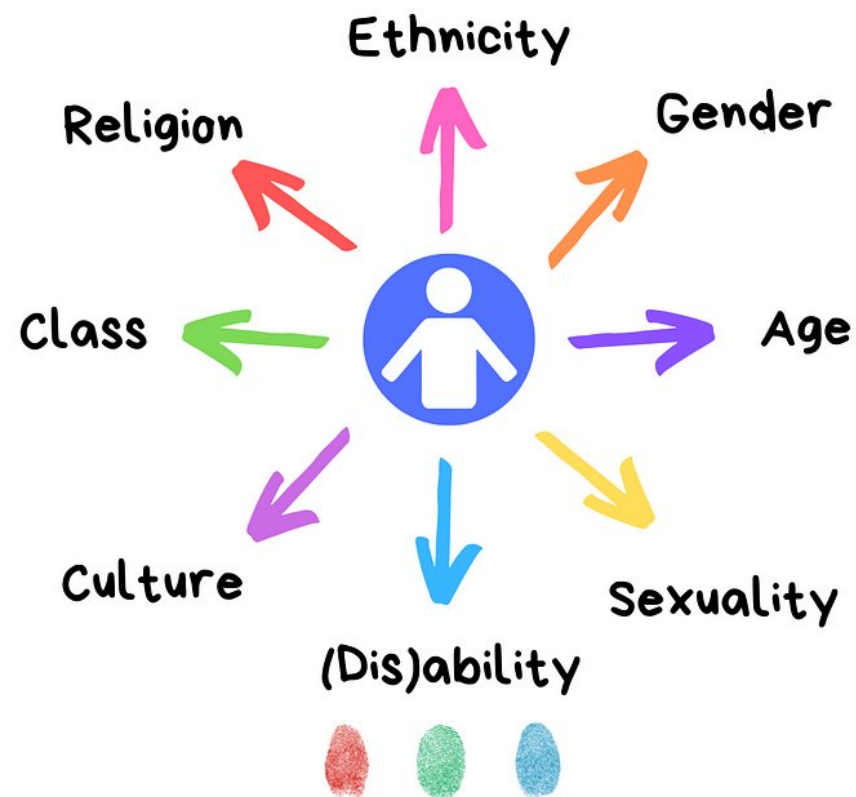


Advance Care Planning (ACP)

Intersectionality and ACP

It's important to understand that one identity alone does not define someone.

All of a person's identities connect and affect the challenges or advantages they may have.



Supported Decision Making



- We all turn to the most important people in our life when facing difficult decisions.
- It helps everyone talk openly about health and care plans together.
- This is a person-centered approach; the person you are supporting is in the driver's seat.
- Discussions and decisions might need to be made with extra supports.



Paula and Lindsey's Story

My name is Paula, and I recently accompanied my big sister Lindsey through her ovarian cancer experience. Lindsey was 57 when she died this spring, and she was also autistic.

I was honoured to be her person, the person she chose to help her create a will, help her create supportive decision-making documents, medical representation agreements, and the person she chose to include in discussions about how, when and which treatments to proceed with, and when Hospice care was best.



Advance Care Planning (ACP)

Remember the Platinum Rule

Golden rule: treat people as we would want to be treated

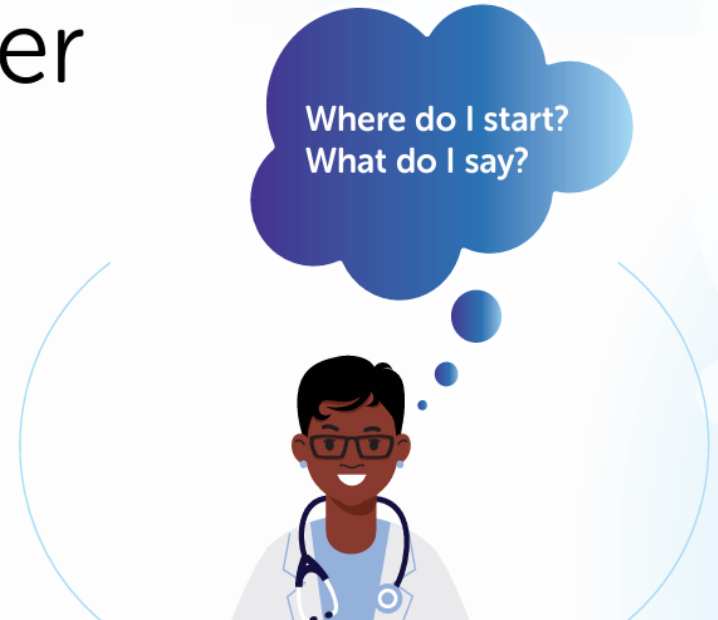
Platinum rule: treat patients as they would want to be treated

The Platinum Rule: A New Standard for Person-Centred Care, Harvey Max Chochinov

3 Questions to ask yourself that make difficult conversations about serious illness easier

Talking with your patients about
their serious illness is not easy

We all have had that uncomfortable feeling of not knowing what to say or
when to say it. Regardless of your role, ask yourself these three questions.

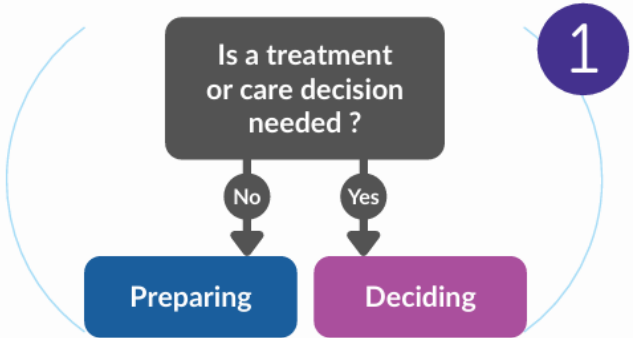


Where do I start?
What do I say?

©2022 Dr. Jeff Myers, Dr. Leah Steinberg, Dr. Nadia Incardona, Dr. Jessica Simon & Dr. Justin Sanders.)



Collaborative Care Planning Conversations



1 Is a treatment or care decision needed?

The answer directs you to the purpose and outcomes of the conversation.

If yes, then you are supporting **deciding**. Make sure illness is understood and decisions align with a person's values and goals.

If no, then you are helping with **preparing**. Prepare a patient and substitute decision makers (SDM) for progressing illness and future decision-making.



2 What do they know?

Up to **70%** of people do not understand that their serious illness cannot be cured and will progress over time. Exploring what the person understands about their illness helps you to know how much and what kind of information to offer.



Collaborative Care Planning Conversations



3 What matters to the person?

There is clear evidence that values and goals guide **as few as 10%** of clinician recommendations. Helping your patient express their values and goals will keep the person at the centre of the decision.

Benefits – When a seriously ill patient and their substitute decision makers (SDM) are prepared, outcomes are better, distress is less and clinicians have greater professional satisfaction.

“Given what you know now, when you think about the future, what matters to you? What is important for us to focus on?”

“What do I need to know about you as a person to give you the best care possible?”





Collaborative Care Planning Conversations

A Team Approach



PSWs/HSWs are often the members of the care team with the most knowledge about the unique perspective of each person and their designated family or caregiver(s)

1) Checking In with Yourself/Self-Care

2) Mindfulness and Social Skills

- Noticing/Listening (at all three levels)
- Adapting
 - ACT
 - DISC
 - 3 Ws and 6 Cs
- Being With Strong Emotions

*What are
you going to
practice?*

3) Collaborative Conversations

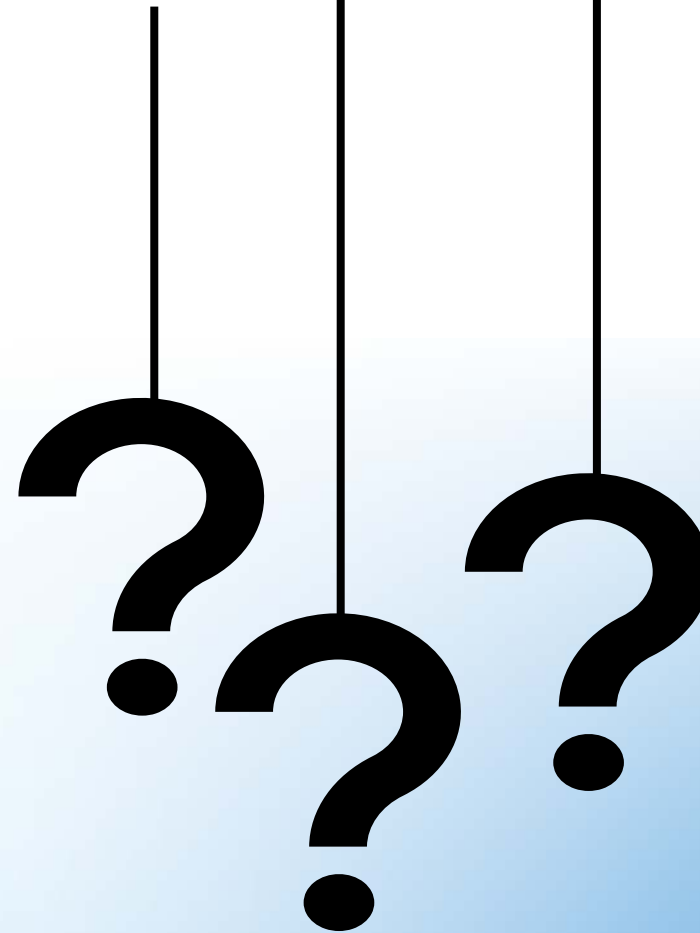
- Integrating the Conversation Guides
- I wish/worry/wonder
- Exploring Illness Understanding
- Identifying “What matters to you?”
- Sharing information as a team

Resources

- Hope for the Best, Plan for the Rest
- The Waiting Room Revolution (podcast) & Resources (www.waitingroomrevolution.com)
 - Help me Ask the Right Questions
 - What are Some Practical Things to Think About?
 - Illness Roadmaps
- Advance Care Planning Canada (www.advancecareplanning.ca)
- Health Canada – Palliative Care for Professionals Providing Care (www.canada.ca)
- Dignity in Care (www.dignityincare.ca)

The image shows a screenshot of a website with several overlapping panels. The top panel is titled "WHAT ARE SOME PRACTICAL THINGS TO THINK ABOUT?" and includes a "How to use:" instruction and a "Do you need and have support for:" section with a dropdown menu showing "Transportation". Below this is a panel titled "HELP ME ASK THE RIGHT QUESTIONS" with the subtitle "Conversation Starters After a Life-Changing Diagnosis" and three buttons: "WHO IS THIS FOR", "WHY USE IT", and "HOW WAS IT CREATED". The main panel is titled "ALS SYMPTOM ROADMAP" and "Understanding Your Symptoms and Illness Impacts". It is divided into two columns: "WHAT IS THIS FOR" and "HOW TO USE THIS". The "WHAT IS THIS FOR" column explains that ALS symptoms vary and provides a list of "MAJOR ILLNESS IMPACTS" including Speech, Swallowing & Salivation, Lower Extremity (Legs), Upper Extremity (Hands/Arms), and Breathing. The "HOW TO USE THIS" column instructs users to take notes and discuss with their healthcare team, with four numbered prompts. The bottom of the page features logos for Health Canada, Santé Canada, and The Waiting Room, along with a QR code.

Questions?



“Do your little bit of good where you are; it’s those little bits of good put together that overwhelm the world.”

-Desmond Tutu

Upcoming Knowledge Webinar

March 19, 2025 | 12:00 pm–1:00 pm ET

Attending to Grief and Loss – Empathy in Action

Build the skills to support families, colleagues, and yourself through grief and loss, fostering healing and emotional resilience.

