

**Pallium Project & Canadian Hospice Palliative Care Association (CHPCA)  
Putting Progress Into Action (PPIA)  
Provincial Hospice Palliative Care (HPC) Service Development Introduction Workshop  
Newfoundland & Labrador, October 6, 2005**

**Record of Small Group Exercise Report Back**

(source – small group flip chart/oral report back)

**Background/Context**

The baseline process The Pallium Project uses to support local/regional hospice palliative care service development is a one-day provincial workshop entitled Putting Progress into Action (PPIA). It is based on the Canadian Hospice Palliative Care Association (CHPCA)'s, *A model to guide hospice palliative care: Based on national principles and norms of practice*.

PPIA is designed as a starting point to protect time, focus attention/energy and facilitate dialogue at the local health authority-level, so local system leaders and hospice palliative care champions can move forward together to strengthen, streamline and improve the quality and sustainability of hospice palliative care services as part of a commitment to primary health care renewal.

In addition to briefings for local communication of hospice palliative care policy and quality/best practice directions and developments at the national-level (e.g., accreditation changes), time is protected for local health service leaders within the province to commence a dialogue about potential opportunities to advance HPC locally/regionally.

This document is a record of the Small Group Work report backs to the plenary for the small group work conducted during the Putting Progress into Action workshop on October 6, 2005, as outlined in the day agenda presented in Appendix A. The information presented in this document is intended as a participant reminder of the report for the day. The reader who was not present during the workshop is urged to use this document with caution due to the exclusion of specific context around the report back comments. Participants were organized in small groups according to the Regional Integrated Health Authority for which they are affiliated, as outlined in Appendix B.

Errors, omissions and clarifying comments can be sent by registered participants to Michael Aherne at [michael.aherne@pallium.ca](mailto:michael.aherne@pallium.ca).

**Small Group Exercise #1**

**What is already in place with your new region (with respect to Hospice Palliative Care)?**

- A) Pain/symptom management**
- B) Supportive services**
- C) Care coordination**

**Eastern Health Authority small group work report back**

A) Pain/symptom management

St. John's

- Pain/symptom management teams
- Dedicated palliative care unit
- Primary care physicians (some better than others with palliative care)
- Hospital capacity
- Oncologists

Around the Bay (ATB)

- No pain/symptom team
- Home care RNs
- No dedicated primary care physicians with formally recognized palliative care special skills.
- Some primary care physicians
- Distance/geography is an issue.

B) Supportive services

- Home care (general) and RNs
- Palliative volunteers
- Interim \$\$\$
- Private insurance (suggested as a largely untapped resource)
- Family
- Pharmacies
- Church/formalized faith communities.

**Western Health Authority small group work report back**

A) Pain & Symptom Management

1) Pain and symptom team regionally

- “Rurban” – all settings; including home visits as required
- Clinical nurse specialist, fellowship trained palliative care physician and access to pain clinic physicians (last in Corner Brook only)

2) Medication for “end of life” – analgesia, antiemetics, decadron covered

3) Pilot project for education (r.e., chronic pain management)

4) Palliative care unit – 24 hr resource; admissions for pain & symptom management

5) “End of life” equipment – e.g., pain pumps

6) Regional education program – e.g., epidural pain management.

B) Supportive Services

1) Coordination of services – liaison nurse “Western Memorial Regional Hospital and outside the region”

2) Interdisciplinary team [in Corner Brook]

3) Palliative Performance Improvement Team (PIT)

4) Training home support – financial conditions of care for patient/family “waived” at “end of life”

5) Telephone support to all the region from palliative care physician, palliative care unit and clinical nurse specialist

6) Medical rounds – regional distribution via video tape circulation

7) Donated funds (currently only can be used for equipment); salary for palliative care physician and clinical nurse specialist; various/sundry end of life “extras”

8) Bereavement support (in many forms)

9) After care follow-up

C) Care coordination

1) Designated palliative care specialists

- 2) “Communication book” initiative to facilitate continuity among many providers/reduce the number of time patient/family has to “tell their story”/keep care notes (but not legal chart – more like a traveling patient diary).
- 3) Staff education department
- 4) Referral system
- 5) Community coordination through the community health nurse/home nursing care coordinator

### **Central Health Authority small group work report back**

#### **A) Pain & Symptom Management**

- 1) Committee looking at a pain assessment tool – East already has one implemented
- 2) Done Q admission & more frequent palliative care (regular re-assessment – e.g., Q4H or more)
- 3) Consult pharmacy – 24 hour on call service
- 4) Consult cancer clinics (East & West) for cases they’ve been involved with to ensure continuity; also for new/difficult cases.
- 5) East has palliative care standing orders (especially good with new physicians/locums)

Comment (taken directly from flip chart) – Palliative care is no place for internal medicine or surgery as the primary care physician *within the community*. Community health nurses have good rapport with the family physicians. Pain/symptom management can be an issue with locum coverage and increased physician turnover. Physicians from different cultures have different perspectives on palliative care. Sometimes the wrong message is given to families – leaving families confused and/or feeling guilty. Need education about philosophy of care.

#### **B) Supportive Services**

- 1) Some palliative teams/committees are in place – multidisciplinary
- 2) Access to services on a consult/referral basis. Some rural/remote sites wouldn’t have as immediate access.
- 3) Home support – would still need financial assessment – can get 24hr support is dying tomorrow (? – but how do we determine somebody “is dying tomorrow”).
- 4) Cancer clinic
- 5) Canadian Cancer Society
- 6) Victoria Order of Nurses (VON) – Home support agency
- 7) Volunteers (?) – in some locales

#### **C) Care Coordination**

- No single point of entry or case management
- Hospital pharmacy provides morphine pumps to the community – morphine may come from the community pharmacy.
- Community health nurse lets hospital S.W. department know when one of her patients admitted and vice versa.
- Some areas generate lists of potential palliative care clients
- Family team meeting/case conference around discharge

**Labrador-Grenfell Health Authority small group work report back**

**A) Pain and Symptom Management**

- Home care RNs – Some training received/given by visiting palliative care specialists
- Individual health care providers – many are a source of valuable expertise
- Local palliative care workshops delivered by RN/Social Worker
- Telephone access to palliative care physicians, RNs, oncologist
- Videoconferencing with oncologists (New)
- Currently no formal guidelines

**B) Supportive Services**

- Home care RNs
  - Goose Bay – available 24hrs/day for last (approx) week of life
  - STA – Not available after working hours
  - Coast – Regional RNs +/- Labrador-Inuit Health Commission funded PH & Home Care RNs
- Provincial home support program
- Personal care aides (PCAs)
- Labrador-Inuit Health Commission and INNU-funded home support
- Social workers, clergy, physical therapy, complementary care
- Community hospital and palliative care bed

Note: access to supportive services varies by place, diagnosis, treatment, type of death and pre-illness care

**C) Care coordination**

- Physician/Home Care RN collaboration
- No coordinator (i.e., “patient navigator”)

**Small Group Exercise #2**

**1) Identify three areas/ideas for a low cost change that will lead to meaningful improvement as measured by:**

- A) an increase in quality and/or**
- B) improved access and/or**
- C) enhanced local/region capacity to respond to HPC need.**

**2) How will you know it made a difference?**

**3) Who will you tell?**

**Eastern Health Authority small group work report back**

- Regional palliative care team
- Single entry (central referral system) which is team based and focused on improved community systems.
- Training/education with focus on regular ongoing skill development
- Consolidating key information – engaging key stakeholders
- Public/professional awareness campaigns

### **Western Health Authority small group work report back**

- Expanded roll-out of Communication Book with a communication of pilot study and results; education of HCPs/public about value of book
- Earlier referrals for palliative care services with a focus on educating nurses, family physicians/oncologists and the public
- Develop a care pathway for palliative care referral

### **Central Health Authority small group work report back**

#### Idea 1 – Volunteer development initiative

- Increase quality and capacity to respond especially in rural areas to respond to concerns about small families/outmigration (i.e., less sons/daughters to support), volunteers could help fill the gap.
- Confident it will make a difference
- Determine the difference it is making through client/family surveys; metrics include volunteer stats/hours given and discussion of where the volunteers are located.
- We will tell the Region's executive team (e.g., through Trudy), the region's palliative care committee, the volunteer coordinator, media/communications department and we will educate staff regarding the volunteer development program.

#### Idea 2 – Increased coordination

- I. Identify the local HPC experts
  - II. Regional committees/teams to focus on integration
  - III. Seek an improved referral process
  - IV. Improve communications
- It is a meaningful improvement/idea because it will improve access and capacity to respond.
  - How we know it is making a difference – Increased patient/family satisfaction and decreased staff frustration; review referral statistics over time; evaluation staff awareness of local experts and new processes.
  - We are going to tell everybody – start with the regional palliative care committee and do a communication strategy (committee would do an environmental scan).

#### Idea 3 – Education

- I. Better use local/regional resources/providers
  - II. Better use of distance learning/telehealth
  - III. Promote certifications that exist for hospice palliative care
- It is meaningful because it will improve quality by making more education available to local caregivers; it will increase access by ensuring local “experts” are dispersed across the region; increase the capacity to respond because more people will know how to do hospice palliative care
  - Evaluate the difference made by undertaking a staff survey to see if staff/caregivers feel more competent and confident; assess if patients are receiving appropriate care as close to home as possible.
  - We will tell/work with the professional/organizational development department to develop an educational plan; we will ask other who've already developed some education; we will tell all staff involved in palliative care; and community groups involved in palliative care.

### **Labrador-Grenfell Health Authority small group work report back**

#### Idea 1 – Form local palliative care committees

- Form local committees throughout the region to develop guidelines for palliative care management (and also forming group with interest regionally)
- It is a meaningful improvement because:
  - This will help improve quality – consistency/coordination
  - Improve access – yes (i.e., criteria to admit to palliative care bed)
- We will know it makes a difference because we will: produce guidelines; get staff to use guidelines; and could give survey to family/staff
- We will tell management and everyone else who will listen!

#### Idea 2 – Palliative care workshop/education (i.e., one day per year)

- Meaningful from quality perspective because it an opportunity to dissemination knowledge; increase “the team”; focus on maintaining/improving quality
- Meaningful for access if “team” is aware of palliative care resources available
- It will make a difference because more people will be aware of issues/how to deal with the “interdisciplinary” approach.
- We will tell everyone!

#### Idea 3 – Find a place to gather all resources (i.e., books, DVD, tapes, etc.) for local access

- Improvement in quality from easy access to the information people did to do the work
- Improve access by making it easier to get resources for palliative care
- People will learn to know where palliative care “stuff” is
- We will know it makes a difference if it gets used
- We will tell everyone – patients, staff, families, management

### **Small Group Exercise #3**

**1) Identify three areas for new/renewed investment in hospice palliative care**

**2) Describe what investment.**

**3) What will the investment contribute to overall regional capacity?**

**4) Who needs to decide about the investment?**

**5) What is the “go forward” plan from today?**

### **Eastern Health Authority small group work report back**

1) A third physician for palliative care

2) Development and proper remuneration of primary-care “foster docs”

3) Enhanced non-professional service in community focused on caregiver support, supplies, medications not currently funded when administered out of an institutional setting.

4) Nurse practitioners, nurse specialists in the community and acute care settings and movement towards more RNs with the CNA Hospice Palliative Care nursing certification.

**Western Health Authority small group work report back**

- 1) Additional investments in home-based services
- 2) Improved bereavement support
- 3) Properly trained volunteers

**Central Health Authority small group work report back**

Hospice residential services – do we need more dedicated “acute” palliative care beds in Gander/GFW or would hospice residential services bridge the gap between home supports and hospitals?

**Labrador-Grenfell Health Authority small group work report back**

- 1) Universal palliative care program through the region
- 2) Visiting oncologist (three month intervals)
- 3) Money for equipment to do palliative care
- 4) Chemotherapy training for physicians at the community-level
- 5) Regional coordinator for oncology and palliative care
- 6) Financial subsidies for extensive travel plus family support to travel with the patient as required (existing model may be something like what the Labrador Inuit can access).
- 7) Bereavement support

**Appendix A – Agenda for PPIA Workshop (Amended per Actual Day Plan)**

<b>FINAL AGENDA, OCTOBER 6, 2005, ST. JOHN'S, NL</b>		
<b>Time</b>	<b>Activity</b>	<b>Facilitator / Speaker</b>
0830am	<ul style="list-style-type: none"> <li>• Welcome</li> <li>• Introduction to Pallium Atlantic</li> <li>• Introduction of Participants</li> </ul>	Michael Aherne, Pallium Project
	Newfoundland & Labrador: Hospice Palliative Care “Snap Shot”	Dr. Mervyn Dean, Laurie O’Brien & Region self-reports
1015-1030	Morning Break	
	Briefing: <i>Yesterday, Today, Tomorrow - Key National Developments &amp; Provincial Implications</i>	Sharon Baxter, Executive Director, Canadian Hospice Palliative Care Assn.
	Briefing: <i>Striving for Change, Leading by Improvement – Accreditation and Other Quality Realities</i>	Laurie Anne O’Brien, Co-Chair, National Working Group on Quality Care & Best Practices, Canadian Strategy on Palliative & End-of-Life Care
1200-1230	Networking Lunch	
	<i>Mapping what you have Regionally</i> (Introduction to using the CHPCA Model Square of Care and Square of Organization) <ul style="list-style-type: none"> <li>• Pain &amp; Symptom Management</li> <li>• Supportive Services</li> <li>• Care Coordination</li> </ul>	Regional Working Groups (Michael Aherne and Provincial Co-chairs)
	<i>Getting Started: Low Cost, High Impact Activities to Improve HPC Regionally</i>	Regional Working Groups (Michael Aherne and Provincial Co-chairs)
1400-1420	Afternoon Break	
	<i>After the Low Fruit Has Been Picked:</i> Early Exploration of High Impact Activities Necessitating Re-investment Regionally	Regional Working Group Exercise (Michael Aherne and Provincial Co-chairs)
	How will we know how we are doing?	Working Groups
1600-1615	Concluding Comments	



Appendix B – Newfoundland & Labrador (New Regional Integrated Health Authority Map)

