Pallium Canada

Quality Improvement
Condensed (QUIC)

Improving Essential Conversations in Long-Term Care

pallium.ca

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About this toolkit

WHAT IS A QUIC?

This Quality Improvement Condensed (QUIC) toolkit is part of a broader collection of QUIC toolkits that help you make small and scalable changes in your practice.

- These QUICs are free to use and are designed to go hand in hand with one another. **Access all available QUIC toolkits here.**
- These toolkits use the Model for Improvement (MFI) of the Institute for Healthcare Improvement (IHI). It consists of three key questions and Plan-Do-Study-Act (PDSA) cycles. You may use other approaches that you are more acquainted with or feel would be more appropriate.
- These toolkits provide a step-by-step approach to undertaking palliative care related quality improvement (QI) initiatives in your practice.

AIM OF TOOLKIT

This toolkit supports those working in long-term care facilities to improve essential conversations with residents and their substitute decision makers.

- This toolkit is designed to be used by leaders and interdisciplinary team members on the frontline, palliative care teams and anyone else who is passionate about incorporating the palliative care approach into long-term care.
- The steps outlined in this QUIC will help guide you through all phases of your quality improvement project.
- This toolkit includes examples throughout that are relevant to essential conversations in the context of long-term care.
- Helpful resources are included such as evidence-based screening tools, communication templates and templates to help you succeed in employing quality improvement and project management methodologies. (See **Resource 1**)

HOW THIS QUIC WAS DEVELOPED

This QUIC was developed by Pallium Canada and a core group of subject matter experts. They collaborated, receiving input and feedback, from a pan-Canadian community of practice, the Long-Term Care Quality Improvement Community of Practice, made up of 97 members from across Canada and professions – all with a shared passion for integrating a palliative care approach in long-term care.

We would like to extend our gratitude to the members of the Long-Term Care Quality Improvement Community of Practice and the following individuals for their support in developing this QUIC:

- Dr. Amit Arya, MD. , CCFP (PC), FCFP
- Elizabeth Wojtowicz, N.P.
- Sharon Kaasalainen, RN PhD
- Holly Finn, PMP, Pallium Canada
- Gloria Nickels, PSW
- Dr. Leah Steinberg, MD, CFPC, FCFP, MA
- Jodi Hall, CEO of the Canadian Association of Long-Term Care
- Diana Vincze, Project Manager of the Palliative Care ECHO Project, Pallium Canada
- Aliya Mamdeen, Program Delivery Officer, Pallium Canada

NEW TO QUALITY IMPROVEMENT?

- Quality improvement (QI) is a systematic, iterative, and formal approach that involves analyzing practice performance and making efforts to improve performance.
- Data collection and analysis are a key component of QI – "Your data will help you understand how well your systems work, identify potential areas for improvement, set measurable goals and monitor the effectiveness of change."[1]
- QI is a team activity, so involve all those who will be affected or involved. Consider including a resident or family member in your team.
- Don't forget to celebrate successes!
- If there are shortfalls or failures, try a different approach. It's about progress, not perfection.
- Want more information about quality improvement methodologies? Check out these **quality improvement resources**.

TERMINOLOGY

Many terms can be used to describe the varying aspects of essential conversations (e.g., goals of care discussions, advance care planning) and a plethora of programs and tools that support clinicians in having these types of conversations (e.g., VitalTalk, Serious Illness Conversations, SpeakUp).

- To avoid confusion, **the Prepare or Decide framework** was developed to help us think about the conversations we have with residents who have serious illnesses and their substitute decision makers.
    - It begins by first asking whether an immediate treatment or care decision is needed.
    - If the answer is no, then our role is to support residents and their substitute decision makers to "prepare."
    - If the answer is yes, our role is to support residents and their substitute decision makers to "decide."
    - Once this question has been answered, the algorithm then guides clinicians on what to do next.
    - This framework is described further in this **video.**

- **Essential Conversations:** In this QUIC, we will be using the term to broadly describe conversations that aim to align medical care and treatment with patients' values, goals, priorities, and preferences. This is an umbrella term that includes the different types of conversations described below.
- **Advance Care Planning (ACP):** Describes conversations focusing on a person's values and wishes for health in the future and designation of a substitute decision maker. While this term is used across Canada, it is interpreted differently in different jurisdictions.
- **Goals of care (GOC) discussions:** These discussions take place in the context of specific health conditions at a specific point in time. These discussions are values-based and focus on ensuring an accurate understanding of both the illness and treatment options to inform **decision-making** or **consent discussions**.[2] To learn more about goals of care discussions and why they are important, visit the **Goals of Care Discussion page**.
- To understand the specific steps involved in these types of essential conversations, **click here**.

Why does this QUIC matter?

In a setting like long-term care, it's never too early for communication about one's serious illness, but it can be too late.

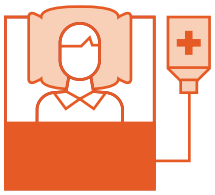
- Research tells us that essential conversations in long-term care are not happening early enough, often enough, nor are they going deep enough.
- Essential conversations are often associated with improved end-of-life care for residents as well as reduced stress, depression, and anxiety for their surviving loved ones.[3,4]
- There are different requirements as to when serious illness communication should be taking place and how often, depending on which jurisdiction you are in. This toolkit is based on what is objectively needed at a minimum for quality care.
- Some provinces require an initial case conference six weeks post admission to long-term care. However, this may not align with what a resident actually needs, and the case conference itself may not actually involve a thorough discussion.
- It is recommended that an essential conversation be a part of every clinical encounter that involves a decision such as starting antibiotics, initiating opioids for symptom management or considering whether to transfer to hospital, especially in the setting of progressive life-limiting illness.
- Prior to these situations, it is important that the clinical team prepare residents (and their substitute decision makers) by helping them to understand the nature of their current illness, their expected prognosis, as well as what to expect in the future as their illness progresses.
- When communication about serious illness only covers do not resuscitate (DNR) and do not hospitalize (DNH) orders, it does not eliminate potentially inappropriate transfers. Residents and their families are more likely to receive care that is not in line with their wishes, and in a setting that is not of their choosing.

  "While some of these transfers might be completely appropriate, some may be considered overly aggressive and burdensome. We found that DNR and DNH orders are not enough to prevent potentially avoidable hospital visits. Instead, the orders need to be explored with explanations about why these orders are in place, and we need to provide additional supports to keep residents in their home."[5]

This toolkit was designed to give long-term care homes the tools and resources to optimize the frequency and quality of these important conversations.

QUADRUPLE AIMS AND QUALITY DIMENSIONS ADDRESSED BY THIS QUIC

- The triple aim is an approach that was originally developed by the **Institute for Healthcare Improvement** to optimize health system performance. The goal of the triple aim is to:
  - improve the resident care experience.
  - improve the health of a population.
  - reduce per capita healthcare costs.
- Recently, an additional dimension has been emphasized by health care professionals, the "improved clinical experience." This has led to the concept of the "quadruple aim."
- This QUIC addresses all dimensions of the quadruple aim, as research has shown that communication about serious illness can improve resident and provider experience, improve resident outcomes, and lower costs through less intensive interventions and ER visits.[6,7,8]



IMPROVED PATIENT EXPERIENCE

IMPROVED PATIENT OUTCOMES

QUADRUPLE AIM

LOWER COST OF CARE

IMPROVED PROVIDER EXPERIENCE

EASE OF IMPLEMENTATION SCALE

- Some QI projects are straightforward and easy to implement. We call these "just do its." Others require several PDSA cycles, each one making small adjustments and improvements.
- This type of project will likely warrant several PDSA cycles — but it is worth it!

READY TO GET STARTED?

- First, review the entire document to understand the big picture.
- Then follow the steps and refer to the **Resources section** and useful links at the end of the toolkit as you go along.

GET CME CREDITS FOR YOUR QI WORK

- Physicians can submit their QI work to the College of Family Physicians of Canada (Linking Learning to Practice) for CME Credits.
- Linking Learning exercises are self-administered, semi-structured exercises. They challenge physicians to look at day-to-day activities as learning opportunities.
- The Linking Learning submission forms help identify a question, and then guide the reader through a series of critical inquiry and practice reflection exercises that lead to answering the question.
- Each completed Linking Learning exercise is eligible for five Mainpro+® certified credits. There is no limit to the number of exercises that can be completed in a cycle.
- Further details, including the form, is available on the **College of Family Physicians of Canada website**.

QUIC steps

STEP 1: GET STARTED

Ask: Is this something I want to do in my own practice or this is a broader quality improvement initiative?

- Sometimes you may need to start small and then highlight your successes to inspire medical directors, attending physicians, nurse practitioners, administrators, and directors of care to make a more sweeping change.

Ask: Who can help me with this?

- Consider one or two colleagues who might have an interest in this. They may be clinical or administrative.

Have an informal chat with the colleagues you've identified

- Explore this QUIC together to start thinking about how to implement improvements in your practice.
- Consider if this type of project makes sense in your long-term care home and what you hope to accomplish.

STEP 2: DOES THIS APPLY TO US?

Consider one or two of the following:

- Chart audit (See **Resource 3**)
- A check sheet (See **Resource 3**)
- Case reflections (See **Resource 3**)
- If this confirms the need to improve essential conversations in your long-term care home, proceed to the next step.

STEP 3: GET PEOPLE ON BOARD

The following steps are recommended:

- Ensure leadership is on board by getting sign off on a project charter. (See **Resource 1**)
- Determine who will be the project lead(s) who will help to keep things moving forward. Ideally, you can pair a clinical lead with an administrative lead.
- Form a project team that is representative of those who could potentially impact, or be impacted, by this initiative. Ensure you are incorporating a variety of perspectives.
- This team will be involved in understanding what the issue is, preparing for the change and implementing the change.
- Start building awareness about this issue across your organization and communicate information that will spark a desire for colleagues to want to be a part of this change. People often need to hear the message multiple times and in a variety of ways before it can take a hold. (See **Resource 1** for communication templates)

STEP 4: A DEEPER DIVE

Ask: What are the root causes of the problem?

- When undertaking QI work, it is important to understand the root causes of the problem at hand; otherwise, you run the risk of finding solutions that don't address the actual root causes.
- Several simple tools are available to help diagnose and understand the problem(s) and its contributing factors. (See **Resource 4**)

Ask: Are we ready to make a change?

- You probably have a general sense of whether or not your long-term care home is ready to make a change in how they communicate with residents and their substitute decision makers around serious illness.
- There are organization readiness assessment tools — such as the **Quality Palliative Care in Long-Term Care: Self-Assessment Checklist** — that can help you to determine readiness for change.
- Perhaps you will find that you are ready to make a change, but the rest of your long-term care home is not ready. If this is the case, you may need to implement changes in your own practice first. If you are successful in your efforts, you may inspire the rest of your team to make changes as well!

Ask: What can help us get there?

- Consider what would help you succeed in making positive changes, including resources or tools that already exist. (See **Resource 5** for examples)

Ask: What could block or hinder us?

- Inevitably, you will run into challenges when trying to change the way people work. Consider what barriers might come up and how you will mitigate these barriers. (See **Resource 6** for examples)

Ask: Who are our project stakeholders?

- In project management, a key area of focus is stakeholder management, which involves the identification of anyone who could be impacted by or have an impact on your project.
- Consider who your stakeholders are for this project and consider what engagement strategies would work best for each of them. (See **Resource 7** for examples)

STEP 5: PREPARE FOR THE CHANGE

What are we trying to accomplish?

Summarize your problem

- A problem statement clearly defines what is currently not working well and what the effect is on quality.
- **Example:** Staff in our long-term care home are frustrated when essential conversations occur without providing information about the prognosis. This leads to uninformed decision making.
- **Example:** We are not having essential conversations with residents and substitute decision makers early enough or often enough at our long-term care home. This is resulting in increased hospital transfers, and diagnostic tests or procedures that may not provide a benefit.

Develop an AIM STATEMENT

- An aim statement helps us understand what we are trying to accomplish by answering the "what," "by how much," and "by when." Aim statements should be SMART (Specific, Measurable, Actionable, Relevant and Timebound).
- **Example:** By April 2024, we aim to have had at least two in-depth essential conversations documented in 80% of residents' charts.
- **Example:** By March 2024, we aim to have had essential conversations with 60% of residents and substitute decision makers who have been transferred back from hospital or had a new treatment initiated.

How will we know it is an improvement?

It is important to determine what you are going to measure so that your team will know whether or not you have made an improvement after implementing changes.

QI is a flexible framework that enables you to select measures that make the most sense for your home. You can get really specific or keep things broad.

Usually, three types of measures are used in a QI project. The following are examples of these three types of measures — see **Resource 8a** for more.

Process measures

- By tracking process measures, we can ensure that we are doing the things that we want to be doing.
- **Example:** Percentage of residents and substitute decision makers who had a conversation about prognosis — an important component of essential conversations — with their care provider(s) following a transfer back from hospital or initiation of a new treatment (e.g., antibiotics, X-ray) within the past month.
- **Example:** Number of staff who have received training on essential conversations (e.g., using the Serious Illness Conversation Guide©).

Outcome measures

- Tracking outcome measures helps us to understand if the change is having the intended impact.
- **Example:** Percentage of residents, or their substitute decision makers, who state that discussions with a health care professional about their serious illness helped them to make treatment decisions.[2]

Balance measures

- Balance measures help us to determine if the change we've implemented has led to any unintended consequences — whether good or bad.
- **Example:** Number of staff, residents and substitute decision makers reporting increased levels of distress after having these conversations.

DATA COLLECTION

- It is possible that your long-term care home isn't currently capturing these types of measures, so careful thought will need to be put into deciding how these measures will be collected and by whom. (See **Resource 8b**)
- Be sure to track measures that will be most meaningful to your project and ensure that these measures are regularly monitored and acted upon.
- Consider measures that are already being collected and monitored for other purposes, ask if there is an opportunity to innovate these processes to meet the goals of this project and to eliminate the need for extra work.

What changes can we make?

It is important to acknowledge that macro- (policy, population and government changes to improve care) level changes are also required. While discussing these changes and how to advocate for them are largely beyond the scope of this project, some of the changes which policymakers and governments should consider to improve essential conversations with residents in long-term care would include:

- Improving funding to address long-standing staff shortages.
- Ensuring that all health workers in long-term care have mandatory training in the palliative care approach, including how to communicate with residents and their substitute decision makers about serious illness.
- Ensuring that essential conversations are included in systems-level assessments (e.g., RAI) and are documented well.

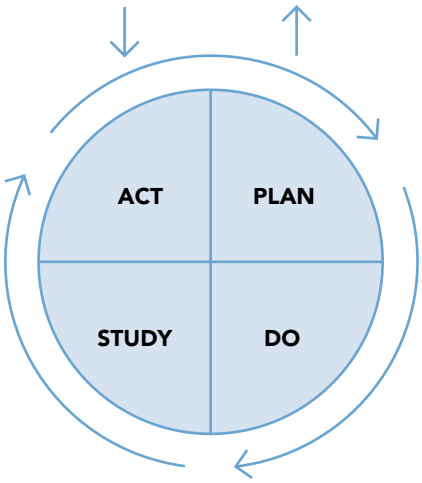
Below are some examples of change ideas focus on the micro- (improving health worker skills to improve care for individual patients) and meso- (improving care at the community and organization levels) level — see **Resource 9** for more.

Table 1: Examples of micro- and meso- level change ideas

Sample root causes	Sample change ideas
Lack of education on the palliative care approach	• Provide education and resources to residents and substitute decision makers regarding the palliative care approach and different aspects of essential conversations. • Implement mandatory training that covers essential conversations for appropriate staff.
Lack of interprofessional collaboration	• Hold interprofessional huddles following the death of a resident, in particular for difficult cases. Consider what went well and opportunities for improvement.
Not built into the current workflow or systems	• Schedule essential conversations as part of the intake process. Consider when it would be the right time for each individual and adjust as needed if things change in the meantime.

STEP 6: PLAN, DO, STUDY AND ACT

- A Plan-Do-Study-Act (PDSA) Cycle is a useful tool for documenting and testing out change ideas.
- Sometimes, more than one PDSA cycle is needed. Make small changes and tweaks after each cycle and test.



Working through the steps

(See **Resource 1** for a PDSA template and sample PDSA worksheets)

Stage	Steps to take *(modify to your practice realities and context)*
Plan	• Start by planning how to test a change. • Be sure to engage the whole team and involve them in the work.
Do	• Implement your plan and pilot the change. • Observe and keep notes. • Collect data — keep it simple, this is not research!
Study	• Analyze what happened when the change was implemented. • Compare the data to predictions. • Summarize what you learned. • Keep the whole team informed with periodic reporting of the results as they come in.
Act	• Determine whether this is a change worth maintaining or if modifications are needed (adopt, adapt or abandon). • If you decide to adapt, make a small tweak or a big change and repeat the PDSA cycle. • If you decide to abandon, do not proceed with implementing this change idea and keep in mind lessons learned. • If you decide to adopt, proceed to step 7.

TIPS

- Be sure to communicate the results of the PSDA cycle with the broader team and highlight any early wins!

STEP 7: CELEBRATE

- When an improvement has successfully been made, CELEBRATE!
- Find a fun way to announce the achievement and to celebrate it. Thank everyone who was involved and give yourself a pat on the back.

STEP 8: SUSTAIN

- Sustainability is achieved when new ways of working and improved outcomes become the norm ... and stay the norm!
- But we are only human and slippage can occur … so keep working at it.

Plan for sustainability from the offset.

- Strategies include forced functions for periodic monitoring and reporting of performance (e.g., periodic audit charts).

What will help for sustainability:

- Periodic reminders (email or mention at team meetings monthly or quarterly).
- Mentions at QI huddles.
- Periodic monitoring (quick audit or check sheet).
- Periodic reporting.

CELEBRATE the improvement's birthday every year!

SHARE YOUR STORY AND LEARNINGS WITH OTHERS

- The lessons we learn are important, whether one succeeds, fails, or continues to try.
- Share your QI work with Pallium! We're here to help you share your successes, by promoting your initiative on our national social media channels, featuring you in our newsletter, and exploring the option of hosting a national ECHO session for your project.
- Consider getting involved in one of the Palliative Care ECHO Project's Quality Improvement Communities of Practice!
- Contact **echo@pallium.ca** or visit **echopalliative.com** if this would be of interest to you.

HELP US IMPROVE THIS TOOLKIT

- As this is the first version of this QUIC, we would like your help by providing us with feedback.
- Your feedback will help us make practical adjustments to this toolkit to ensure it's meeting the needs of long-term care quality improvement champions like yourself.
- Please take a few minutes to complete our **short feedback survey**.

Resources

RESOURCE 1: TEMPLATES

Project charter/plan templates

- The **QUIC project charter/plan template** can initially be used to get leadership on board.
- Once the project has gotten started, this template can evolve into a detailed project plan, summarizing key decisions (e.g., AIM statement, measures identified).

Communication templates

- Communicating your quality improvement initiative is an important part in determining the success of your project.
- Access these **email templates** for customizable templates to help you spread the word about your quality improvement project.

PDSA worksheets

- A PDSA cycle is a useful tool for documenting and testing out change ideas.
- **Sample PDSA cycle worksheets.**
- **PDSA cycle template.**

RESOURCE 2: ESSENTIAL CONVERSATIONS RESOURCES

Sample templates to embed in charting system

- **Person-Centred Decision-Making: Documenting Goals of Care Discussions Ontario**

General Goals of Care discussion resources

- **Choosing Wisely, "Time to Talk"**
- **Ontario Palliative Care Network: Approaches to Goals of Care Discussions**

Serious Illness Conversation Guide and related programs

- **Ariadne Labs' Serious Illness Conversation Guide©**
- **Canadian Serious Illness Conversation (CSIC) training by Pallium Canada**. This course is designed to provide health care professionals with the tools and knowledge needed to effectively use the Serious Illness Conversations Guide© to have compassionate and effective conversations with patients and their families dealing with serious illnesses.

Screening tools to trigger essential conversations

Palliative Performance Scale (PPS)

- The Palliative Performance Scale (PPS) is a reliable and validated tool for assessing a resident's functional performance.
- It has been translated into as many as 17 languages.
- **See the Palliative Performance Scale (PPS)**

The Surprise Question

- The Surprise Question promotes the initiation of a palliative care approach earlier on.
- For any resident with a serious illness, ask, "would I be surprised if this resident died within the next 6–12 months?" If the answer to the question is "No," then a palliative care approach should be activated if it has not yet been activated.
- Not designed to be used as a prognostic tool.

Gold Standards Framework

- Practical guide for clinicians enabling earlier recognition of decline for residents considered to be in their final year/s of life, enabling better assessment of their needs and planning care in line with their needs and wishes.
- **See the Gold Standards Framework here.**

Supportive Palliative Care Indicators Tool (SPICT)

- The Supportive and Palliative Care Indicators Tool (SPICT) is derived from the Gold Standards Framework (GSF) prognostication tool (UK).
- Consists of a single page that includes general (i.e., weight loss, hospital admissions) and broad specific disease indicators (i.e., breathlessness at rest for heart and respiratory disease).
- Includes an assessment approach.
- Can be applied across all care settings.
- Not disease specific.
- **See the Supportive Palliative Care Indicators Tool (SPICT) here.**

Clinical Frailty Scale

- A 9-point scale that quantifies frailty based on function in individual patients.
- It is complemented by a visual chart to assist with the classification of frailty.
- Higher scores indicate increased frailty and associated risks.
- **See the Clinical Frailty Scale here.**

Prognostication tools

RESPECT: Risk Evaluation for Support: Predictions for Elder-life in the Community Tool

- A newly developed electronic prognostic algorithm.
- Currently in the process of research validation and community-based evaluation in Ontario.
- The aim is to improve identification of individuals who are frail (i.e., need long-term support) but are not necessarily in the last year of life.
- It uses a wider range of predictors — routinely collected in the home care setting — to determine the survival of low-risk and high-risk community-based individuals.
- It can be used to support clinical judgment and care planning.
- Since it uses data routinely collected in home care, it can be used to identify all individuals within home care populations who are at risk of clinical decline and may benefit from palliative care.
- It is a web-based tool that asks questions that can be readily self-reported by individuals.
- It can be used either by the patients themselves or supported by clinicians.
- **See Project Big Life Elder Care Calculator here.**

ePrognosis

- Offers a range of prognostic tools and calculators related to prognosis in elderly patients.
- A resource for health care professionals, particularly those caring for older adults, to assess and understand the likely outcomes and risks associated with various medical conditions and treatments in older patients.
- These tools help health care providers make more informed decisions about the care and treatment of elderly patients.
- These tools often take into account factors such as age, comorbidities, and functional status to estimate life expectancy and the potential benefits and risks of different interventions.
- **See ePrognostis tools and calculators here.**

RESOURCE 3: CONFIRMING THE NEED

Chart audit

- This strategy involves reviewing a sample of charts. A randomized sample will likely suffice as most residents in your home would likely benefit from a palliative care approach already. If you would like to look at a more targeted sample, you could search for residents who have had hospital transfers, a Palliative Performance Scale (PPS) completed in their chart, or consider reviewing a list of residents and asking yourself the surprise question. (See **Resource 2**)
- When reviewing these charts, check to see how often these conversations are happening or when. For example, if there was a transfer back from the hospital or a new treatment initiated (e.g., antibiotics, X-ray), did an essential conversation take place? It is recommended to check how many residents have had an essential conversation at least two times per year.
- In cases where you come across a goals of care conversation or advance care planning that has taken place, check to see if the conversation went beyond a DNR and DNH discussion. Were common future complications of the underlying disease discussed (e.g., falls, aspiration, infection)? Was a palliative care plan proposed? Was there a plan to treat the underlying disease or complication in the long-term care setting with the resources available?

Check sheet (prospective)

- Prepare a simple check sheet such as a paper-based, word document or excel document.
- For every resident with a serious or advanced illness that you see over the next one to two months — determine a time frame that is most realistic — add them to the list and complete the columns.
- Use the results to confirm or exclude an improvement opportunity.

Case reflections

- Reflect on a case, or multiple cases, of residents in your practice with a serious illness whose end-of-life care could have been better.
- Using a resident safety approach, review the cases and reflect if earlier, more frequent, or deeper goals of care discussions could have made a difference. Use these cases to inform the improvement opportunity.

Table 2: Sample check sheet

Chart #	Recent transfer back from hospital or new treatment?	Did a GOC conversation take place?	What was discussed as part of this conversation?
234532	Yes	Yes	DNR, DNH
324325	No	N/A	N/A
342132	Yes	No	N/A

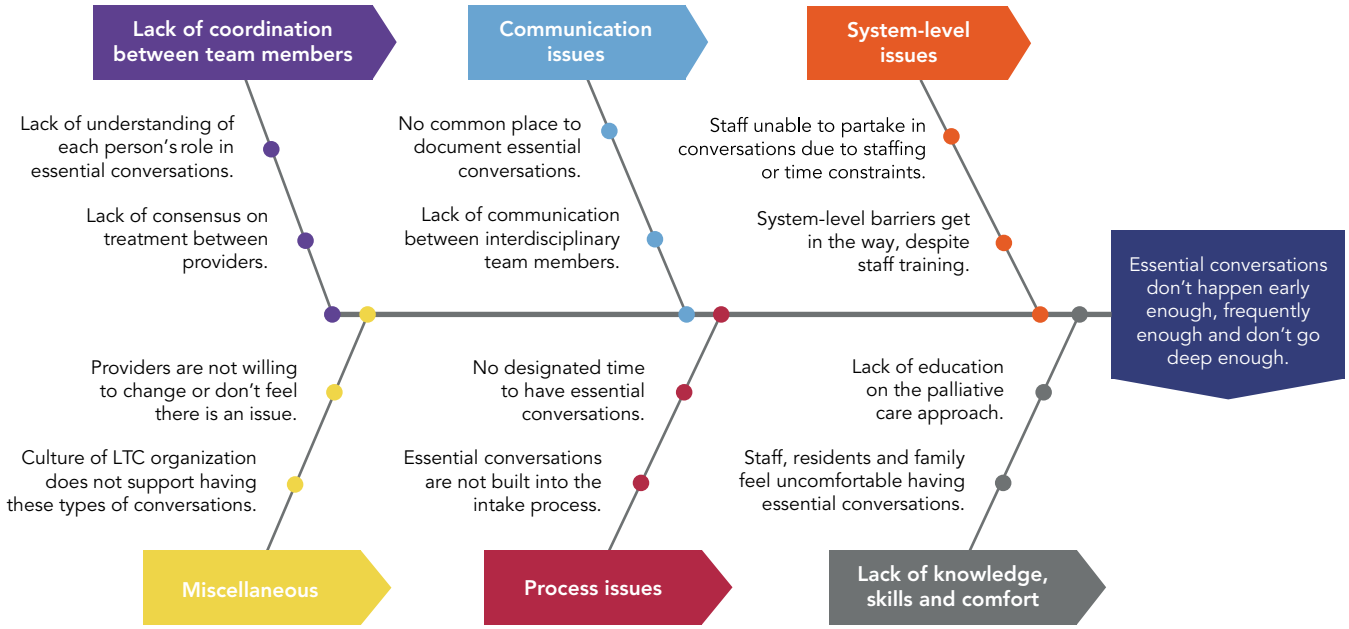
RESOURCE 4: ROOT CAUSE ANALYSIS

Fishbone (or Ishikawa) diagram

- A fishbone diagram is an organizational tool that helps teams to understand and display the many causes contributing to a certain issue.
- Below is an example of a fishbone diagram that is relevant to essential conversations communication.

FIGURE A: FISHBONE DIAGRAM

(CLICK TO ENLARGE FOR A MORE IN-DEPTH EXAMPLE)

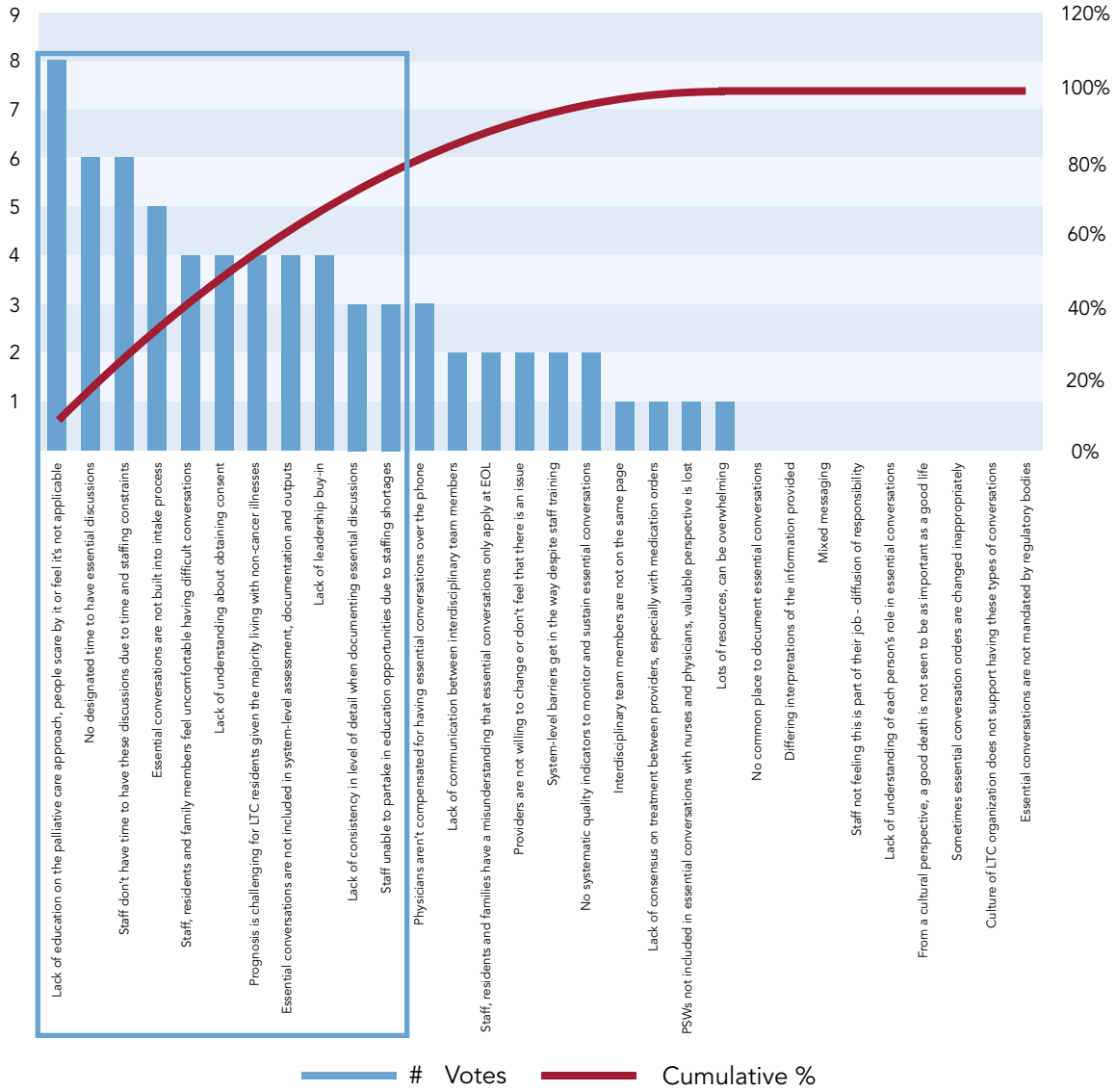


Pareto diagram

- A Pareto diagram is a type of bar graph that helps you prioritize root causes based on the perception that they have had the highest impact on the issue at hand.
- It encourages your team to focus on the "vital few," which have the largest contribution to the effect and therefore warrant the most attention, as opposed to the "useful many," which are still important but have a relatively smaller contribution to the effect.
- **Figure B** shows the results of a team voting exercise on priority root causes. Each team member was given a set number of stickers with different values (e.g., green = 3 points, yellow = 2 points, red = 1 point). Once everyone had placed their votes, the scores were tallied, and the following Pareto diagram was created.

FIGURE B: ROOT CAUSE VOTING EXERCISE AND PARETO DIAGRAM

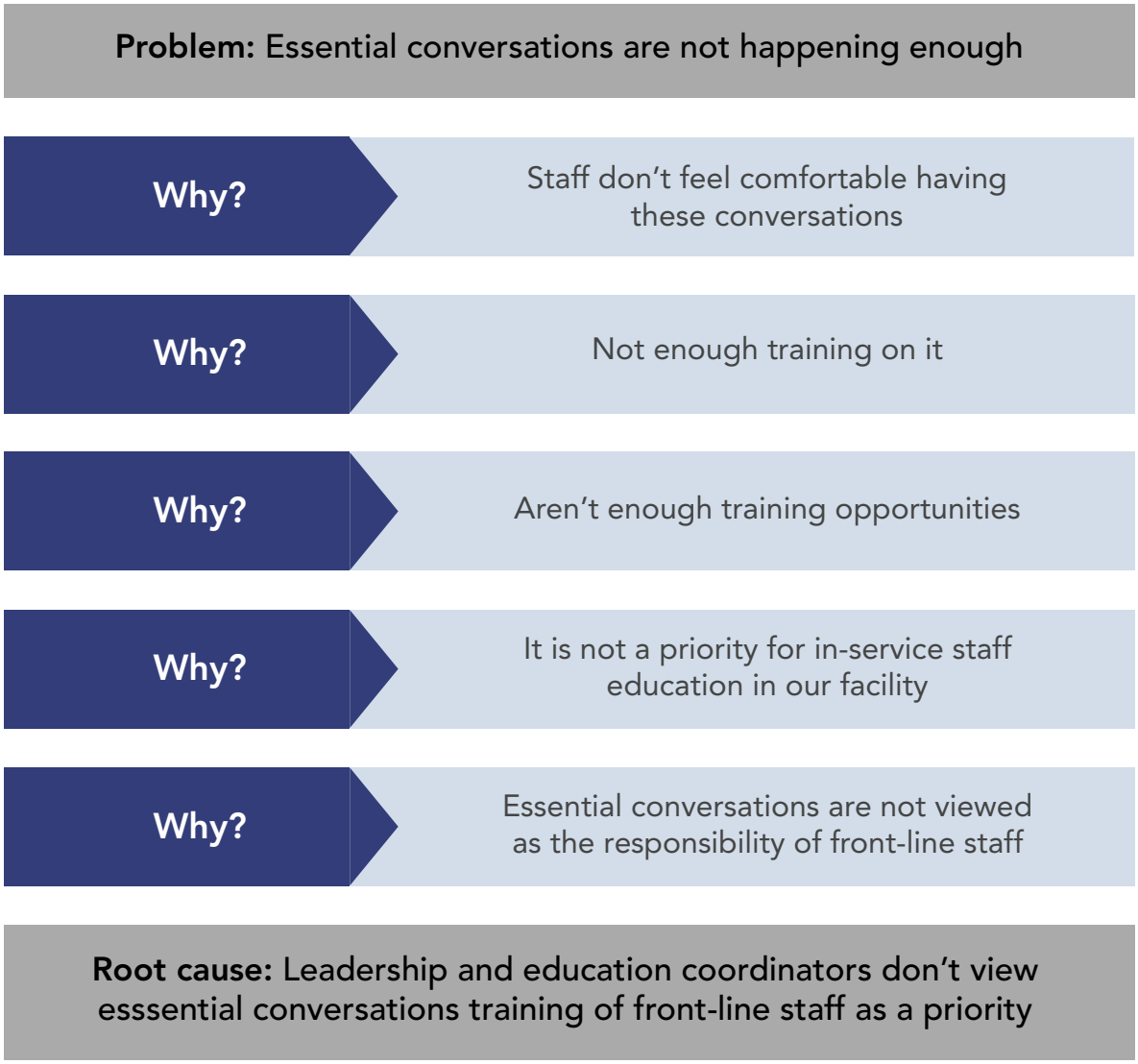
(CLICK TO ENLARGE)



The five whys

- The five whys is a brainstorming method where the team repeatedly asks the question "Why" until the root cause of a problem is identified.
- **Figure C** shows an example of the five whys in action.

FIGURE C: EXAMPLE OF THE FIVE WHYS



Process mapping

- A process map is a visual representation of the steps in a given process. According to IHI, "understanding the process as it currently operates is an important step in developing ideas about how to improve it."
- By working with your team to map out a process in detail, you may be surprised at what you learn. You may uncover assumptions you held about the process that are incorrect, root causes you hadn't thought of and much more.

FIGURE D: A CURRENT STATE PROCESS MAP

This is a **current state** process map that was created before making any quality improvement changes. After creating this map, the team identified that a more inter-professional approach was needed. They also determined that waiting six weeks to have a care conference was too long for some residents.

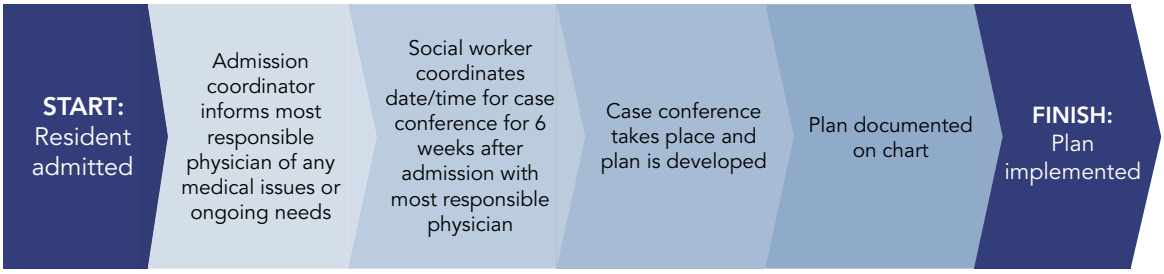
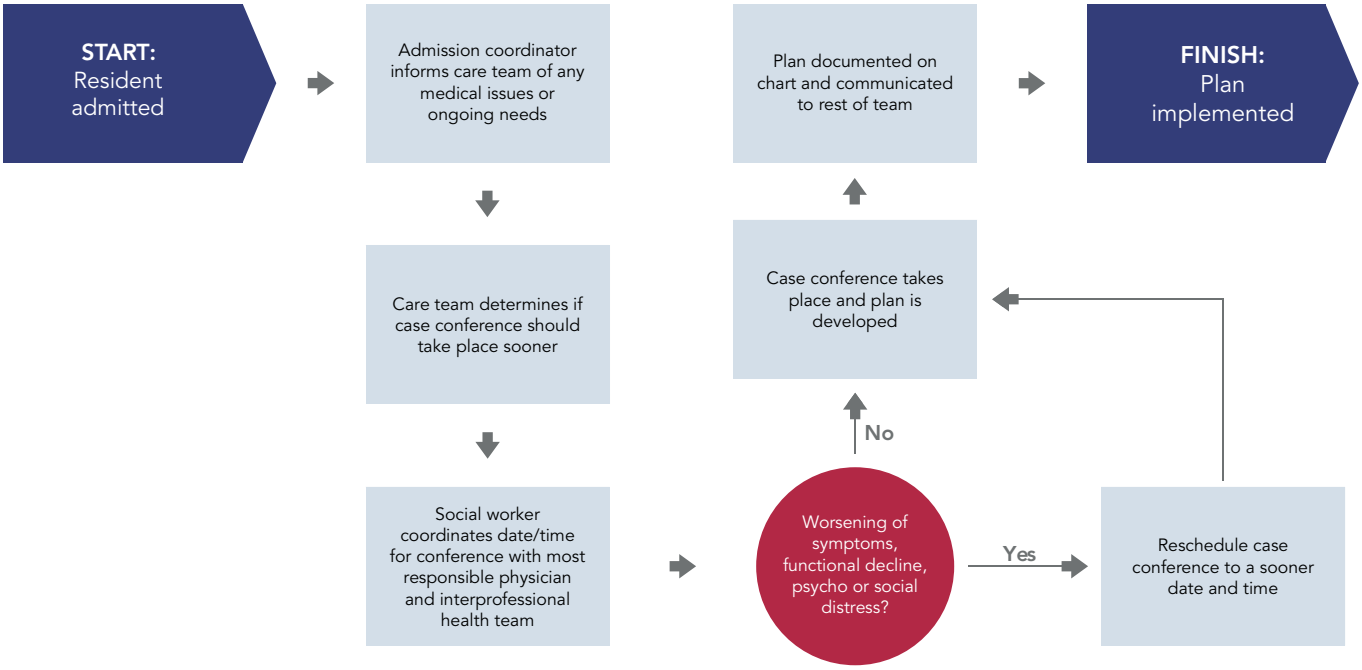


FIGURE E: A FUTURE STATE PROCESS MAP

Working together, the project team developed a **future state** process map that they felt would address the issues identified in the current process. Their first PDSA cycle focused on implementing this new process.



RESOURCE 5: REFLECTING ON FACILITATORS

When engaging with Pallium Canada's Long-Term Care Quality Improvement Community of Practice, members proposed great ideas for facilitators which are described below.

- Build changes into already well-established processes such as making essential conversations part of care conferences or part of the intake process.
- If your home is in Ontario, emphasize the alignment of your QI project with the **Fixing Long-Term Care Homes Act**, which states that every long-term care resident in Ontario should have a right to receive palliative care. As part of integrating a palliative approach to care for long-term care residents, it would be important to improve the quality of essential conversations.
- Provide general education for residents, families, and staff about the palliative care approach.
- Identify champions who can mentor others on essential conversations.
- Empower staff to be part of essential conversations — this includes PSWs!
- Leverage the bonds that staff already have with residents and their loved ones.
- Make use of existing resources – there is already a lot of great stuff out there! (See **quality improvement resources**)
- Ensure you have leadership support.
- Access funding for healthcare providers to receive education, both for the education itself and the coverage to allow staff to attend this training.
- Keep processes and changes as simple as possible.
- Consistency — keep talking about it, keep providing education, don't give up!
- Share success stories.
- Consider using a variety of communication channels to get the message out, including social media.
- Senior management should work with staff and physicians to find ways to make time for nurses and PSWs to participate in care conferences.
- When discussing serious illness with residents and their substitute decision makers, include information about the specific disease trajectory for their condition, as this often helps them to understand what to expect.
- Foster a team culture that views a palliative care approach, including having essential conversations, as everyone's responsibility. This will help with buy-in when trying to implement change ideas.
- Spend focused time discussing the staff members' individual barriers to implementing changes. Often an individual barrier could be grief as care providers can become very close to residents.
- Foster palliative care champions or committees in your home, whose mandate is to look for palliative care improvement opportunities in the home.
- Use education supports that are available in the home to simplify training (electronic learning platforms, adding to annual education plans, incorporate into orientation).

RESOURCE 6: ANTICIPATED BARRIERS

When engaging with Pallium Canada's Long-Term Care Quality Improvement Community of Practice, members proposed several examples of challenges and how you could deal with them, which are described below:

Concerns that having these types of conversations will cause distress for residents and their substitute decision makers.

- Research has shown that essential conversations are associated with improved end-of-life care for patients as well as reduced stress, depression, and anxiety for their surviving loved ones.[3,4]
- This research could be shared with front-line staff and senior leadership, along with more training in serious illness communication.
- You could also be prepared for the possibility of increased distress for residents and have resources available for staff, residents, and substitute decision makers.

Concerns that there is not enough time to have these conversations.

- Strategies can be used to build these new activities into existing daily workflows (e.g., update assessment templates in the electronic health records).
- Consider broadening the mandate of an existing team (e.g., wound care management team) to include the championing of the palliative care approach.

Lack of ownership around the palliative care approach and concerns around the scope of practice.

- Providing high-quality palliative care is everyone's business, not just the responsibility of a small number of palliative care specialist physicians and nurses.
- Every long-term care home has the potential to become a champion of the palliative care approach.
- Each member of the team has an important role to play, whether it's observing and reporting signs of pain, anxiety and decline, completing functional assessments, communicating directly with residents and substitute decision makers regarding their serious illness or addressing specific concerns in the psychosocial, emotional and spiritual realm — the list goes on.
- Excellence in the palliative care approach requires collaborative decision making between all members of the care team. There is a lot that each person can contribute, while staying within their scope of practice.
- It is important for all members of the team to feel empowered, included, while at the same time, understanding their limitations. A key facilitator for this is breaking down professional hierarchies so that team members can feel comfortable communicating openly with one another.

TIPS

- A palliative care approach involves working as a team!
- The **Taking Ownership: Online Module** provides an introductory overview of the palliative care approach and how health care professionals across disciplines can make primary-level palliative care a part of their daily work.

RESOURCE 7: ENGAGING STAKEHOLDERS

- Consider who your stakeholders are for this project and consider what engagement strategies would work best for each of them.
- Also consider what, if anything, you will be asking them to do differently and what barriers they might have in making such changes. (See **Resource 6**)

Table 3: Examples of engagement strategies for stakeholders

Stakeholders	Sample engagement strategies *(modify to your practice realities and context)*
Residents and their substitute decision makers	• Provide updates about your quality improvement initiative at the resident or family council meetings and ask for input.
Leadership/admin	• Ensure they have signed off on a project charter. • Ask for their commitment to help break down any obstacles that arise. • Ask if they would like to be part of the project team or if they would prefer to be kept informed on a regular basis.
Frontline staff (e.g., MDs, NPs, RNs, RPNs, PSWs, SW, OT, RD, PT, volunteers, kitchen staff, cleaning staff)	• Consider whose work will be impacted by this project and ask representatives from multiple disciplines to be involved as team members. • Provide updates and encouragement and solicit feedback during team meetings.
Palliative care committee (note: could include a blend of the categories listed above)	• If your home already has a palliative care committee, it might make sense for them to be the project team for this QI project.

RESOURCE 8A: MEASURES TO TRACK CHANGE

Measures

The following are provided as examples only. It is important to identify measures that will best suit your practice or long-term care home.

Process measures

- Percentage of residents with up-to-date advance care plans who have documented them in their medical record within the last 6 months.[2]
- Average number of essential conversations taking place per resident per year.
- Percentage of residents who have had at least one essential conversation involving more than simply DNR and DNH (e.g., plan for future infections, falls, aspirations) in the past year.

Balance measures

- Number of workload complaints.
- Number of complaints about staff working out of their scope of practice in relation to this project.

Outcome measures

- Percentage of residents (or their substitute decision makers) who reported that essential conversations with a health care professional happened at the right time.[2]
- Number of individuals who received end-of-life care in long-term care rather than in hospital.
- Percentage of staff reporting to feel somewhat comfortable or very comfortable in having conversations with residents and their families about end-of-life decision-making and other care decisions.

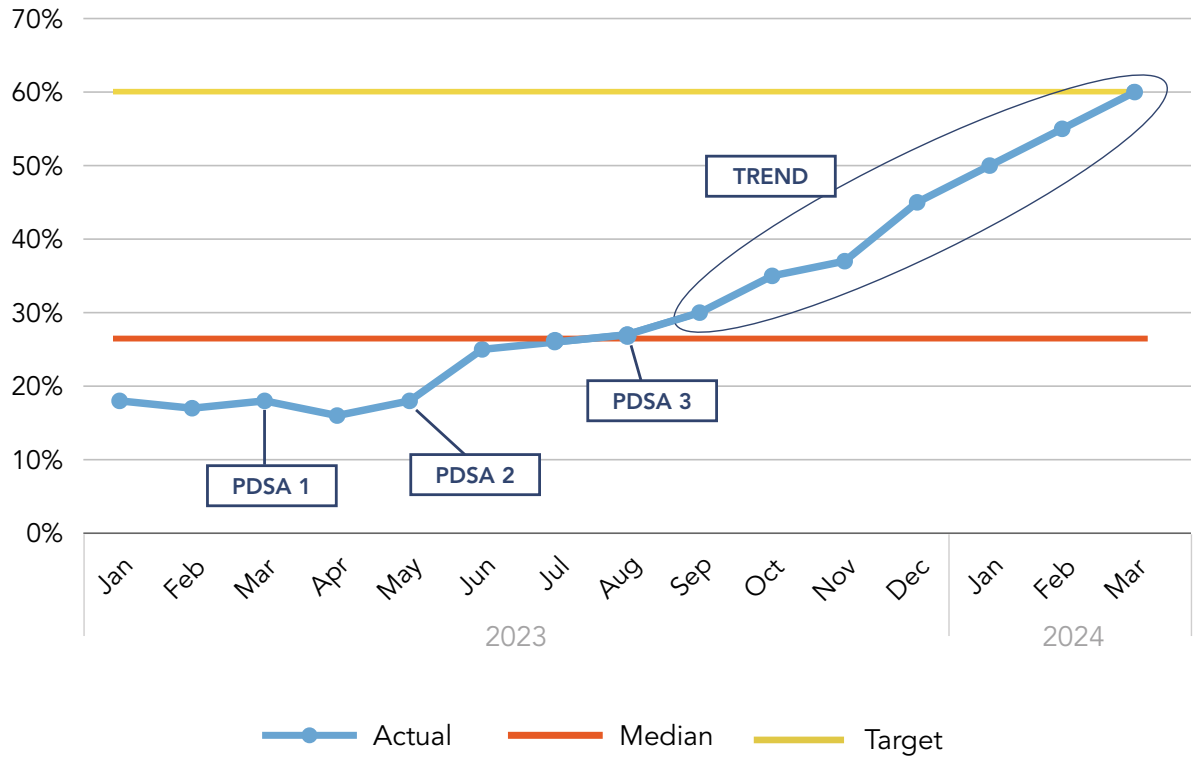
RESOURCE 8B: HOW WILL WE COLLECT AND REPORT THE DATA?

Run chart

- A run chart is simply a graph of data over time. By annotating this graph with information about when change ideas were implemented, this tool can help you to determine whether your change ideas are working or not.
- There are four simple rules to help you determine if you are making a real change, for more information, refer to this **Run Chart Rules Reference video**.

FIGURE J: SAMPLE RUN CHART

Percentage of residents and substitute decision makers who have had an essential conversation prior to transfer to hospital or initiation of new treatment within the past month.



RESOURCE 9: SAMPLE CHANGE IDEAS

When engaging with Pallium Canada's Long-Term Care Quality Improvement Community of Practice, members proposed several examples of change ideas, which are described below:

Table 4: Examples of change ideas

Sample root causes	Sample change ideas

Lack of education on the palliative care approach (leading to lack of skills and knowledge around serious illness communication)	• Implement mandatory training that covers essential conversations for appropriate staff (consider training for all new staff vs. regular refreshers for existing staff):
	  • **Learning Essential Approaches to Palliative Care (LEAP™) Long-Term Care** training from Pallium Canada.
	  • Training on how to use the **Serious Illness Conversation Guide.**
	• Foster mentorship and opportunities for staff to practise what they've learned:
	  • Tap into the support and wisdom of palliative care consultants. Seek out mentorship opportunities from palliative care specialist teams in your local area whose role is to help build capacity in the region.
	  • Have a community of practice or palliative champion team at the care home level or regional level to sustain educational efforts.
	• Provide education and resources to residents and substitute decision makers regarding essential conversations.
	  • Provide resources, such as brochures, at resident admission. This will help them to avoid feeling overwhelmed with information and will prime them for these types of conversations. Consider including this information as part of a pre-admission package.
	  • Provide education at the family/resident council.
	• Make tools and resources readily available for staff.
	  • Put up posters in the staff room with key information.
	  • Provide laminated copies of the Serious Illness Conversation Guide to support these conversations.

Lack of time	• Review daily routines to determine how daily time is being utilized and if there are opportunities to adjust how much time is spent on certain activities. • Ask for support in how to have these conversations from palliative care nursing consultants if this is an available resource.

Sample root causes	Sample change ideas
Lack of interprofessional collaboration	• Hold staff pre-briefs and debriefs around care conferences including all levels of staff in these conversations. • Hold interprofessional huddles following the death of a resident, in particular for difficult cases. Consider what went well and opportunities for improvement. • Invite essential substitute decision makers to care conferences. • Enact policies and procedures that help to break down hierarchies between professions. • Develop a standardized way for PSWs or care aides to document what they've learned regarding resident's values and wishes. • Clarify the roles and responsibilities of each team member.
Not built into the current workflow or systems	• Ensure essential conversations are scheduled at a minimum twice a year, but also with any change in status, and prior to and before hospital transfer or an initiation of a new treatment, and at end-of-life. • Schedule essential conversations as part of the intake process, considering when would be the right time for each individual and adjust as needed if things change in the meantime. • Think of ways to incorporate essential conversations more informally or on the fly. It doesn't have to be all or nothing! • Create and implement a "template" in the residents' chart to help guide these conversations. • Find ways to integrate essential conversations within other chronic disease conversations. • Build in alerts through the electronic medical record, especially for NPs or MDs to lead these discussions at the ideal times.
Challenges with prognosis	• Consider using a validated prognostic tool, such as the RESPECT Tool described in **Resource 2,** for each resident prior to formal care conferences. • Implement policies and procedures that address prognostic uncertainty, in particular for those with non-cancer illnesses. • Consider common causes of decline in long-term care residents (e.g., aspiration, infection, falls) and develop a prospective plan for each resident that would be in line with their wishes.

RELEVANT RESEARCH ARTICLES

- Beddard-Huber, E., Gaspard, G., Yue, K. Adaptations to the Serious Illness Conversation Guide to be more Culturally Safe. International Journal of Indigenous Health. Volume 16, Issue 1, 2021.
- Beddard-Huber, E., Strachan, P., Brown, S., Kennedy, V., Marles, M., Park, S, Roberts, D. Supporting Interprofessional Engagement in Serious Illness Conversations. JHPN. Volume 23, Number 1, Feb. 2021.

GENERAL QUALITY IMPROVEMENT RESOURCES

- HQO Quality Improvement
- Quality Improvement Plan Guidance
- IHI QI Essentials Toolkit
- TOP Alberta Quality Improvement Guide
- Engaging People in Quality — EPIQ

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FUNDING

Health Canada Santé Canada

Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.