SPA-LTC

Phase 2

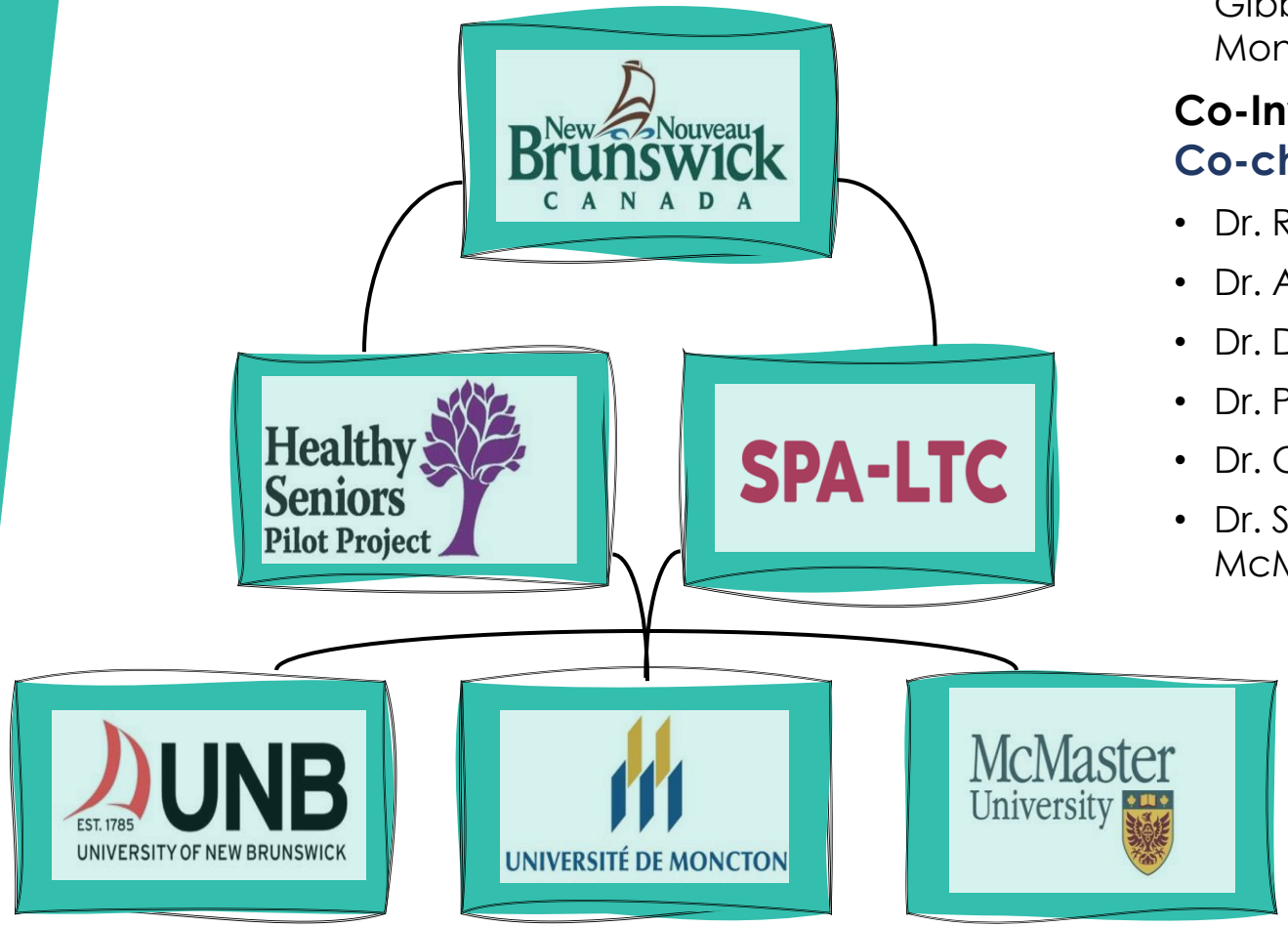
Strengthening a Palliative Approach to Care

In New Brunswick's Long-Term Care

Renforcer l'approche palliative

Dans les soins de longue durée au Nouveau-Brunswick

Project Partners
Équipe du projet



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Land Acknowledgement
Reconnaissance des terres

- We respectfully recognize that this project takes place on the unceded territory of the Wolastoqiyik, Mi’kmaq & Peskotomuhkati peoples
- Nous reconnaissons respectueusement que ce projet se déroule sur le territoire non cédé des peuples Wolstoqiyik, Mi’kmaq et Peskotomuhkati.

SPA-LTC

Strengthening a Palliative Approach in Long-Term Care

Agenda

- Palliative Care vs Long-Term Care
- Evidence for the SPA-LTC program
- SPA-LTC Palliative Approach to Care
- Implementation of SPA-LTC in NB LTC
- Lessons learned
- Future Plans

Plan de la présentation

- Les soins palliatifs vs soins de longue durée
- Preuves à l'appui du programme de SPA-LTC
- L'approche palliative de SPA-LTC
- La mise en oeuvre de SPA-LTC au N.-B.
- Lecons apprises
- Projets futurs

Palliative Care
vs
Long-Term Care

Les soins palliatifs
vs
soins de longue durée

Does Palliative Care have a place in long term care?

Les soins palliatifs ont-ils leur place dans les soins de longue durée?

Myths about Palliative Care

1. Palliative care is only for people who are actively dying
2. Palliative care is only provided in a hospital
3. Palliative care means my doctor has given up and there is no hope for me
4. Palliative care hastens death

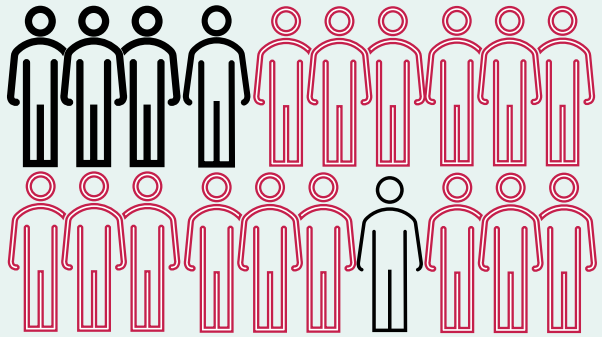
Mythes entourant les soins palliatifs

1. Les soins palliatifs sont réservés aux personnes en fin de vie
2. On peut seulement recevoir des soins palliatifs à l'hôpital
3. Les soins palliatifs son un aveu d'abandon de la part des médecins, ils sont le signe que tout espoir est perdu
4. Les soins palliatifs accélèrent la mort

Canadian Long-Term Care Statistics (2021-22)

Average resident length of stay
18 months – 2 years

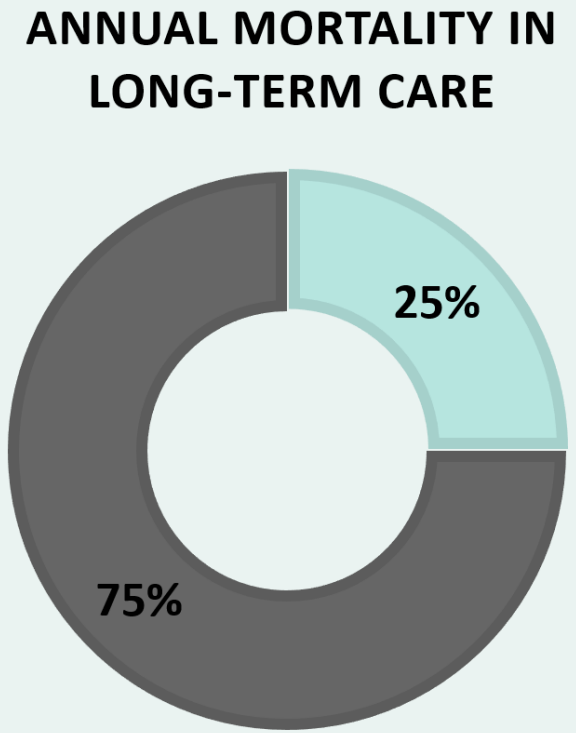
More complex, multiple comorbidities
at admission



19% of residents received
palliative care in
their last year of life

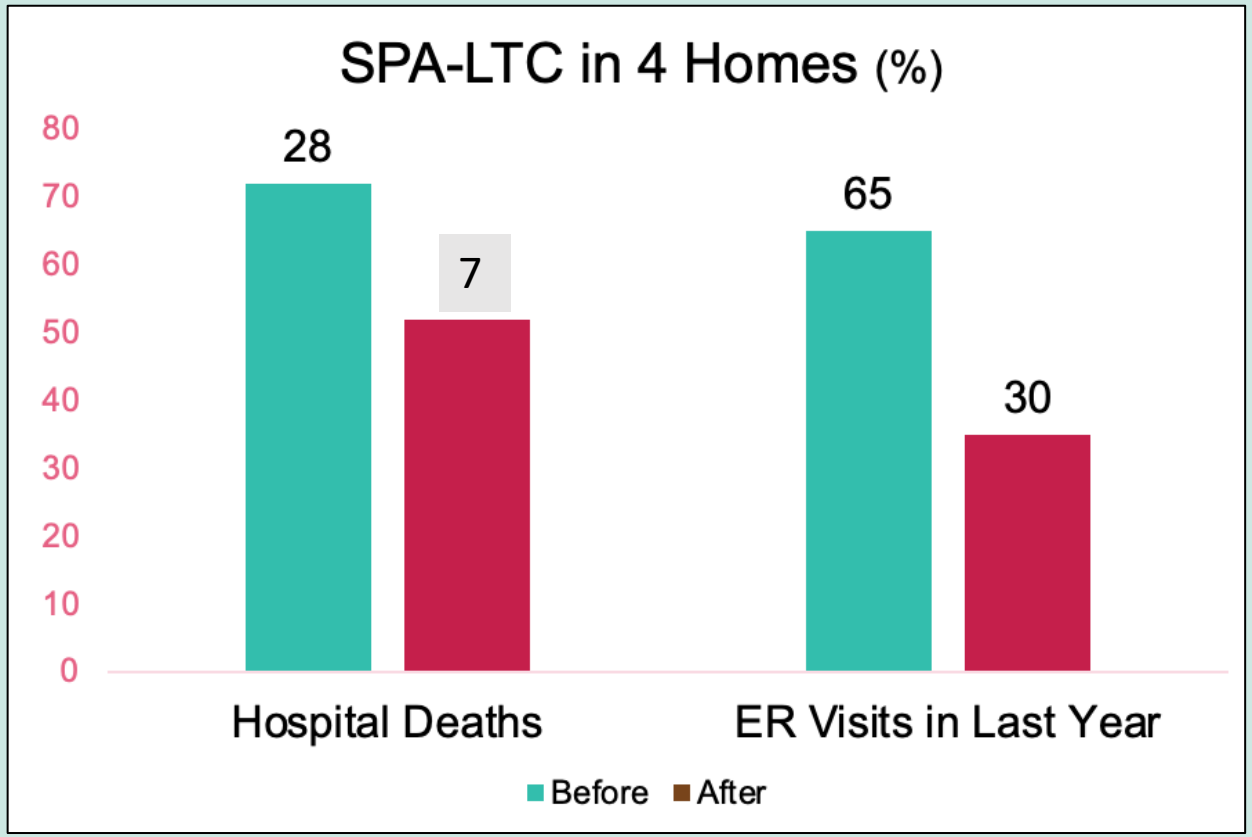
28% of residents transferred to hospital for palliative care

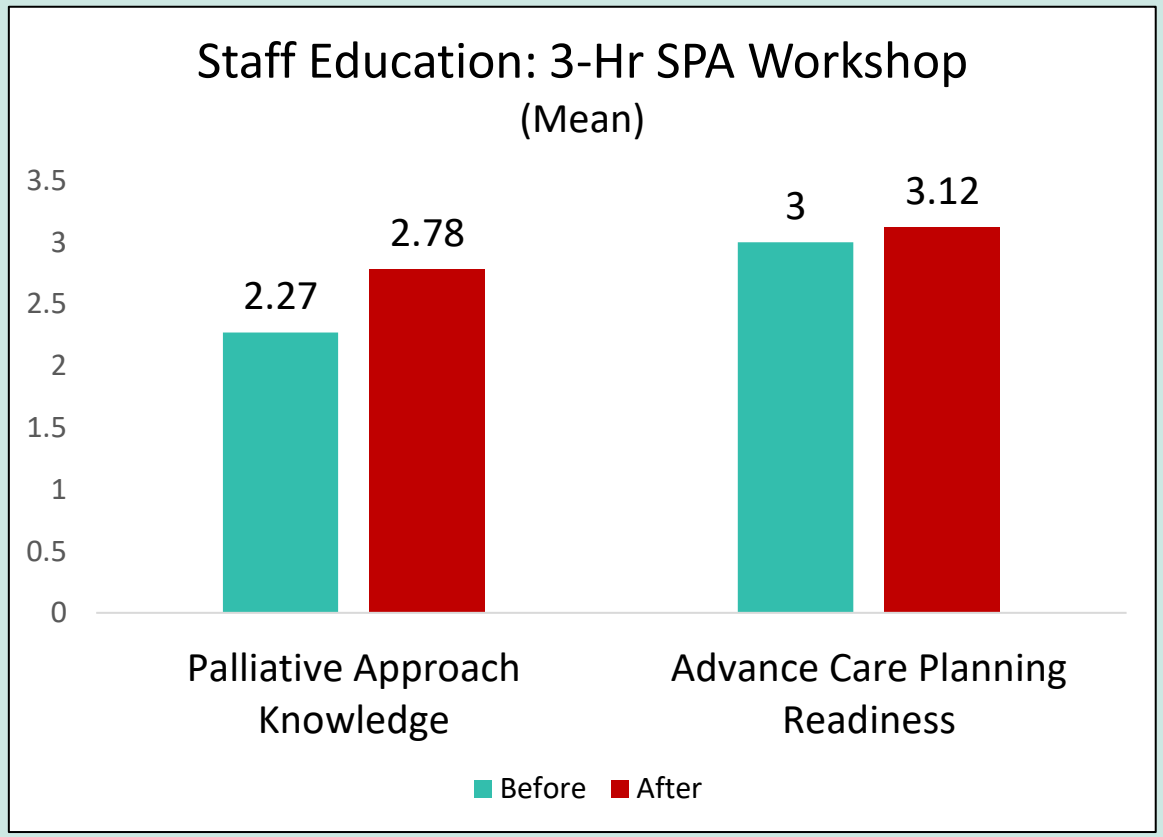
53% LTC staff felt confident to deliver a palliative approach



(CIHI, 2023)

Previous Evidence for SPA-LTC





- 72% Reduction in Hospital Deaths
- 54% Reduction in Hospital Transfers

- Increased Knowledge
- Increased Advance Care Planning Readiness

(Kaasalainen et al., 2020; Velani et al., 2023)

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Strengthening a Palliative Approach to Care

Created at McMaster University

- Palliative program & toolkit
- Consistent process, sample policies
- Standardized assessment & communication tools

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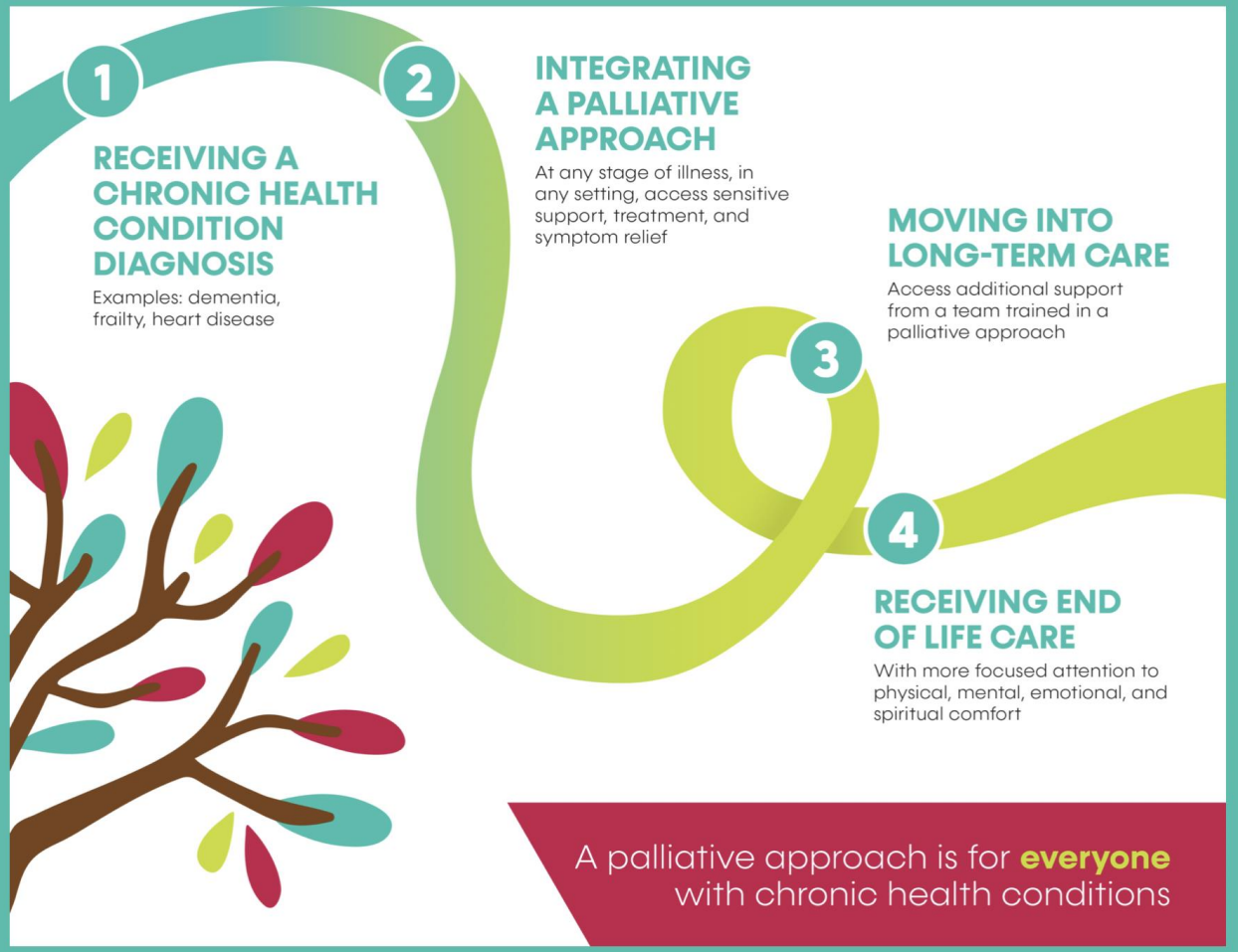
Renforcer l'approche palliative des soins

Établi à l'Université McMaster

- Programme et trousse à outils de soins palliatifs
- Procéssus cohérent, exemples de politiques
- Évaluations normalisées et outils de communication



SPA-LTC Teaches a Palliative Approach

A Palliative Approach:

Is for residents in long term care (LTC) with **progressive conditions** that have **no cure**

Shifts focus from prolonging life to **maintaining quality of life**

Is an **active approach** that can start at **any stage of chronic illness**

Is part of **usual care**

Does not require a referral

SPA-LTC enseigne l'approche paliative

Est destiné aux résidents en soins de longue durée (SLD) **souffrant de maladies progressives sans guérison**

Redirige l'attention de la prolongation de la vie à la **préservation de la qualité de vie**

C'est **une approche active** qui peut commencer à **n'importe quel stage** de la maladie chronique

Fait partie des soins habituels et ne nécessite pas de référence

SPA Model: Core Components

- Palliative Champion Team
- Functional Status Assessment
- Palliative Care Conferences
- Bereavement Care
- Comfort Care Rounds
- Education
- Illness Trajectory Information

Modèle SPA

- L'équipe championne des soins palliatifs
- L'évaluation des
- Conférences en soins palliatifs
- Soins de deuils
- Rondes palliatives
- Éducation
- Trajectoires des maladies

SPA-LTC

Phase 1: Understanding the Concepts

- Environmental scan & situational analysis of palliative programs in New Brunswick long-term care homes
- Education to build capacity within LTC homes to enhance or implement a formal palliative program
- Began building relationship with Bilijk (Kingsclear) First Nation and identified interest in palliative care

SPA-LTC e-Learning Modules

Modules d'apprentissage en ligne SPA-LTC

Palliative approach	Approche palliative
Communication	Communication
Advance Care Planning	Planification préalable des soins
Recognizing Changes	Reconnaître les changements
Recognizing Pain	Reconnaître la douleur
Quality of Life	Qualité de vie
End-of-Life Care	Soins de fin de vie
Loss & Grief	Perte et deuil

Your homes logo

Interprofessional Palliative Care Champion Team

Terms of Reference

Purpose

The interprofessional palliative champion team (PCT) is a key element necessary for the successful delivery of palliative care. A multi-disciplinary team made team of staff, and volunteers, whose members are passionate about delivering a palliative approach; motivated to participate in a change initiative and willing to act as leaders in the home to help guide implementation. The team meets on a regular basis to facilitate collaborative palliative care for all residents through continuous recognition and improvement. Members of this team are critical to providing a localized, comprehensive perspective that will make the program feasible, relevant, and sustainable.

Responsibilities

- Attend monthly meetings, plan for implementation of elements of a pallliative program and report on progress/issue/changes required
- Attend training sessions as needed to learn more about each component of the palliative program
- Help organize elements of a palliative approach i.e. Palliative Performance Scale, Comfort Care Rounds, Palliative Care Conferences and Post bereavement follow up
- Consider how to best incorporate the implementation process of a palliative approach considering the organizational context of the specific site
- Identify anticipated barriers and facilitators that will impact the implementation process of the palliative approach to care
- Disseminate important information regarding palliative care to the appropriate departments within the home
- Offer ad-hoc consultation with other staff seeking information and support with implementation of the program
- Promote palliative care within the home through activities associated with the implementation of a palliative approach to care that emphasizes evidence-based practice, quality of care, resident safety and practice enhancement
- Enhance collaboration within and between disciplines with regards to palliative care

Palliative Champion Team

- Multidisciplinary team members
- Implement a Palliative Approach to Care

Palliative Champion Team
Meeting Agenda & Minutes Template

Date:
Attendees:
Regrets / unable to attend:

Note to facilitator: Since it will likely not be possible to review every item at every meeting, agenda items are listed in priority order, and you can make choices about which items to highlight on any given day. The second section is marked in grey because as these items are completed/or in progress, there are fewer of them to review with the team, and once they are all completed, it is no longer necessary to review them.

Discussion Item	Action Items
1. Reminder of our goal: *"As a reminder, the purpose of our work together is to strengthen a palliative approach in long-term care. As we do this, #_____ residents and families are helping us to evaluate the changes that we are making. One of our goals is to make sure we are paying special attention to communicating with and supporting these residents through their changes in health, and of course, we also include other residents and families in need of this support."*	
2. Initiation Activities (to be completed upon creation of a PCT) a. Complete PPS training b. Implement PPS process (ongoing, quarterly) c. Complete first PPS for all residents in home d. Invite staff to the palliative approach champion team e. Make staff aware who is on the palliative approach champion team f. Participate in a training workshop (if available) g. Encourage staff to participate in educational self-study modules	
3. Palliative performance scale (PPS) a. New PPS% scores completed on admission b. Updated quarterly PPS%	
4. Palliative Care Conferences (PCC)	

Équipe championne de l'approche palliative

Mandat

Août 2022

Objectif

L'équipe championne de l'approche palliative (ÉCAP) est un élément nécessaire à la réussite de la prestation de soins palliatifs. Cette équipe pluridisciplinaire est composée de membres du personnel qui se passionnent pour l'approche palliative, ont envie de participer à une initiative locale de changement et souhaitent agir en tant que leaders dans l'établissement pour aider à sa mise en œuvre. L'équipe se réunit régulièrement pour faciliter la collaboration en matière de soins palliatifs pour l'ensemble des résident(e)s par l'entremise d'une reconnaissance et d'une amélioration continues. L'ÉCAP fait également le lien entre l'établissement et l'équipe de recherche en aidant à cerner et à résoudre les problèmes liés à la mise en œuvre du programme. Les membres de cette équipe apportent une perspective locale et globale qui rend le programme réalisable, pertinent et durable.

Responsabilités

- Prendre part à des réunions mensuelles pour examiner le programme de recherche, planifier sa mise en œuvre et rendre compte des progrès, des enjeux et des changements nécessaires.
- Participer à des formations, au besoin, pour approfondir les différents éléments du programme palliatif.
- Aider à organiser les éléments d'intervention de l'étude, c'est-à-dire l'échelle de performance pour les soins palliatifs, les tournées de soins de confort, les conférences pour les familles et le suivi après le deuil.
- Réfléchir à la meilleure façon d'intégrer le processus de mise en œuvre d'une approche palliative en tenant compte du contexte organisationnel de l'établissement.
- Déterminer les obstacles et les catalyseurs potentiels qui pourraient avoir une incidence sur le processus de mise en œuvre de l'approche palliative des soins.
- Diffuser les renseignements importants concernant les soins palliatifs aux services concernés de l'établissement.
- Offrir de la consultation ponctuelle à d'autres membres du personnel à la recherche de renseignements et de soutien relativement à la mise en œuvre du programme.
- Promouvoir les soins palliatifs au sein de l'établissement par des activités liées à la mise en œuvre d'une approche palliative des soins qui met l'accent sur les pratiques fondées sur des données probantes, la qualité des soins, la sécurité des résident(e)s et l'amélioration des pratiques.
- Renforcer la collaboration au sein des disciplines et entre elles en ce qui concerne les soins palliatifs.

SPA-LTC
Renforcer une approche palliative dans les soins de longue durée

Ordre du jour des réunions de
l'équipe championne de l'approche palliative
(insérer la date et l'heure)
(insérer le lieu)

Profession des personnes participantes de [nom de l'établissement de SLD] :
Participants de l'équipe de recherche de SPA-LTC :
En attente d'une réponse :
Absences justifiées :

[Nome de l'établissement de SLD] – Mises à jour en matière de soins palliatifs

1. **Cas de soins palliatifs :**
   a. Décès :
   b. Cas actifs :
   c. Sur le radar :

2. **Échelle de performance pour les soins palliatifs**
   a. Nouveau pointage de performance pour les soins palliatifs à l'admission :
   b. Mise à jour trimestrielle de la performance pour les soins palliatifs :

3. **Conférences sur les soins palliatifs**
   a. Conférences récentes sur les soins palliatifs
   b. Conférences prévues sur les soins palliatifs

4. **Tournées des soins de confort**
   a. Tournées récentes des soins de confort
   b. Tournées prévues des soins de confort

5. **Dépliants sur la trajectoire de la maladie**

6. **Suivi après le deuil**
   a. Familles récemment endeuillées ayant reçu un suivi
   b. Familles endeuillées nécessitant un suivi

7. **Suivi général**
   a. Nouvelles initiatives de l'établissement en matière de soins palliatifs
      i. Quels sont les enjeux?
      ii. Quelles sont les politiques favorables?
   b. Formation et éducation du personnel

Functional Status Assessment: Palliative Performance Scale v.2

Évaluation de l'état fonctionnel: Echelle de performance Palliative v.2

VICTORIA HOSPICE

PPS Level	Ambulation	Activity Level & Evidence of Disease	Self-care	Intake	Conscious level
PPS 100%	Full	Normal activity & work **No evidence** of disease	Full	Normal	Full
PPS 90%	Full	Normal activity & work **Some evidence** of disease	Full	Normal	Full
PPS 80%	Full	Normal activity & work *with* effort Some evidence of disease	Full	Normal or reduced	Full
PPS 70%	Reduced	Unable normal activity & work **Significant** disease	Full	Normal or reduced	Full
PPS 60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance	Normal or reduced	Full or confusion
PPS 50%	Mainly sit/lie	Unable to do any work **Extensive** disease	Considerable assistance	Normal or reduced	Full or drowsy or confusion
PPS 40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
PPS 30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or Reduced	Full or drowsy +/- confusion
PPS 20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal sips	Full or drowsy +/- confusion
PPS 10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Drowsy or coma
PPS 0%	Dead	-	-	-	-

Instructions: PPS level is determined by reading left to right to find a 'best horizontal fit.' Begin at left column reading downwards until current ambulation is determined, then, read across to next and downwards until each column is determined. Thus, 'leftward' columns take precedence over 'rightward' columns. Also, see 'definitions of terms' below.

Niveau perfor mance	Mobilité	Activité et intensité de la maladie	Autonomie pour les soins personnels	Alimentation	Niveau de conscience
100 %	Complète	Activité et travail : normaux *Aucune manifestation de maladie*	Autonome	Normale	Normal
90 %	Complète	Activité et travail : normaux *Certains signes de maladie*	Autonome	Normale	Normal
80 %	Complète	Activité normale avec effort *Certains signes de maladie*	Autonome	Normale	Normal
70 %	Réduite	Incapable de travailler normalement *Maladie évidente*	Autonome	Normale ou diminuée	Normal
60 %	Réduite	Incapable d'accomplir passe-temps/tâches ménagères *Maladie évidente*	Aide nécessaire occasionnellement	Normale ou diminuée	Normal ou confusion
50 %	Surtout assis/couché	Incapable de faire tout travail *Maladie avancée*	Beaucoup d'aide nécessaire	Normale ou diminuée	Normal ou confusion
40 %	Surtout alité	Incapable d'accomplir la majeure partie de ses activités *Maladie avancée*	Assistance requise la plupart du temps	Normale ou diminuée	Normal ou somnolence +/- confusion
30%	Toujours au lit	N'accomplit aucune activité *Maladie avancée*	Soins complets	Normale ou diminuée	Normal ou somnolence +/- confusion
20%	Toujours au lit	N'accomplit aucune activité *Maladie avancée*	Soins complets	Réduite à des gorgées	Normal ou somnolence +/- confusion
10%	Toujours au lit	N'accomplit aucune activité *Maladie avancée*	Soins complets	Soins de la bouche seulement	Somnolence ou coma +/- confusion
0%	Mort	-	-	-	-

Palliative Care Conference

Conférences palliatives

For residents with a significant decline: PPS < 40%

- Interdisciplinary care team, family, resident
- Family concerns
- Illness trajectory review
- Holistic care: physical, psychological, spiritual
- Goals of care / quality of life

Le plan: Pour les résidents avec un déclin significatif

- PPS/EPP inférieur à 40%, fragilité avancée et un prognostique inférieur d'un an
- L'équipe interdisciplinaire, familles, soignants et les résidents
- Plan de soins
- Plannification des soins et viser qualité de vie

PALLIATIVE CARE CONFERENCE: STAFF PLANNING CHECKLIST

Name of Resident: _____

Date of Palliative Care Conference

Date: ____/___/____ at ____:____ HRS.
DD/MM/YYYY

Location: _____

Room booked (yes/no): _____

Name of the legal SDM: _____

If it is a POAPC, has the document been provided to the long-term care home? Yes/No

Palliative Care Conference Facilitator: _____

RESIDENT/SDM/FAMILY QUESTIONNAIRE:

A Palliative Care Conference has been scheduled for _____ on _____.
Name of Resident Date

This Conference will be facilitated by _____.
Name of Facilitator

Please complete this questionnaire and return it to the facilitator before the conference if possible.

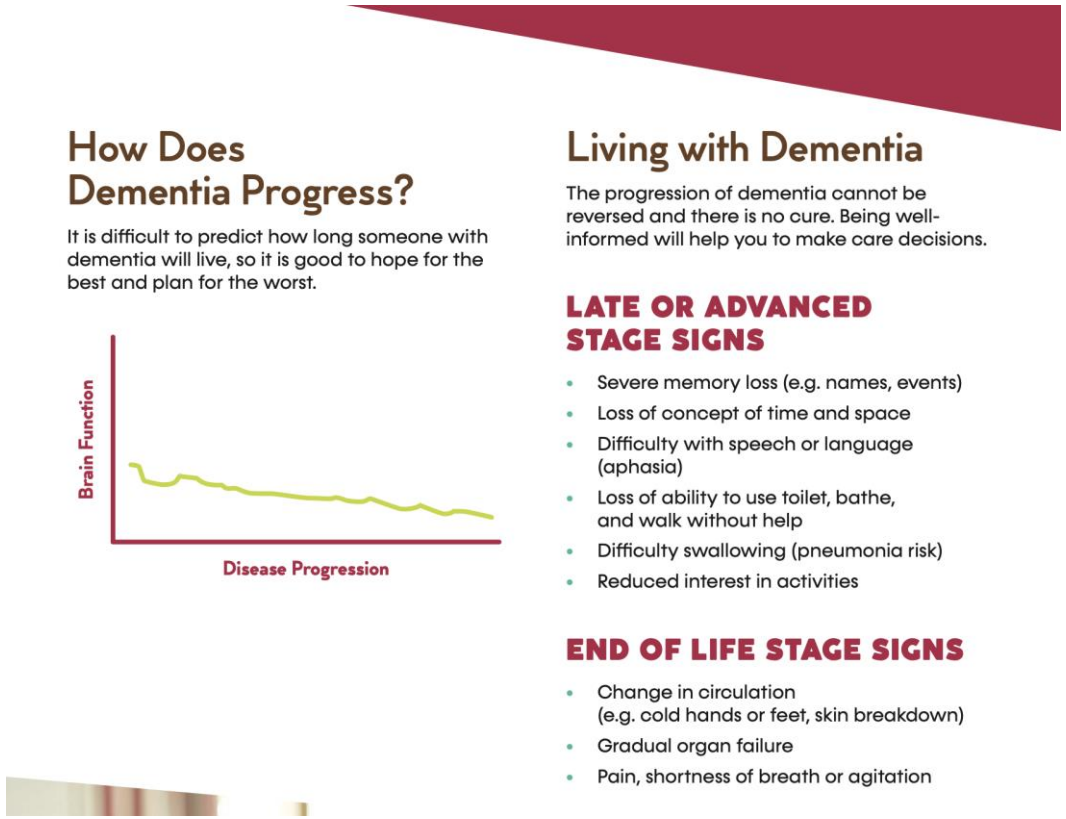
Today's date is: _____ My name is: _____

Please select one of the following.

☐ I am a resident living in this long-term care home
☐ I am the substitute decision maker (SDM) for a resident living in this long-term care home

Illness Trajectory Pamphlets

- Education of 5 high prevalence life-limited syndromes in LTC
- Tool to initiate discussion about end-of-life topics



How Does Dementia Progress?

It is difficult to predict how long someone with dementia will live, so it is good to hope for the best and plan for the worst.

Living with Dementia

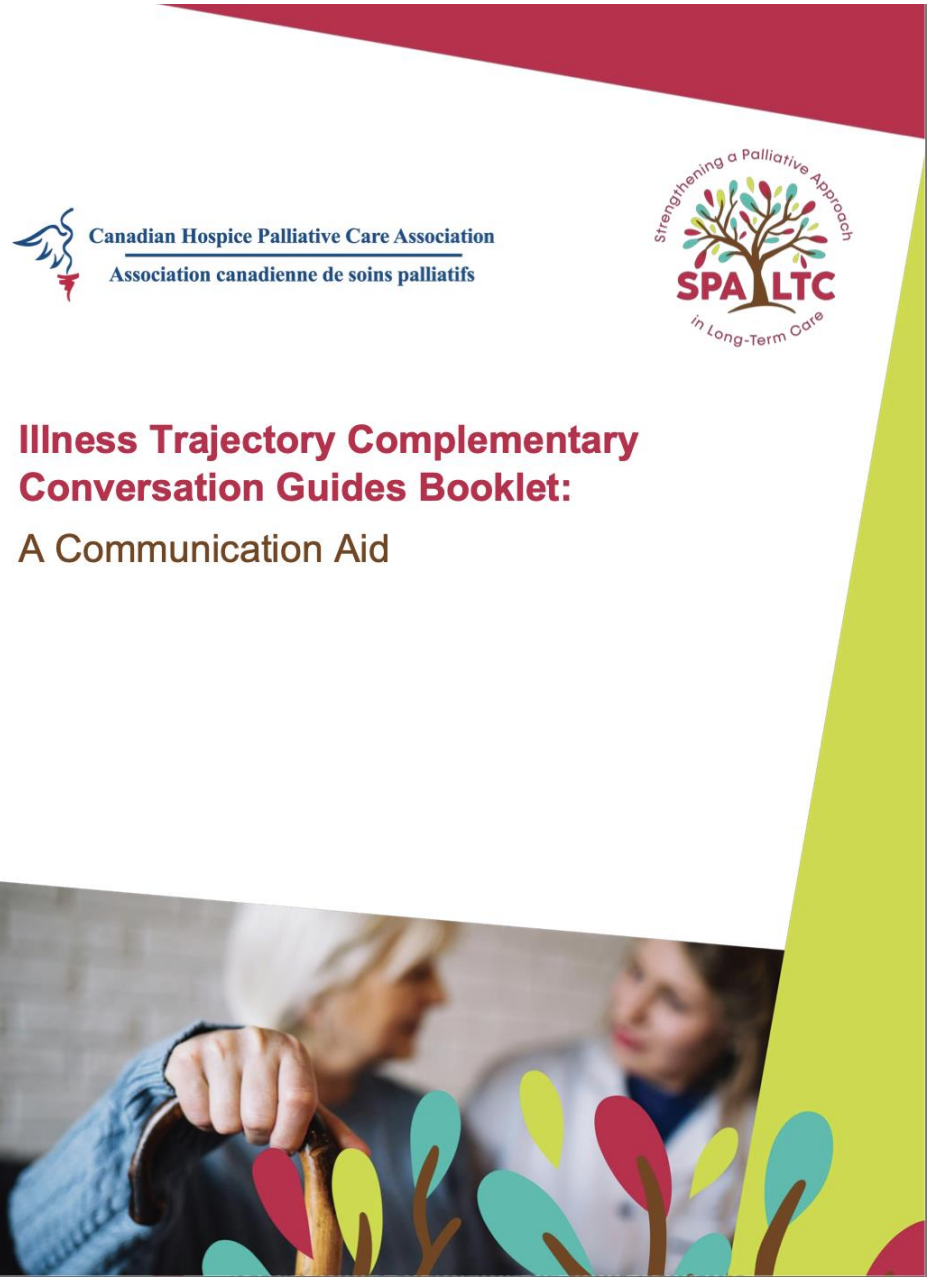
The progression of dementia cannot be reversed and there is no cure. Being well-informed will help you to make care decisions.

LATE OR ADVANCED STAGE SIGNS

- Severe memory loss (e.g. names, events)
- Loss of concept of time and space
- Difficulty with speech or language (aphasia)
- Loss of ability to use toilet, bathe, and walk without help
- Difficulty swallowing (pneumonia risk)
- Reduced interest in activities

END OF LIFE STAGE SIGNS

- Change in circulation (e.g. cold hands or feet, skin breakdown)
- Gradual organ failure
- Pain, shortness of breath or agitation



Canadian Hospice Palliative Care Association
Association canadienne de soins palliatifs

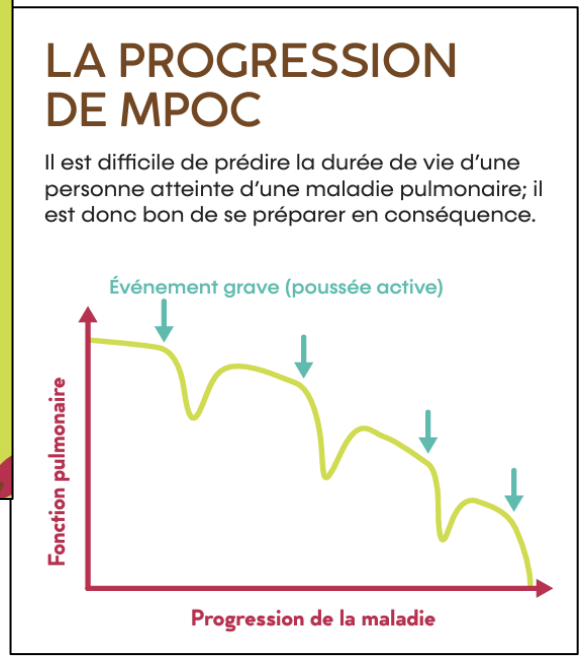
Strengthening a Palliative Approach in Long-Term Care
SPA LTC

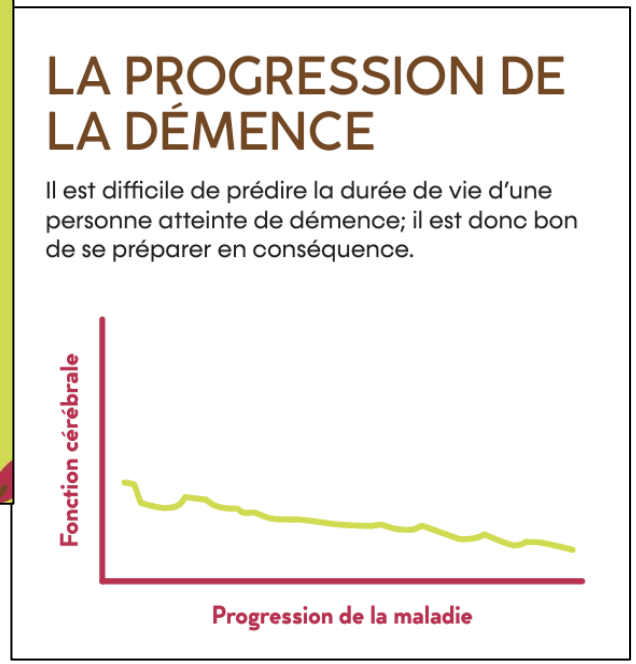
Illness Trajectory Complementary Conversation Guides Booklet:

A Communication Aid

Ressources sur la trajectoire de la maladie

- 5 ressources pour l'éducation des résidents et des familles
- Insuffisance cardiaque, insuffisance pulmonaire, insuffisance rénale, démence et fragilité





Advance Care Planning /

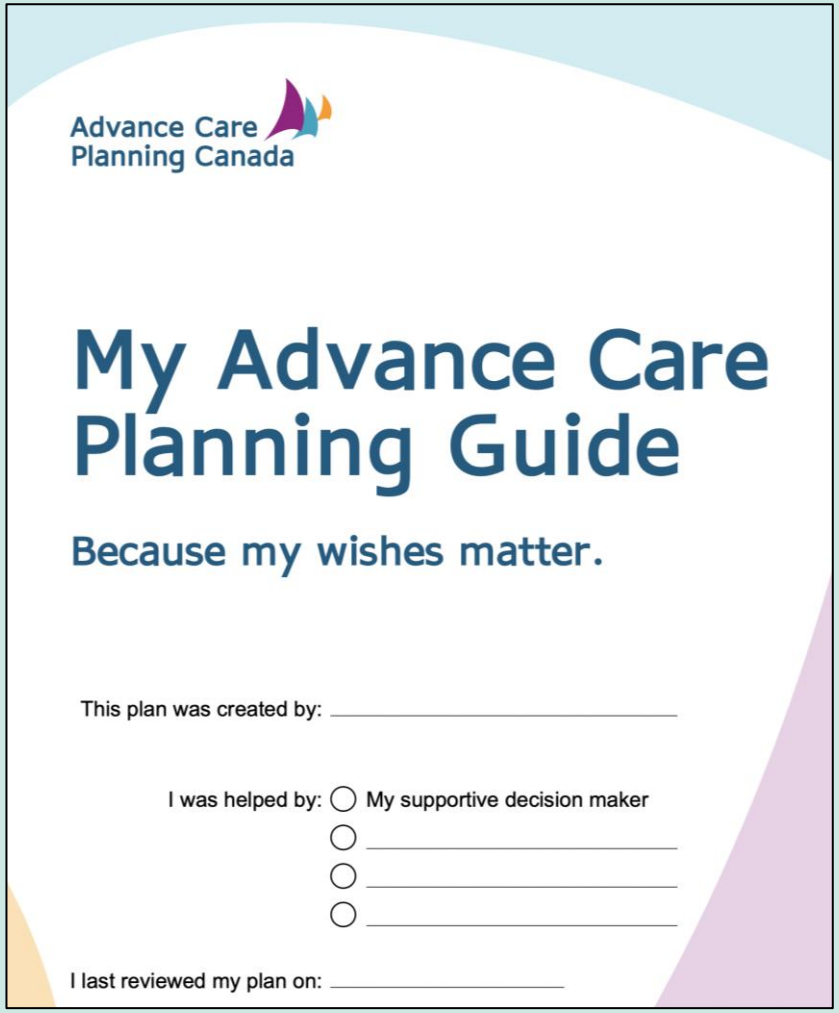
la planification préalable des soins

[Via SPALTC.CA]
Advancedcareplanning.ca
Planificationprealable.ca

Advancecareplanning.ca

Created by:

- Canadian Hospice Palliative Care Association
- Advance Care Planning Canada



planificationprealable.ca

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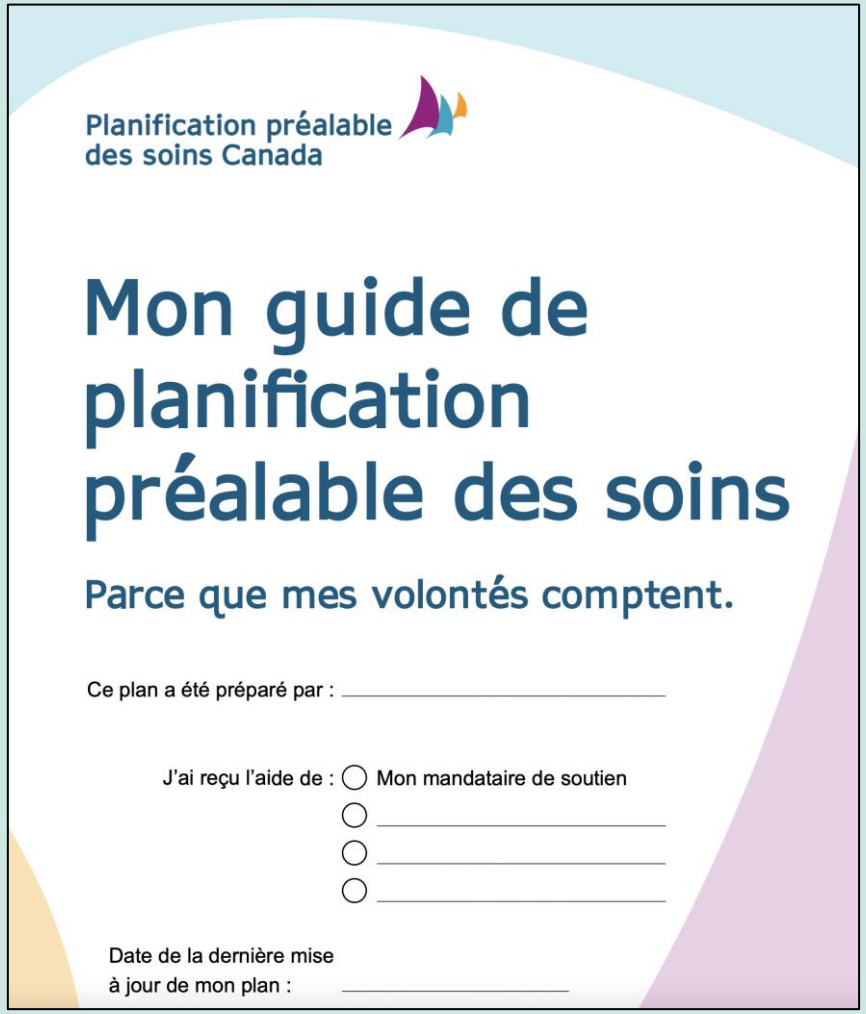


End of Life Care

HELPFUL THINGS TO CONSIDER:

- *The **body requires less food and fluid** during this time, it's the body's way of **preparing for a natural death**.*
- *Be reassured people are **not starving or thirsty**, this is a normal part of the dying process. It is the underlying disease that is causing these normal changes.*
- *Difficulty drinking and swallowing may **increase the risk of choking** and be **stressful for your loved one**.*
- *Keeping the **mouth clean and moist**, including lips, provides great comfort.*

After Death Care

Practical approaches to post-mortem care

SPA-LTC

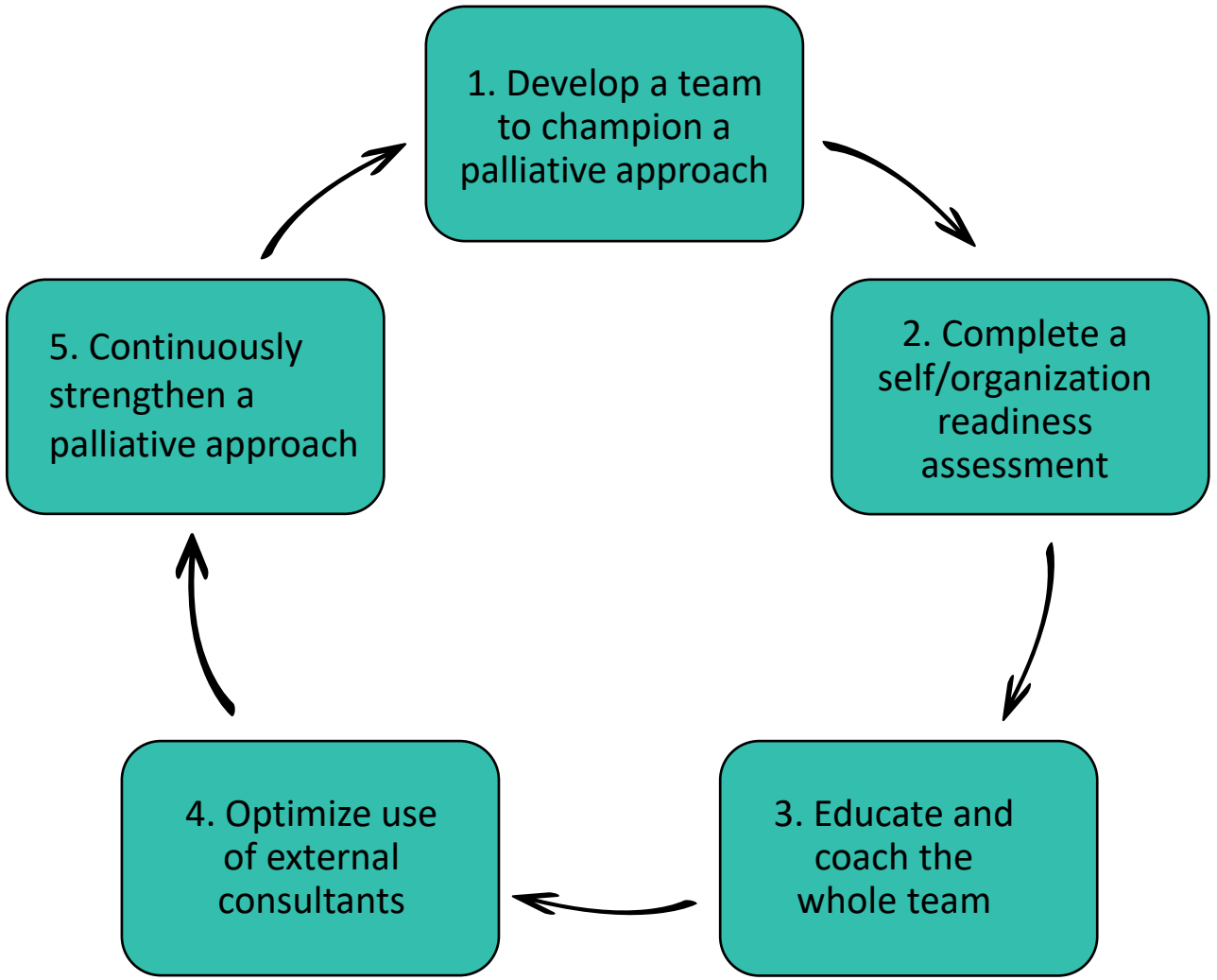
Phase 2 Implementation

1. Expanded Champion Education:
   - Bereavement Support
   - Integrating PPS into Process of Care
   - Leading Palliative Care Conferences
   - Educating Families / Advance Care Planning
   - Cultural Humility
2. New Leadership Masterclass: Culture Change
3. New Briefing for Medical Providers: Palliative Approach to Care & Medical Order Set
4. Virtual Community of Practice
5. Mentorship through consultations with Provincial Champions

CARE Process

1. EARLY Introduction to a Palliative Approach
   - Illness trajectory pamphlets
   - Clear, consistent communication
2. Regular Assessment Screening
   - Palliative Performance Scale (PPS)
3. Palliative Care Conference
   - PPS <40% or change
   - End-of-life care planning
4. Provide Bereavement Support

ORGANIZATIONAL Process



SPA-LTC Culture Care Series

1. Cultural Awareness
2. Trauma & Violence-Informed Care (TVIC)
3. Honouring Indigenous Wisdom

*Led by **Shae McCoy-Mackenzie**, LPN & Indigenous Provincial Palliative Care Champion with SPA-LTC*

Série de webinaires liés aux soins culturels de SPA-LTC

1. Sensibilisation culturelle dans les soins
2. Soins tenant compte des traumatismes et de la violence (TVIC)
3. Honorer la sagesse autochtone

*Animée par **Shae McCoy-Mackensie**, une IAA autochtone et Championne provinciale des soins palliatifs autochnones avec SPA-LTC.*

Phase 1 Engagement

Participation:	• 84% of LTC homes (61 / 73)
LEAP-LTC Education:	• 108 Palliative Champions from 57 facilities
SPA-LTC Training:	• 136 Champions, 90-113 attendees / webinar
End-of-Life Order Set Education:	• 17 LTC homes

Phase 2 Engagement - TBD

Case Examples

- Improved Functional Status Assessments:
  - Resident returned from ED with PPS 10% & End-of-Life orders
  - RN reassessment using PPS showed 40%
  - RN advocated for change in treatment plan, resident now participating in ADLs and showing improved QoL
- Improved Pain Assessment:
  - RN had differing pain assessment than PSWs
  - Supported RN in developing leadership to better understand PSW's assessment and education on utilizing the PAINAD tool
- Decreased transfers to acute care:
  - Uncontrolled pain for resident post-fall
  - Supported DOC to advocate for new opioid d/t suspected opioid toxicity
- Improved family satisfaction:
  - Resident verbalizing distress daily & desire to no longer live
  - Supported DOC to arrange Interdisciplinary care meeting with family to create resident-centred care plan

Thank you!

Merci!

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Informations générales sur l'étude